An investigation into the preparedness for and experiences in working with Māori nursing students among New Zealand tertiary institutes, schools and nurse educators

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Jennifer Rebecca Roberts

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Abstract

Nursing education in Aotearoa New Zealand is situated in a unique bicultural context. Māori, the Indigenous people of Aotearoa New Zealand have overall, poorer outcomes in health and education compared to non-Māori, which relate to the colonial legacy of the nation. One strategy to address Māori health outcomes is to increase the Māori nursing workforce. Despite a range of strategies in tertiary education and in nursing, the number of Māori nurses remains relatively static, and overall Māori nursing students do not have equity of educational outcomes in nursing. With a critical lens informed by Freire's Pedagogy of the Oppressed, this explanatory sequential mixed method study uses a questionnaire followed by interviews to understand the experiences and preparedness of nurse educators in working with Māori nursing students. The findings of the questionnaire demonstrate that throughout New Zealand, nursing schools and the educational institutes in which they are situated are informed by a range of strategies aimed at supporting Māori learners. Overall, nurse educators felt prepared to work with Māori, but the questionnaire also revealed resistance to Māori as priority learners. This finding was followed up in the interviews. Interview findings demonstrated that environments encompassing te ao Māori (the Māori world) and staff practises that aligned with this were enabling for Māori nursing students. Despite this, a counter-narrative described many barriers to this becoming fully realised in nursing education practice. Ongoing colonising practices in education, racism, varied understandings and practices of Cultural Safety and dissatisfaction with current Cultural Safety regulatory guidelines were found to be hindering a nursing culture that is responsive to Māori. The research posits that the nursing profession needs to develop a shared critical consciousness and refocus efforts to position Cultural Safety as a critical concept in nursing education and practice. One method proposed to achieve this is in returning to the original intent of Kawa Whakaruruhau/ Cultural Safety and begin to apply it as a decolonising model for nursing education and practice.

Acknowledgements

While this work carries my name there are many who have contributed to enabling me to complete it. I want to acknowledge those nurse academics who have gone before me and claimed space for nursing and nursing research.

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Finally, to my whānau- Ka nui te aroha!

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Glossary of Te Reo Māori

Ako	to learn, study, teach
Aotearoa	New Zealand
Awhi	to cherish, embrace, hug, surround, offer support
Hapū	sub-tribe
Iwi	tribe
Kaiāwhina	helper, assistant, advocate
Kaitiakitanga	guardianship, stewardship
Karakia	prayer
Kaumātua	older person with status within the family
Kawa Whakaruruhau	In New Zealand nursing, refers to Irihapeti Ramsden's theory of Cultural Safety. Irihapeti chose to capitalise both Cultural Safety and Kawa Whakaruruhau to denote the terms as legitimate evidence-based nursing theories.
Kia ora	hello, thank you, cheers
Kuia	older woman
Mana	personal prestige, power, influence, charisma
Manaakitanga	hospitality, kindness, care, support
Marae	formal Māori meeting place
Mātauranga	knowledge, education, understanding
Mihi	greeting
Pākehā	New Zealander of European decent
Pepeha	saying of one's ancestors
Pōwhiri	official welcome
Tamariki	children
Tangata Whenua	Indigenous people of the land
Tauira	student
Teina	younger, junior
Tino rangatiratanga	self-determination, autonomy
Te Reo	Māori language, an official language in New Zealand

Te ao Māori	the Māori world
Te Whare Wānanga o Awanuiārangi	Māori university based in Whakatāne
Tikanga	correct custom, procedure and practice
Tiriti o Waitangi	Te Reo Māori version of the Treaty of Waitangi singed between the Crown and Māori chiefs in 1840. Both the Reo and English versions are legal documents.
Tuakana	elder, more senior
Tuakana-Teina students	mentoring relationship between older and younger
Whānau	family group, extended family, may include people without kinship ties
Whanaungatanga	connection, relationships
Whakawhanaungatanga	establishing relationship and connections with people
Whare wānanga/ wānanga	university, place of higher learning
Waiata	song, to sing
Wairua	sprit, soul
Wairuatanga	spirituality
Whakatau	welcome
Whakataukī	Māori proverb

Chapter One

Introduction and Background

Tungia te ururu, kia tipu matomato te tupu o te harakeke

Clear the overgrowth to set the way for the new flax shoot that will spring forth

Introduction

This is a study about nursing education in Aotearoa New Zealand[1]. The study seeks to understand educational contexts, specifically nurse educators' understandings and experiences of working with Māori[2] nursing students. The above whakataukī[3] (Māori proverb) has been selected to begin this study as a metaphor to illustrate that a 'clearing' (of the past) is required to 'set the way for the new' if nursing education is to be genuinely responsive to the needs of Māori who are studying nursing in Aotearoa New Zealand. This investigation aims to clarify the challenges that exist for nursing educators by exploring and understanding their experiences that may lead to improved models of nursing education delivery, resulting in better outcomes for Māori students.

In this chapter, I introduce the motivation for this research and provide insight into my experiences, my place in Aotearoa New Zealand and my position in this study. Background context is then provided to describe the nursing educational landscape in New Zealand. The unique bicultural context of nursing in New Zealand, the colonial legacy, Cultural Safety and current context for Māori in nursing are described. The study purpose, aim and research questions are also stated in this chapter. This chapter concludes with a summary of the chapters that structure the thesis.

Te Reo Māori (Māori language) words and phrases are used throughout this thesis and approximate English translations are provided alongside each word or phrase in brackets. A glossary of Te Reo Māori used within this thesis is also provided. Though many of the words and phrases are commonly understood in New Zealand health and education contexts, translations are provided to ensure this work can be understood by an international audience.

[1] The Māori name for New Zealand, translated as 'Land of the Long White Cloud'. For this thesis the unified term of Aotearoa New Zealand is used.
[2] Indigenous person of Aotearoa New Zealand.
[3] Commonly translated as 'proverb' or 'aphorism', that utilises Māori imagery, ideologies, values and beliefs through 'set words' or 'formulaic expressions' to help describe or explain an idea and/or make a comparison – a Māori form of metaphor. These are being used throughout the thesis and feature mostly at the beginning of each chapter and in other selected parts.

Motivation for the Research

Understanding and improving education for Māori nursing students was the motivation for this study. The Ministry of Health have a clear goal to reduce health inequities for Māori (Ministry of Health, 2019). Part of this strategy involves growing the Māori nursing workforce so that it reflects the overall proportion of the Māori population, which will require a substantial increase of Māori nurses completing nursing education and entering the workforce. Understanding and improving education for Māori nursing students is an important part of achieving this goal.

My experiences in nursing and in nursing education have made me acutely aware of the educational and health inequities faced by groups that are not of the dominant, white New Zealand culture. As a member of the dominant culture in New Zealand, and as a nurse educator I am aware of my positions of privilege. In considering a meaningful topic to explore, I wanted to understand what it is that Pākehā can contribute to strategies designed to positively influence Māori in nursing and, to help realise Māori right to equity.

Ko wai au – Who am I?

I am Pākehā (non-Māori) and have a connection to European immigrants who came to the United States of America in the early 1900's. I was born in the state of Oregon, the daughter of a nurse. My family immigrated to New Zealand in the 1980's. I feel very privileged to call Aotearoa- New Zealand my turangawaewae (my standing place), my home, and it was around the time that I was enrolled in nursing school that I made the decision to become a New Zealand citizen.

I am aware that I have a place of privilege in society, by birth, ethnicity, education, and status, simply by belonging to the dominant culture in Aotearoa New Zealand. This privilege is referred to in literature as white privilege, that is, the benefit white New Zealanders have simply by being of the dominant group, where to be white is to be considered normal (Amundsen, 2018). I self-identify as Pākehā to acknowledge my place in Aotearoa New Zealand, to acknowledge that I am an immigrant and by extension, to acknowledge Māori as Indigenous to Aotearoa New Zealand. Identity as Pākehā is inseparably linked with Māori identity. Amundsen (2019) describes that identifying as Pākehā can be a political statement, and that to do so acknowledges Aotearoa New Zealand as a colonised nation and the relationship with Māori as tangata whenua (Indigenous people of the land).

My identity is also shaped by my profession. I have been a registered nurse for more than twenty years. I was a degree graduate in the 1990's when Cultural Safety[4] was a relatively new concept in undergraduate nursing curricula however, my interest in the topic wasn't particularly developed at that time, to me it just seemed a logical part of caring for people. As a new nurse I was full of inquiry, eager to learn, motivated to challenge the status quo and to be involved in change.

I commenced postgraduate study early in my career before there was government funding available for nurse's professional development. I found employers who encouraged me, invested in me, and gave me opportunities in clinical practice, education, research, and leadership positions that led me to where I am today. I have a Master of Nursing degree, which had a strong clinical focus reflecting my nursing practice role in cardiology at that time. However, teaching was always an aspiration.

Locating Myself in the Research

When I commenced this study, I was working in tertiary nursing education in the Institute of Technology and Polytechnic (ITP) sector. I started working in nursing education teaching students nursing practice, and then moved on to teach as an academic staff member in undergraduate and postgraduate nursing programmes. I did not have particular ambition to move into leadership however, my desire to have greater involvement in curriculum development led me to a position of leadership in a school of nursing delivering education in the Tairāwhiti and Hawkes Bay regions of Aotearoa New Zealand. Māori students represented almost fifty per cent of the student demographic in the organisation where I worked, which is significantly higher than most regions in Aotearoa New Zealand.

I first became interested in the experiences of Māori nursing students after being involved in several cases where Māori nursing students had been unsuccessful in the undergraduate programme. Extensive dialogue occurred with the students and their whānau (family), the local iwi (tribe), the Māori Health Unit of a regional District Health Board and Māori workforce development agency who had invested in these students. These were challenging situations, in which it became evident that there were gaps in communication and in the identification of student needs. Further to this, Māori graduates who had been successful in completing their nursing degree gave feedback about the difficulties they encountered throughout their period

[4] Cultural Safety is a New Zealand nursing theory by Ramsden (1990), that posits nursing care must be delivered in a way that is respectful and non-judgemental of culture and that all nursing care must take this into account. Care that is Culturally Safe is determined by the individual receiving care.

of study, where at times, a perceived lack of understanding and valuing of te ao Māori (Māori world view) was felt by students from within the educational environment.

The responsibility of being accountable for student achievement and student experience in my position at that time, led to my interest in better understanding how tertiary institutions, schools of nursing and staff within schools, understand and respond to Māori students' needs. This led me to my initial question, are we practising Cultural Safety[5] in the nursing education classroom?

As a registered nurse in New Zealand, I am accountable to the Nursing Council of New Zealand, the regulatory body that sets competencies and standards for nursing practice and nursing education programmes. My responsibility for Māori student experience led me to question how nurses within tertiary education demonstrate the Nursing Council competencies related to the application of the principles of the Tiriti o Waitangi or Treaty of Waitangi, Cultural Safety, and cultural competence within the learning environment. My personal experiences are not in isolation. Nationally and internationally perceived inequities in indigenous student education are well documented and are discussed in the review of literature chapter.

Halfway through this study my whānau (family) moved, and I started work in a strategic policy role at the Nursing Council of New Zealand (NCNZ) in Wellington. This role broadened my view of the literature and influenced the way that I have interpreted my findings. In addition to my experiences in education, I was able to look at this study with greater understanding of nursing regulation and how regulation may or may not influence education. Some of the data identified aspects of nursing that are within the Nursing Council's area of responsibility, so with that in mind, I have tried to understand the interplay between regulation, policy, education and practice when considering the findings and their implications.

I am critically aware in undertaking this study that my lens is Pākehā (non-Māori), and while I seek to understand issues related to Māori, I am limited in my interpretations because I am not. Many of the themes and recommendations reflect the ongoing effects of colonisation and are critical of my profession and the dominant culture that I belong to. I have at times questioned the legitimacy of my work as it relates to anything Indigenous, however, I am encouraged by the words of Donald (2009) who asserts, "If colonialism is indeed a shared condition, then decolonisation needs to be a shared endeavour" (p. 5). Berryman and Eley (2017) similarly speak of the collective responsibility to affect educational change, and that to

[5] Ramsden chose to capitalise Cultural Safety to emphasise it as a theoretical model, as a process that has a legitimate place in nursing education and practice (2002). For that reason, both Cultural Safety and Kawa Whakaruruhau are capitalized throughout this study.

be transformational, all individuals have a role to play in achieving equity. It is with a sense of collective responsibility for social justice as an educator and as a nurse that I have undertaken this research, a project that connects issues of inequities in education and health and seeks ways to redress them.

The Context of Nursing and Nursing Education in Aotearoa New Zealand

This section provides an overview of nursing in Aotearoa New Zealand as background and context to the study. It is helpful to commence by explaining the legislation and legislative authority in relation to nursing and nursing education and the key historical developments in nursing education in Aotearoa New Zealand. The current context of undergraduate nursing education for the registered nurse is then described, including the range of settings of nursing education in Aotearoa New Zealand, as well as programme and student characteristics. Socio-political influences and current issues in nursing and nursing education are then explored, with discussion on health and education of Māori (Indigenous people of Aotearoa New Zealand).

Nursing is a regulated professional in Aotearoa New Zealand. Nurses in Aotearoa New Zealand have been registered since 1901 under the Nurses Registration Act and were the first internationally to achieve this (Jacobs, 2005). For years after this, nurses were regulated under the Nurses Act (1977). Today, nursing is one of seventeen regulated health professions under the Health Practitioners Competence Assurance Act (HPCAA) (2003). The purpose of the act is, "to protect the health and safety of members of the public by providing for mechanism to ensure that health practitioners are competent and fit to practise their professions" (HPCAA, 2003, s3(1)).

The HPCAA (2003) requires each profession to be regulated by a legislated responsible authority, and delegates core responsibilities to named authorities whose statutory role is to regulate its practitioners. For nurses, this is the Nursing Council of New Zealand (NCNZ).

The NCNZ has a number of regulatory functions under the HPCAA, many which relate to nursing education. Some of the functions of professional regulation include to determine scopes of practice of the profession, prescribe the qualifications required for the profession's scopes of practice, accredit and monitor schools of nursing and set standards of clinical and cultural competence and for conduct (HPCAA, 2003). There are three NCNZ scopes of nursing practice in Aotearoa New Zealand:

- Enrolled nurse
- Registered nurse

- Nurse practitioner

NCNZ prescribes the qualifications, programme standards and competencies for each scope. Whilst there are currently three scopes of nursing practice and specific educational preparation for each, this study is concerned with the largest group of nurses in Aotearoa New Zealand, registered nurses. Discussion of nursing education in this study specifically focuses on undergraduate preparation for the registered nurse scope of practice, unless otherwise stated.

History and Development of Nursing Education in Aotearoa New Zealand

Nursing education in Aotearoa New Zealand was based on a hospital apprenticeship model until the 1970's. At that time, the government invited Dr Helen Carpenter a World Health Organisation (WHO) consultant from Canada to review nursing education in New Zealand (Jacobs, 2005; Vernon, 2013). The review was commissioned at a time when student fail rates were high in apprenticeship programmes. In 1971, the report *An improved system of nursing education in New Zealand* (Carpenter, 1971) (the Carpenter Report) was released. The Carpenter Report recommended the transfer of nursing education from hospitals to tertiary education institutes, with student's practical learning experiences occurring in local hospital and health settings. The Carpenter report recommended that nursing education should be in 'technical' institutes or polytechnics, and transfer to these educational settings began in 1973. The last hospital programme closed in 1989 (Jacobs, 2005; Workforce Development Group, Department of Health, 1988).

Polytechnic based vocational education comprising of three-year nursing diplomas became the mainstay of nursing education until the 1990's. Following an amendment to The Education Act (1990) that enabled polytechnics/Institutes of technology to offer degree level programmes, a group of nursing leaders met in 1991 to discuss moving nursing education for registered nurses to a degree (Jacobs, 2005). *Vision 2000- A Framework for nursing/midwifery education* (1992) was the report produced by the group, which proposed that entry to the register going forward be by degree qualification. The proposal was accepted by the profession and was in line with education trends for nursing internationally. Soon after, NCNZ amended its education programme standards so that programmes leading to the registered nurse scope of practice were now by degree.

Despite nursing having transferred to educational settings through the 1980's and nursing degree qualifications being the educational standard from the 1990's, differing views remain around this. Discourse about 'hospital' training being superior and producing more work-ready nurses than those with degrees persists today. Some literature refers to this as 'too posh to

wash', or that nurses have become too academic to be caring (Darbyshire, Thompson & Watson, 2018; Oliver, 2017). Conversely, there is a wealth of literature discrediting these viewpoints, that demonstrate the positive influence on patient safety and other health outcomes that are directly related to the level of nursing knowledge, skill and competence of degree-prepared nurses (Aiken, Clarke & Cheung, 2003; Kelly, McHugh & Aiken, 2012; Aiken, Clarke, Sloane, Sochalski & Silber, 2002). However, tensions remain within the profession and are illustrative of a division in nursing values and understandings of nurse education.

Tensions and power struggles over nursing education have also played out in public and political fora. Perhaps a most noteworthy illustration of this was the introduction of Cultural Safety to nursing education in the early 1990's. The historical origin, interpretations of and development of Cultural Safety are explored in more detail in chapter two, however, it is a critical aspect of the development of nursing education in Aotearoa New Zealand and plays a central role in this study.

Introduction of Cultural Safety to Nursing

Cultural Safety was originally introduced as part of regulated educational requirements by the Nursing Council in 1992. Cultural Safety was designed as a model of education to educate nurses to be non-judgemental of people they may care for, to be aware of their own culture and how that may impact on others, to be aware of cultural differences and importantly of the impacts of colonisation on Māori (Ramsden, 1990; 1992).

Cultural Safety is considered an outcome of nursing education, that is, to produce reflective, self-aware, and culturally safe nurses for practice. The first guidelines were explicit in their origins in Māoritanga (Māori way of life). Titled, *Kawa Whakaruruhau: Guidelines for Nursing and Midwifery Education*, the document is clear about Cultural Safety needing to begin with Māori (Ramsden, 1992). It states, …

> because of the serious health status of the indigenous people of Aotearoa and the real possibility of the disappearance of the culture and language under the stress of the colonial history…Cultural Safety must begin with the tangata whenua (indigenous people of the land) (Ramsden, 1992, p.4).

However, Cultural Safety also applies to others. The extension of the theory as it applies to non-Māori is described as a protective cloak. As the original guidelines describe, Māori have defined Cultural Safety and, "extend its principles as a korowai (cloak) to shelter those other cultures who come to live in this country" (p.4).

From the inception, the introduction of Cultural Safety into nursing was surrounded by controversy, with close media attention and public scrutiny (Papps & Ramsden, 1996). Nursing education and regulation came to public attention in the 1990s for the inclusion of Cultural Safety in curricula, the state exam and as a competency for nurses. Public outcry ensued, and a Parliamentary select committee enquiry was triggered, but was satisfied by an external review of Cultural Safety in nursing education undertaken by Murchie and Spoonely (1995). The result was that Cultural Safety was retained in nursing education, although the definition was significantly revised to make it more palatable to the public, as it was clear at that time there was racist resistance and ignorance in Aotearoa New Zealand of the critical link of culture to health and wellness.

Current Landscape of Registered Nurse Education

Currently, there are seventeen schools of nursing offering twenty undergraduate nursing degrees in New Zealand (Table 3) (Nursing Education in the Tertiary Sector (NETS), n.d.). Most undergraduate students of nursing are located in the Institutes of Technology and Polytechnics (ITP) sector, with smaller numbers located in universities.

Table 1

Tertiary Institutes Offering Baccalaureate Nursing Programmes that have Nursing Council of New Zealand Approval [6]

Institute	**Location(s)**
Northtec	Whangarei, Northland
University of Auckland	Auckland
Auckland University of Technology (AUT)	Auckland
Unitec- Auckland	Auckland
Manukau Institute of Technology (MIT)	Auckland
WINTEC	Hamilton
Toi Ohomai Institute of Technology	Rotorua, Tauranga
Te Whare Wānanga o Awanuiārangi	Whakatāne
Massey University	Auckland, Palmerston North, Wellington
Universal College of Learning (UCOL)	Palmerston North, Wairarapa, Wanganui
Eastern Institute of Technology (EIT)	Hawkes Bay, Tairāwhiti
Whitireia Community Polytechnic	Porirua
Western Institute of Technology (WIT)	New Plymouth, Taranaki
Nelson Marlborough Institute of Technology (NMIT)	Nelson-Marlborough
Ara Institute of Canterbury (Formerly CPIT)	Christchurch, West Coast
Otago Polytechnic	Dunedin
Southern Institute of Technology (SIT)	Invercargill

Some schools of nursing offer more than one registered nurse programme. Whitireia and Manukau Institute of Technology both offer 'mainstream' nursing degrees as well as culturally specific nursing degrees with Māori and/ or Pacific foci. Te Whare Wānanga o Awanuiārangi offers Te Ohanga Mataora: Bachelor of Health Sciences Māori, a programme designed to be delivered in a Kaupapa Māori (Māori world view) environment. This programme, like other culturally specific nursing programmes, was designed to foster the cultural knowledge and strengths of nursing students so they may bring this to their nursing practice, as well as to help grow the Māori workforce. In 2019, the Wānanga experienced growth in their student

[6] Note: This was the nursing educational landscape during the data collection phase of the research, however, this changed 1 April 2020 following the Labour government Review of Vocational Education (RoVE) and subsequent legislative changes which merged all ITP's into one entity, The New Zealand Institute of Skills and Technology.

numbers, and increased demand for their programme by non-Māori (D. Rowe, personal communication, June 13, 2019).

A more recent trend in Aotearoa New Zealand is the development of graduate entry pre-registration programmes. Graduate entry programmes are designed for students who already have a bachelor's degree (from a discipline other than nursing) who are looking to change career and become registered nurses. Advantages of this programme of nursing mean graduates can qualify in a shorter two-year time frame and achieve a higher qualification (University of Otago, 2019). The first graduate entry programme in Aotearoa New Zealand was developed by the University of Otago, accredited by NCNZ in 2015 and had the first intake of students in 2016. Graduate entry programmes appear to be a growing trend in Aotearoa New Zealand with five schools now offering pre-registration programmes at master's level. There were two at the commencement of this study and neither had graduated a cohort of students at that time, hence they were not included in this study.

Students of Nursing in Aotearoa

In 2016 NCNZ collated data from school of nursing annual reports to create a picture of student demographics in nursing (NCNZ, 2016a). In 2016 there were 6,859 students enrolled in Bachelor of Nursing programmes nationally. The majority (5, 522) were in fourteen ITPs with a smaller proportion (1,337) in three universities. Student demographics varied across programmes and regions. In general, students studying in universities were younger and those in ITPs were older. The universities, and one polytechnic had the greatest percentage (≥80 per cent) of younger learners. The remaining ITPs had less than 60 percent of students aged under 25. Most students were domestic with international students making up only 5 percent of student cohorts nationally. Ten percent of students identified as Pacific and 17 percent Māori nationally. There were a smaller proportion of Māori learners in the universities with the greatest percentage of Māori students located in regions with a greater general population of Māori, such as Northland, Whakatāne, Tairāwhiti, Hawkes Bay and Rotorua.

Changes in the Education Environment

Political influence continues to affect nursing education, related to funding and both health and education ministerial priorities and expectations. Most recently the reform of vocational education (RoVE) announced by the Labour government has resulted in the disestablishment of the sixteen ITPs and the creation of one educational entity, the New Zealand Institute of Skills and Technology. This required a change to legislation and the Education (Vocational

Education and Training Reform) Amendment Bill (2019) was enacted as of 1 April 2020. Though this reform stated that degree programmes were not part of the scope, the major structural and governance changes may influence nursing education going forward, given that nursing makes up the largest cohorts of degree students within the ITP sector. The full implications of this change are yet unknown.

The Context of Aotearoa New Zealand's Colonial History and Current Impacts

Aotearoa New Zealand is a colonised nation. Māori are Indigenous to the land, having inhabited it since the 1300's. Westerners arrived in the 1800's and began trade and settling in Aotearoa New Zealand (Belgrave, 2019). Unlike many colonised nations, Aotearoa New Zealand has a treaty, the Tiriti o Waitangi or Treaty of Waitangi which was signed between Māori and the British Crown in 1840. The Tiriti or Treaty is considered a foundational document in Aotearoa New Zealand and both versions signed in Te Reo and English are recognised legal documents. Crown/ government entities such as health and education providers are required to uphold the principles of the Tiriti orTreaty, recognising the unique position of Māori in their daily business.

The effects of colonisation on Māori, like many Indigenous populations worldwide, have been well documented (Hingangaroa- Smith, 2000). Colonisation and the subsequent devaluing of Māoridom by the dominant Pākehā (non-Māori) culture has negatively impacted Māori on many levels including health, education, political, economic and social levels (Harris, Tobias, Jefferys, Waldegrave, Karlsen & Nazroo, 2006a; Hingaangaroa-Smith, 2000; Huria, Cuddy, Lacey & Pitama, 2014). In recognition of the effects of colonisation and the unique struggles of Indigenous people around the world the United Nations Declaration on the Rights of Indigenous People (2008) and in New Zealand the commitment to the Tiriti o Waitangi or Treaty of Waitangi go some way to protect Māori and make reparation for the damage caused through colonisation. Though this is contestable.

The United Nations Declaration on the Rights of Indigenous People (UNDRIP) (2008) calls for societies to ensure the rights of Indigenous peoples to improved economic and social conditions particularly, education, employment, health, and social security. Article 21 of the declaration says, "States shall take effective measures and, where appropriate, special measures to ensure continuing improvements of their economic and social conditions" (United Nations, 2008, p. 9). This document while not legally binding, provides the most comprehensive internationally agreed upon framework for the rights and wellbeing of Indigenous peoples. In some countries around the world these rights are upheld, and efforts

are made to ensure Indigenous protection and equity is reflected in government policy and action. Unlike UNDRIP, the Tiriti o Waitangi or Treaty of Waitangi are legally binding and the two are closely aligned in principles (Human Rights Commission, 2016). The eventual acknowledgement of the Tiriti o Waitangi or Treaty of Waitangi by New Zealand governments is reflected to some extent in the education and health sectors today and has shaped the delivery of both.

Māori and Tertiary Education

Diversity and inclusivity are important social drivers in education in New Zealand, particularly, the notion of parity and success for all learners. The Tertiary Education Strategy 2014-2019 (Ministry of Education, 2014) recognises the interconnectedness of socioeconomic inequities and strategically positions Māori students as priority learners. Currently there is a growing younger Māori population and while participation in tertiary education has increased, participation is less than non-Māori. Likewise, completion of qualifications remains less than non-Māori. The Tertiary Education Strategy indicators of success for Māori include progression through lower level qualifications and enrolment in qualifications that are level four and above and better employment outcomes for Māori graduates. Within tertiary education organisations, the strategy suggests targets should be set for Māori student achievement to close the gap between Māori and non-Maori learners as well as in increasing the number of Māori academic staff (Ministry of Education, 2014).

Educational disparities in tertiary education are unacceptable. While Māori engagement in tertiary education has increased in recent years, more progress is required. Māori participation in programmes at level four and higher is below average (16% compared with 23% of total population) and qualification completion rates are 62% for Māori compared with 74% of total population (Ministry of Education, 2014). Statistics for Māori in nursing education while better than the national average of completion rates for all qualifications, still reflect that Māori achieve less than non-Māori (Ngā Manukura o Āpōpō, 2014, Wilson, McKinney & Rapata-Hanning, 2011). In part, these statistics can be explained by the barriers that Māori students face in tertiary education, a Eurocentric educational system, socio-economic factors extrinsic to the classroom as well as intrinsic factors in the classroom such as teaching style. As described, there are seventeen schools that offer nursing education in Aotearoa New Zealand each with a different curriculum. Although every school is audited against the Nursing Council's standards for nursing education, there are undoubtedly differences in organisational culture, approach to Māori students, and variance in teacher capabilities and expertise.

Nursing education is the foundation for the profession's approach to practice. This includes the commitment to the Tiriti o Waitangi or Treaty of Waitangi and developing each nurse's competence in cultural care and Cultural Safety (Nursing Council of New Zealand, 2011).

Achievement of Māori nursing students is critical not only for the betterment of those individuals in achieving a tertiary qualification and entering the workforce, but also in their potential to positively influence the health of Māori. Nurses, particularly Māori have the potential to reach those most in need of health services. Internationally, Indigenous nursing students are seen as critical to the future workforce due to their unique ability to contribute to the health and wellbeing of Indigenous communities (Bednarz, Schim & Doorenbos, 2010; Gilchrist & Rector, 2007; Martin & Seguire, 2013; West, Usher, Buettner, Foster, & Stewart, 2013). However, the achievement rates of Indigenous nursing students are less than non-Indigenous nursing students.

Leaders in nursing education in New Zealand are charged with ensuring the nursing curriculum leading to registration meets the standards set by the Nursing Council, that graduates are safely prepared for employment and are able to meet complex health needs of the population. The Ministry of Health has called for an increase in the Māori nursing workforce to better reflect the general population (Wilson et al., 2011). Currently eight per cent of the nursing workforce identify as Māori as compared with 16.5 per cent of the general population (Nursing Council of New Zealand, 2020; Statistics New Zealand, 2013). As the largest health workforce, nurses, particularly Māori nurses, have the potential to positively affect health disparities in New Zealand (Harris et al., 2006a; 2006b, Ratima, Brown, Garret, Wikaire, Ngawati, Aspin & Potaka, 2007; Theunissen, 2011; & Wilson et al., 2011). Nurses are well positioned to exert their influence in addressing the health disparities between Indigenous and non-Indigenous people; however, the ability to address these is hindered, in part, by the disproportionately low numbers of Indigenous nurses (Foxall, 2013).

Research Aim, Purpose, and Questions

The aim of this research is to determine how New Zealand tertiary education institutions, schools of nursing and nurse educators respond to Māori nursing students' learning needs.

The purpose of this study is to explore how New Zealand tertiary educational institutes prepare for and work with Māori nursing students. The study is guided by the following research questions:

- What are the institutional and school strategies that seek to support Māori nursing students?
- What are nurse leaders' and educators' perceptions of barriers and enablers in providing nursing education to Māori nursing students?
- How do nurse educators understand and interpret cultural safety in nursing education?
- How do nurse educators' practice and apply the concepts of cultural safety in nursing education?

Conceptual Framework/Study Design

This study is about undergraduate nursing education in New Zealand. Within the scope of the study are schools of nursing within tertiary education institutions that offer undergraduate nursing education programmes. Participants include those in leadership positions (such as head of school, programme leader) within schools of nursing and academic staff who teach in undergraduate nursing programmes (See Figure 1). The study does not include students.

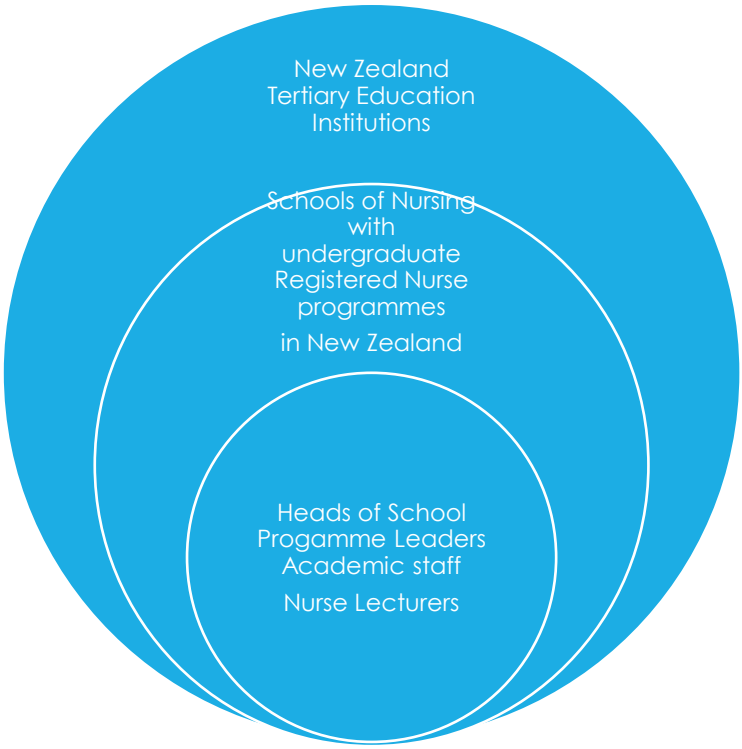

Figure 1. Conceptual framework/scope of proposed study.

Significance of the Research

At a macro level, this research is framed from a social justice position, where equity for all citizens is paramount. Furthermore, in the context of Aotearoa New Zealand, equity is a

guaranteed right to Māori under the Tiriti o Waitangi or Treaty of Waitangi. In the context of nursing education, the significance of this research is in understanding practices in nursing education that will contribute to achieving a positive learning environment and promote equity of outcomes for Māori.

This research will be relevant and significant to the Aotearoa New Zealand nursing profession and to the tertiary education sector in general. It describes current practice in relation to Māori student success in schools of nursing in New Zealand. It also may assist nursing leaders and educators to identify barriers and enablers in providing nursing education to Māori nursing students and explore the application of Cultural Safety in nursing education practice. The findings also have implications for policy and the nursing regulatory body to consider in terms understandings, standards, and measurement of Cultural Safety. Findings and recommendations may also be of interest internationally for educators working with Indigenous students of nursing.

Structure of the Thesis – Chapter Summaries

Chapter one: Introduction and background

This thesis is made up of eight chapters including this one. This chapter has provided an introduction and background to the research and to the researcher. The research aim, purpose and research questions have been stated. The context of nursing and nursing education and significant historical events in Aotearoa New Zealand have been provided as background. An introduction to the theoretical concept of Cultural Safety in nursing has been provided and will be built upon throughout this research. The current landscape of nursing education, student characteristics, distribution of nursing education providers have been outlined. The significance of this research has been described and positioned in the colonial context of Aotearoa New Zealand, and the impacts of this on Māori learners outlined.

Chapter two: Review of the literature

Chapter two reviews the literature from a range of disciplines nationally and internationally. This study is situated in nursing education and draws from nursing knowledge and educational knowledge. Additionally, literature exploring Indigenous knowledge and understandings have been drawn upon to inform this work and to identify gaps within the current knowledge base. The review of literature begins with an exploration of the barriers and enablers of Māori student success. Factors involving student, external barriers, teaching practices and institutional culture are explored. Examples of culturally responsive education models are

explored, with specific emphasis on Māori specific approaches. Cultural Safety is explored in greater depth, from its inception in Aotearoa New Zealand, to international examples of how it has been adapted and applied. Māori nurses' experiences are also explored. This chapter situates this study within the context of the wider literature and identifies gaps in the existing knowledge. In doing so it provides a reference point for the commencement of this study.

Chapter three: The research design and process

Chapter three provides detail about how the study has been designed and conducted. The chapter begins by identifying the intrinsic assumptions of the research and locates me as a researcher within the work. Formal theoretical perspectives of the research are then outline, which include how Critical Theory, Freire's Pedagogy of the Oppressed, and Kaupapa Māori principles have informed and guided my approach. The research is a mixed method, explanatory sequential design, the rational for this design is explained. Ethical considerations are addressed in this chapter including how I have addressed my responsibilities as a researcher in Aotearoa New Zealand to be responsive to te Tiriti o Waitangi or Treaty of Waitangi. The research process of the two phases of the study, a questionnaire, followed by participant interviews are then described in detail so that the processes I have undertaken in this study are clear and auditable.

Chapter four: Phase one: Findings of the questionnaire

Chapter four is the first of three chapters, presenting the findings of the study. Here, the first phase of the study findings, the results of the questionnaire are presented. Questionnaire findings are presented under seven headings that align with the sections of the questionnaire. The demographics of the participants are first described. Nurse educators from around Aotearoa New Zealand, working in both the ITP and university sectors provided data about institutional and school of nursing approaches to working with Māori students. The results were varied and reveal a disjointed approach to working with and supporting Māori nursing students nationally. The latter part of the questionnaire explored school of nursing staff preparedness for working with Māori. While participants overall expressed confidence in working with Māori, there was a sense of resistance and some negativity to Māori as priority learners[7] that was evident in the text comments. This was an area of interest that helped to inform the interviews in phase two of the study.

[7] This terminology, *Māori as priority learners*, is used throughout the study. It is based on the Ministry of Education's Tertiary Education Strategy (2014) which uses this phrase as part of a strategic plan for the provision of tertiary education to achieve equity for Māori.

Chapter five: Phase two: Findings of the interviews – Part one

Chapter five presents the first half of the findings from the 10 participant interviews. Here, the participants are described to provide context to their narratives. In this chapter nurse educators' understandings and practices of Cultural Safety are described through themes constructed through a thematic analysis process. Participants understanding of Cultural Safety varied and a distinction was made between the concepts of Cultural Safety and Kawa Whakaruruhau. Practices of Cultural Safety were framed through themes based on te ao Māori (Māori worldview) and values. These participant descriptions provide insight into what culturally safe practice in nursing education may look like.

Chapter six: Phase two: Findings of the interviews – Part two

Chapter six presents the second half of the findings from the interviews. This chapter provides a counter-narrative to the positive practices described in the previous chapter. Here, challenges to teaching Cultural Safety, and resistance to Māori as priority learners are revealed. The findings in this chapter uncover deep seated issues related to colonial power, control, structures and thinking that impact nursing education and practice. Issues with Cultural Safety as a concept and practice in nurse education and nursing practice are identified.

Chapter seven: Discussion

Chapter seven begins with a summary of the research findings as an integrated whole and demonstrates how the findings have provided responses to the research questions. In depth, critical discussion is then offered, linking with literature and theoretical principles.

Chapter eight: Conclusion and recommendations

Chapter eight conclude this thesis. Here, recommendations to the nursing profession, to the regulator and to nursing education are offered. The limitations of the research, the contribution this research offers, and reflection on the process are provided.

Chapter Summary

This chapter has provided an introduction and background to nursing education in Aotearoa New Zealand so that the research can be placed and interpreted in context. The unique bicultural landscape of Aotearoa New Zealand has been outlined, because it is a critical context for this study. The research aim, purpose and research questions have been identified and the rationale for the study has been provided. Importantly, an introduction to me as the

researcher has been provided, so that my experience, credibility, and biases may be transparent to the reader. The next chapter takes an in-depth examination of the literature and identifies gaps in the knowledge base which serve to position this study.

Chapter Two

Literature Review

Ma pango, ma whero, kai oti te mahi

With the black thread and the red thread, the work is done

Introduction

This review of literature seeks to identify what is known about Indigenous student success. Literature from the compulsory and tertiary education sectors will be explored with respect to barriers and enablers to Indigenous student success. The focus of the review is on Indigenous students in general and then narrows to explore Indigenous student success in nursing education. International literature is explored, and then specific literature related to Māori students in New Zealand is examined. The concept of Cultural Safety in nursing education in Aotearoa New Zealand is then defined and discussed in relation to Māori nursing student success.

Barriers and Enablers to Indigenous Student Success

> Pākehā and Māori are joined at the historical hip. (Colquhoun, 2012, p. 38)

Barriers and enablers to Indigenous student success are common across the education spectrum. Bolstad, Gilbert, McDowall, Bull, Boyd, & Hipkins, (2012) describe 'wicked problems' as those that span multiple realms, economic, social, educational, health, political and moral (p. 12). Many of the barriers hindering Indigenous student success are characteristic of deeper problems that are interconnected and are not easily solved.

History and colonisation provide the background context for numerous disadvantages faced by Indigenous people internationally. These disadvantages can be seen in Indigenous people's overrepresentation in the lower socioeconomic bracket, with lower levels of, and participation in education, higher morbidity and mortality rates and poorer health status overall (Harris et al., 2006a; 2006b; Huria et al., 2014; Theunissen, 2011). It is against this background context that student success is examined. While focussing on barriers and enablers of Indigenous student experience, and actions within the learning environment which may be influential on Indigenous student success, the complex historical and contemporary socio-political context are acknowledged as powerful influences in education.

The following themes related to Indigenous student success emerged from the literature: preparedness for study, self-concept(s); effective relationships, institutional culture and racism and unconscious bias.

Preparedness for Study

Internationally Indigenous students achieve less than non-Indigenous students in the compulsory school sector as well as in tertiary education. Bowser, Danaher and Somasunsaram (2007) describe the disadvantage Aboriginal and Torres Strait Islanders experience in Australia where in 2004, eighteen per cent of Aboriginal and Torres Strait Islanders and forty-one per cent of non-Indigenous Australians were likely to complete the final year of high school. A longitudinal three-year study of Aboriginal and Torres StraIt Islander students in university found these students were not only less prepared for tertiary study, but they lacked specific skills to learn in adaptive ways over the duration of the study (Boulton-Lewis, Marton, Lewis, & Wilss, 2004). Pacific Islands students in New Zealand have similar high school completion statistics where a quarter of Pacific Islands students left with no qualifications and less than ten per cent achieved a qualification that would enable university entrance (Benseman, Coxon, Anderson & Anae, 2006; Education Counts, 2010).

A national survey of 108 Māori nursing students found that although students met the programme entry requirements 63 per cent reported that they were not prepared for academic study and required additional support to complete assessment requirements (Wilson, McKinney, & Rapata-Hanning, 2011). Overall poorer educational preparation leading into tertiary study and a lack of appropriate guidance were cited as barriers to student success (Benseman et al., 2006; Foxall, 2013).

Preparation for tertiary study begins long before enrolment. The recruitment of Indigenous students into a health career is referred to as a pipeline commencing in secondary school through to postgraduate education and ongoing workforce professional development (Curtis, Wikaire, Stokes & Reid, 2012). Curtis et al., (2012) considers the educational pathway and recruitment activities that occur in secondary school that may help prepare or direct students into a health career. This early exposure may build cultural capital within potential tertiary students and their families through school visits, family involvement as well as through additional academic preparation. The provision of information about career pathways and accurate information about salary and employment prospects are described as important preparation for student success. However, much of the literature refers to stair casing or bridging programmes as highly effective enablers to Indigenous student success in the tertiary

environment (Benseman et al., 2006; Curtis et al., 2012; Foxall, 2013; Katz, Smart & Paul, 2010; McKenzie, 2005).

Financial

Socioeconomic pressures, such as transport, financial hardship, and childcare issues were all common in the literature related to tertiary students (Benseman et al., 2006; Foxall, 2013). In nursing study, the costs of textbooks, transport to clinical practicum venues and clinical uniforms were all cited as pressures for Indigenous students (Lindsay, Millar, Millar & Usher, 2005). Zepke and Leach (2010) report a correlation between students who decreased to part time study status and decreased engagement with study. An additional link was cited between students working in paid employment and interference with academic success (Zepke & Leach, 2010). In the current economic climate, the reality for most tertiary students is the necessity to work part-time while studying.

Stereotypes regarding the perceptions of financial privilege of Indigenous students who receive scholarships are reported however, only a small number (two per cent) of Māori nursing students surveyed reported receiving scholarships in the study by Wilson et al. (2010). Scholarships and other financial assistance such as support with accommodation costs (Cech, Metz, Babcock & Smith, 2011; Katz et al. 2010; Metz, Cech, Babcock & Smith, 2010) and extra tutelage although present in the literature as an enabler assisting with access of Indigenous to education, do not feature strongly as enablers of overall success.

Self-Concept(s)

Two themes were apparent in the literature related to self-concept. These were related to the individual's self-confidence or mind-set and cultural identity.

Self-confidence/Mind-set

Peer group pressure was reported in younger tertiary students either in relation to staying at high school or choosing a tertiary academic pathway (Benseman et al., 2006). Some Indigenous students describe peer pressure to leave school when friends did or dumbing down their successes "in order to maintain status quo" (Cumming-Ruwhiu, 2015, p. 50). Pasifika students surveyed in a tertiary setting describe not having confidence in large classes where they did not want to speak out to avoid drawing attention to themselves as well as reporting difficultly adapting to a Eurocentric system (Mayeda et al., 2014). Some students report not having the discipline to be self-directed (Benseman et al., 2006) or attributed poor self-esteem, the

perception of having to compete with non-Indigenous students, poor time management and attempting to learn in isolation as significant barriers. Further intrinsic motivating factors cited were personal determination and the fear of failure (Chittick, 2017; Chittick, Manhire & Roberts, 2019; Lindsay et al., 2005).

Having a positive, strong self-concept was noted to be an important enabler for Māori, Aboriginal and Torres Strait Islander and First Nation people of Americans (Cumming-Ruwhiu, 2015; West, Usher, Buettner, Foster, & Stewart, 2013). This was discussed as self-belief, confidence and believing in personal competence by Zepke and Leach (2010) where learners are motivated and able to engage with learning. Student engagement is explored in an in-depth synthesis of 93 research studies where Zepke and Leach conceptualise the perspectives of the research related to student engagement and put forward ten proposals for action (2010). Two of these strongly relate to self-concept, "(1) enhance students' self-belief; (2) enable students to work autonomously, enjoy learning relationships with other and feel they are competent" (Zepke & Leach, 2010, p.169).

Cultural identity

Defining what determines cultural identity is complex and as such is beyond the scope of this review. However, it can be generalised that Indigenous culture and cultural identity are derived from holistic and collectivist viewpoints (Houkamau & Sibley, 2010).

For Māori, health and wellness are defined holistically where elements of the mind, physical body, spirit and family must be balanced in order to achieve wellbeing (Durie, 1998). Some commonly accepted conceptions of Māori cultural identity are those of Pere (1988 as cited in Houkamau & Sibley, 2010) and Durie (1998). Pere determined aspects of Māori culture: a sense of belonging to/with the land; spirituality; whakapapa or ancestral ties; tikanga Māori which encompasses language, customs and practices; whānau; and a sense of belonging to the wider community (Pere, 1988 in Houkamau & Sibley, 2010). Durie's Te Whare Tapa Wha model of Māori health and wellness is widely used in nursing education and in health care settings in Aotearoa- New Zealand (1998). In this model four sides of the whare (house) illustrate the four aspects of Māori wellbeing: taha tinana (physical health); taha wairua (spiritual health); taha whānau (family health) and taha hinengaro (mental health).

Houkamau and Sibley (2010) undertook research using a "Multidimensional Model of Māori Identity and Cultural Engagement", a survey tool, and found that while many aspects of traditional Māori identity remain unchanged, "cultural efficacy and active identity expression" and group membership were important factors in self-esteem (p. 20). Within this, they found

that those with higher cultural efficacy, that included Te Reo (Māori language), understanding of customs and strong links to ancestry, related very much to an individual's self-confidence and esteem. Likewise, those that strongly related to the group (as being Māori) and that had positive relationships within their groups was, "personally important or central to their self-concept" and contributed to, "measures of collective self-esteem" (p.20). Houkamau and Sibley also suggest that Māori who have close relationships with whānau and their marae should have greater access to social support and resource, "which should underpin high educational achievement" (p. 20).

This was evident in two examples in the literature related to nursing students. First, students having a strong cultural identity and resilience and second, an internal motivating desire to make a difference in the health of Indigenous people and to give back to their communities (West et al., 2013; Wilson et al., 2011). Katz et al. (2010) describes an altruistic motivation amongst First Nation people of America in choosing to study nursing as a career, this being the motivation to give back to and better the socio-economic circumstances for self, family, and community. West et al. (2013) explored the enablers for Aboriginal and Torres Strait Island students in pre-registration tertiary nursing courses from the perspective of both academics and Indigenous students. Themes related to institutional culture and identification with Indigenous staff were evident as well as an intrinsic motivation from students to give back to their people and community. Boulton-Lewis et al., (2004) also described Indigenous student persistence with learning as being motivated by giving back to family and community more than from personal gains.

Mayeda et al. (2014) determined that student motivation to achieve is grounded in pride that originates from a strong cultural identity. This was also described as tino rangatiratanga (strong self-concept), cultural capital, self-determination, autonomy, confidence, self-efficacy, and ability to adapt and relate to others (Cumming-Ruwhiu, 2015; Zepke & Leach, 2010). Cultural identity determines the way in which individuals and groups interact, for Indigenous in particular, cultural identity is very much grounded in family, extended family connections and group relationships. Effective relationships are therefore central to Indigenous student success.

Effective Relationships

Indigenous people generally are from collectivist cultures (Houkamau & Sibely, 2010) where community and family are of central importance. Effective relationships, particularly

connection with family and community or iwi feature strongly in the literature. These connections are closely related to cultural identity.

Family/whānau

Whānau has been described as a paradox; being at times, both a support and a hindrance (Mayeda et al., 2014; Williams, 2011). Family could present barriers to students particularly where there is decreased cultural capital within the family in terms of knowledge and experience with education with which to guide their family member (Benseman et al., 2006; Mayeda et al., 2014). Tinto's theory of student departure alleges that in order for students to achieve in tertiary environments students must become fully immersed in academic life and in doing so must separate themselves from their family, past social life and community (Tinto, 1993 as cited in, Williams, 2011). Tinto's theory has been criticised, however, and appears to be at odds with Indigenous cultural values and identity.

Mayeda et al. (2014) explored high achieving Māori and Pacific students in a university setting. Students in this study reported that although family could be a hindrance through their lack of understanding of the time required for tertiary education, more often, family were described as a positive influence on students. This is described as family having less cultural capital, because they had not themselves experienced higher education. The term cultural capital was coined by Bourdieu, and the central idea of cultural capital is defined as when "Each generation passes to the next generation not just economic wealth, but also a rich set of dynamic traditions, values and artistry that comprise a young person's cultural inheritance" (Dalziel and Saunders, 2014, p. 46).

Zepke, Leach and Prebble (2006) draw on Bourdieu's theory of social reproduction where the idea of cultural capital can help explain inequities and explain that greater cultural capital is a predictor of student success. A lack of cultural capital within a family may in part explain competing demands for time where commitments to church, sports and caring for family members physically and financially are expected of the student (Benseman et al. 2006; Foxall, 2013; Mayeda et al., 2014) however, this could also be explained by collectivist cultures placing higher priority on family than on studying (Houkamau & Sibley, 2010; Williams, 2011). This was described as guilt, and a challenge managing time for multiple commitments and at times feeling conflicted where in, "collectivist cultures maintaining whānau relationships and responsibilities is culturally expected" (Williams, 2011, p. 65).

In a study of Aboriginal and Torres Strait Island nursing students in Australia, caring for and involvement with extended family was likewise considered normal and for some could be a

barrier to success (Lindsey et al., 2005). Involvement with and the time requirements of family obligations (such as funerals) were also described as not well understood by staff and presented barriers when student requested extra time for assignment completion (Lindsay et al., 2005).

Mature tertiary students may have parental responsibilities to manage and nursing students who were required to travel for study reported this as particularly difficult (Curtis, Townsend & Airini, 2012; Foxall, 2013; Katz et al., 2010). Interestingly, students in relationships (married, defacto, partners) were reported as significantly more likely to be compromised in their learning as compared to those who were sole parents. (Wilson et al., 2010).

While family could be unhelpful, demanding of time and requiring additional responsibilities (Wilson et al., 2010), family was also widely described as a source of motivation and inspiration in the literature. Whānau (family) involvement, support and acknowledgement were very important, as students were often the first from their whānau to engage in tertiary study (Chittick, 2017; Chittick, Manhire & Roberts, 2019; Mayeda et al, 2014, Wilson et al, 2011).

Williams (2011) studied adult Māori who came to tertiary study later in life to tertiary study and who successfully obtained university degrees. This research was conducted using a Kaupapa Māori framework and therefore interpreted the experiences of participants from a Māori world view. In this study, whānau (family) was the main theme attributed to student success (Williams, 2011). Whānau provided the motivation for these students to give back to their people, the encouragement to continue study and ongoing support through advice and personal empowerment (Williams, 2011). Family was often the first enabler identified by participants in research internationally. Mayeda et al. (2014) also found family enablers where students report family helped with transport, requiring less chores at home enabling more time for study and by extended family providing childcare.

Many Indigenous students were the first in their family to undertake tertiary study and wanted to be a positive role model for their whānau and community and desired to improve their family position financially (Mayeda et al., 2014). The literature recommends that institutions capitalise on Indigenous family and communities support networks by engaging with them (Curtis et al., 2012; West et al., 2013) and by supporting whānau to purposive roles in supporting their family member in study (Cumming-Ruwhiu, 2015).

Teachers

"Teaching and teachers are central to engagement" (Zepke & Leach, 2010, p. 170). The teacher's approach probably has the biggest influence on the students. The literature reports

teachers and teaching as being either positive or negative in terms of influencing Indigenous student success.

Mayeda et al. (2014) describe teacher's lack of cultural awareness or skill in working with Indigenous or minority students, as well as assumptions or negative stereotypes, ignorance, fear, or a mono-cultural view as negatively influencing Indigenous students. Further descriptions of negative teacher attitude include perceptions of Māori and Pacific students that teachers were disinterested, aloof, not available, negative, and strict. Some students felt staff made assumptions about how Indigenous student learn and expected all students to learn from the same approach and did not accommodate for individual differences (Lindsay et al., 2005). Zepke, Leach and Prebble (2006) surveyed 681 students across seven tertiary institutes. Of the students that considered withdrawal, one-fifth cite, "inadequate teaching, a lack of recognition of their learning needs and an absence of a sense of belonging" as contributing to their thinking (p. 597). However Indigenous nursing students in Aotearoa New Zealand report that seventy-four per cent of teaching met their needs and seventy-nine per cent found the teaching environment was supportive and culturally safe (Wilson et al., 2011).

Teachers who were seen as genuine, having an interest in students with some knowledge of student cultural background, who could be accommodating and flexible towards students, were viewed positively (Lindsay et al., 2005). Enabling teaching practice included challenging, setting high expectations or standards for Indigenous students (Zepke & Leach, 2010) and teachers who were understanding of external stressors in students' lives as one student described, "It's not just the education part that they care about. They actually give a crap about what's going on at home…They accept that part of you" (Mayeda et al., 2014, p. 174).

Learner centred teachers improve student retention (Zepke & Leach, 2007). The literature describes learner centred practices in a number of ways such as, being approachable, helpful and genuine (Cutis et al, 2012; Zepke & Leach, 2007), the ability to form positive relationships with learners that enables social and academic engagement (Benseman et al., 2006) and those teachers that 'go the extra mile' and create a sense of whakawhanaungatanga (connectedness) (Cummings-Ruwhitu, 2015; Curtis et al., 2012). The concept of connectedness was not isolated to Māori experience. In Australia, Aboriginal and Torres Strait Island nursing students echo this, speaking about the support from Indigenous staff, "they're interested in where you come from and who your family are and suddenly you find you're connected some way" (West et al., 2013, p.127).

Teacher skill, particularly a genuine approach to cultural diversity was a dominant theme in the literature. This skill was described as valuing student culture and valuing the lived experiences that students bring to the classroom (Mayeda et al., 2014). This approach enables teachers and students to connect on a more meaningful level, described as creating whānaungatanga (connectedness) where teacher-student communication is better and student needs are easier to recognise (Bevan-Brown, 2005, Bishop, Berryman & Wearmouth, 2014). Bishop's work describes the teacher as a critical influence on student success; the way a teacher interacts with Māori and the 'ways teachers taught' had a greater influence on students' engagement than school philosophy or external factors such as home life (Bishop, 2008). The process of peer whānaungatanga was also described as important where students formed tight-knit supportive relationships with other Māori. Much of what is described in the literature related to teaching strategies for Indigenous student success could be described in general terms as good teaching practice rather than targeted approaches to Indigenous students.

Role models

Role modelling was described in the literature in several ways: The institute or school role modelling bicultural practises or a demonstrative commitment to Indigenous student success, Indigenous role model teachers or nurse colleagues or role modelling from peers or whānau (Mayeda et al , 2014; West el al., 2013; Wilson et al, 2011). Katz et al., (2010) found in a study exploring Native American/Alaskan Native high school students that role models were particularly important in helping students to understand the difference a career in nursing can make to their family and community as well as helping them 'understand that barriers can be overcome' (p.12). Maeyda et al. (2014) describe role models as those providing active support, encouragement, and mentoring, caring about the student and by setting high expectations for student achievement. Mentoring by other Indigenous students was also important (Lindsay et al, 2005).

The presence of Indigenous staff members was important to Indigenous student's sense of connection and belonging within learning institutions. While role models could be teachers, a family member or friend, Indigenous staff were particularly important and were recognised as a role model with whom students could form a connection with due to a shared culture (Mayeda et al., 2014). Likewise, West et al (2013) describe the importance of Indigenous staff being able to present the 'lived experience' when teaching Indigenous nursing students which students value, "To have black academics there…seeing other people having gone through it. It's inspiring" (p.127).

While family, teachers and role models were the dominant relationships identified in the literature, peer relationships within programmes of study were also mentioned. Students valued building networks of support within their student class groups as well as with their teachers and other support staff. This was important to student's sense of belonging and cohesiveness in feeling part of the group rather than being segregated in an Indigenous group of students (Lindsay et al., 2005).

Institutional Culture

> The capacity of educational facilities to retain students is a function of the interface between students and institutions, and the institution and the community. (Benseman, et al., 2006, p. 147)

Positive institutional approaches to Indigenous students

The institutional culture can be both a barrier and enabler to Indigenous student success. Leadership that acknowledges and values other cultures is seen as effective. In Aotearoa- New Zealand, this is described as bicultural governance or leadership (Bevan-Brown, 2005, Curtis et al., 2012, Henderson, 2013, Ministry of Education, 2013, Ratima et al., 2007). How the organisation is structured in terms of governance, leadership and management is important in articulating the values of the school and therefore what is valued in students. Jones and Creed (2011) describe the differences in bicultural partnership between two professional nursing organisations in New Zealand- one which was explicit in its partnership and one where the relationship was more of a power struggle. Leadership that is culturally aware and facilitating is cited as an important enabler of Māori students (Bishop, Merryman & Wearmouth, 2014).

The overarching philosophy and leadership approach to Indigenous students determines the culture of an institute and the values and strategies employed to support Indigenous students in education. Durie (1998) cautions there are a lack of institutions that promote Māori values. While this may have changed in more recent years given the emphasis on Māori student success in Aotearoa New Zealand, institutions wanting to promote Māori student success in particular, need to have a foundation of Māori knowledge, aspirations, realities and reflect te ao Māori (Māori world view) (Henwood, 2007; Theunissen, 2011). Strategies to promote Indigenous world views beyond leadership and institutional vision that were significant themes in the literature included specific support for Indigenous students, professional development for academic staff, recruitment strategies for Indigenous staff, and Indigenous content threaded through curricula.

Support services

Targeted support offered by educational institutions, specifically for Indigenous students is discussed favourably in the literature. Support from institutes and schools situated outside of the classroom, such as the provision of Indigenous specific support persons (for example, kaumatua or kuia (elders) for Māori students), academic support persons, and culturally specific spaces (such as a whānau room) on campus were all described as important enablers to Indigenous student success (Curtis et al., 2012; Mayeda et al., 2014; Wilson et al., 2011). Such support services have contributed to Indigenous students feeling of belonging (Mayeda et al., 2014), feeling a stronger identity and of being accepted as an Indigenous student within what is at times viewed as a 'white' or Eurocentric institute (West et al., 2013). The presence of Indigenous support services can, "counterbalance experiences of marginalization and hostility" (Cech et al., 2011, p. 530).

Cech et al. (2011) and Metz et al. (2010) describe one support programme designed for First Nation nursing students in America which was delivered in partnership between the university and Native American Reservation, "Caring for our Own: A Reservation/University Partnership Program" or CO-OP (Cech et al., 2011 p. 542). In the CO-OP multi-faceted support was offered: Tangible support such as, financial incentives of 250 US dollars a month if grades were maintained at a pre-determined level; Information support through extra tutelage and organised study groups; Emotional support from a CO-OP advisor employed to provide pastoral support and mentorship; Promoting belonging and providing motivational support (Cech et al., 2011). The latter was described as very important by the participants involved in the study as helping them to form a sense of belonging within the institution because they described that they did not feel they belonged overall with the institution or within the school of nursing.

What is significant about this study is that considerable investment and commitment was made in setting up this network in partnership with the Reservation and student outcome measures were tracked over a ten-year period. Retention rates for First Nation nursing students went from forty-nine per cent to eighty-five per cent, a seventy-five per cent increase from the commencement of the support programme. Additionally, pass rates for final nursing licensure exams for First Nation nursing student improved (Cech et al., 2011; Metz et al., 2010). While the study explored student's perceptions of the support service and attempted to understand which elements of support had the most influence on student success the results from this are limited due to the small regional sample however the overall retention certainly improved since the inception of the support service. Although this is a promising, and positive

predictor of Indigenous student success, not all institutions would have access to the resources needed to establish such a programme.

Employment of Indigenous staff

Educational institutes were commonly referred to as Eurocentric and white places in the literature mainly due to the western dominance in philosophical approach but also due to the small numbers of Indigenous staff. The presence of Indigenous staff was perceived as important because they were role models and people with whom Indigenous students could instantly connect with helping them to feel a sense of belonging in the educational environment. Additionally, "Indigenous role models and mentors have the advantage of having cultural and social insight and understanding of student realities" (Wilson et al., 2011, p. 73). Teachers who were Māori or Pacific helped create cultural pride amongst other Māori and Pacific students by, "drawing positively from their cultures during lectures" (Mayeda et al., 2014, p. 172). In Wilson et al. (2010) "Only 49% were able to freely access Māori nursing faculty or registered nurses as mentor and role models, while 32% were unable to access them at all" (p.70). This reflects the overall low number of Māori Registered Nurses. Recommendations to appoint more Indigenous academic staff were common internationally (Curtis et al., 2012; Foxall, 2013; Katz et al., 2011; Mayeda et al., 2015; West et al., 2013; Wilson et al. 2011) however, this appears to be an issue with a workforce supply and demand imbalance.

Cultural acknowledgement by the incorporation of Indigenous content within the curriculum was reported as important in all the literature reviewed. Appropriate cultural content within curricula improved self-esteem, feelings of belonging within the institution and reinforce cultural identity and pride, all previously described as enablers of Indigenous student success. As Mayeda et al., emphasise, "embedding cultural content fosters ethnic identities compatible with university success" (2014, p. 174). A lack of incorporation of Indigenous culture equated to a lack of value placed on Indigenous students overall within the literature reviewed.

Within predominantly Eurocentric curricula the inclusion of cultural content may fail to achieve inclusivity. If cultural content is included in some instances, "some lecturers perpetuated a deficit model framing racialized disparities through victim blaming" (Mayeda, 2015, p. 175). The deficit approach or discourse refers to the focus of Indigenous issues being on weaknesses or deficiencies and in general viewed in negative terms. This approach plays a powerful role in perpetuating resource and power inequities and there is evidence that it has impact of identity formation, educational achievement, and health (Lowitja Institute, 2018). The deficit approach

has also been described as a barrier in New Zealand literature, where instead the 'Māori Potential Approach' developed by Te Puni Kōkiri is favoured (Ratima et al., 2007). This is a strengths-based approach emphasising culture, human rights, partnership, holism and wellbeing" (Lowitja Institute, 2018).

Henderson (2013) discussed the barriers to inclusion of cultural content from non-Indigenous teachers who are either disengaged with biculturalism or cross-cultural skills, or who do not believe it is their responsibility within their role. Furthermore, she argues that there is danger in including cultural content where it is not respected or understood by the teacher as it is at risk of being seen as a tick box exercise and even being delivered in an offensive manner, further alienating Indigenous students (Henderson, 2013).

In New Zealand nursing education, the incorporation of cultural content, specifically content related to the Treaty of Waitangi or Tiriti o Waitangi and Cultural Safety is required by the regulating body that oversees professional standards of practice and education (NCNZ, 2011). In research by Wilson et al. (2011) cultural content was clearly embedded within curricula, specifically the Treaty of Waitangi, Māori culture, models of health and ways of knowing. Over eighty per cent of Indigenous nursing student participants saw this content as valid and sixty-four per cent said there was an appropriate balance between European and Indigenous knowledge in programmes (Wilson et al., 2011).

The way in which cultural content was delivered was particularly important in nursing when health disparities, the Treaty of Waitangi or Tiriti o Waitangi or Māori models of health were explored. Richardson and Carryer, (2005) studied nurse lecturers who taught Cultural Safety within a Bachelor of Nursing programme. They found the subject matter challenged both the teacher and the student. At times students felt uncomfortable as the subject challenged individuals to examine their own beliefs which can, as Richardson and Carryer describe, "generate resistance and rejection from students. Management of this process can make teaching stressful, as Cultural Safety teachers must be prepared to address not only the uncertainty of what may arise but also how to work with vulnerability and conflict" (Richardson & Carryer, 2005, p. 207). Conflict and vulnerability are both areas nurses address daily in practice.

Eurocentric institutions

Some literature describes educational institutes as Eurocentric or mono-cultural organisations (Harris, et al., 2006, Henderson, 2013, Huria, et al., 2014). In a study by Lindsay et al. (2005), Aboriginal and Torres Strait Island nursing student participants in Australia viewed their

institute as Eurocentric and, “highly governed by rules and regulations that appeared to be at odds with Aboriginal philosophies of life” or understandings (p. 4) and for some, the experience of university was described as a ‘culture shock’.

Rolleston (2004, as cited in Benseman et al., 2006) found that amongst Māori and Pacific students there were more external reasons for leaving study such as, family, social or personal reasons, however, thirty-five per cent of student comments cited institutional reasons for leaving tertiary study. Cultural issues experienced by Indigenous students within educational institutes appear to jeopardise retention and completion rates. This is significant and worth exploring in further research as this falls within the institute’s ability to influence (Lindsay et al., 2005). Institutional racism formed part of the commentary around Eurocentric organisations in the literature and is discussed in the following section.

Racism and Unconscious Bias

> The most difficult thing about majorities is not that they cannot see minorities, but that they cannot see themselves. (Colquhoun, 2012, p. 38)

Racism is an international phenomenon and reported widely in the literature. It affects Indigenous people in educational settings and is deemed a determinant of health and wellbeing (Barnes, Taiapa, Borell & McCreanor, 2013; Harris et al., 2006b). Henderson (2013) suggests that racism in schools (compulsory school sector) may be due to stereotypes and/or victim blaming. It may be subtle, “and the subtleties of institutional racism are hard to eliminate” (Henderson, 2013, p. 12). Henderson also believes that within New Zealand schools’ low-level racism often goes unchallenged. Ignorance or arrogance may the cause of some racism and she argues that professional development is required for teachers to be effective cross culturally (Henderson, 2013).

In 2018 a report from the New Zealand School Trustees Association (NZSTA)[8] and Office of the Children’s Commissioner (OCC) presented the opinions and experiences of children at New Zealand schools that were obtained through interviews and online surveys from over 1600 children in late 2017. Key themes emerged from the research that were important to children in their learning environment:

- Understand me and my whole world

[8] New Zealand School Trustees Association is a member-based organisation that provides leadership to strengthen governance of school boards of trustees. Most school boards of trustees are NZSTA members. (NZSTA, 2020).

- People at school are racist to me
- Relationships mean everything to me
- Teach me the way that I learn best
- I need to be comfortable before I can learn
- It's my life-let me have a say

(NZSTA & OCC, 2018a, p. 11).

Knowing children and where they come from, their home life, values or culture was important to children. Sadly, an entire theme was focused on children's experiences of racism from both teachers and classmates. A further detailed report focused on experiences of tamariki (children) Māori in the research. It noted the importance of culture, the feelings of conflict of the children's Māori culture in the Pākehā school system, the importance of language, tikanga and Māori values. Racism also greatly impacted children's experience, sense of self-worth and ability to achieve at school, as this child's quote illustrates, "racism exists-we feel little and bad" (NZSTA & OCC, March 2018a, p.26).

While most people recognise racism, unconscious bias may impact minorities even more as it permeates society. Houkamau and Clarke (2016) define unconscious bias as, "an automatic tendency for humans to perceive people, situations and events in stereotypical ways" (p.114). In health care settings specifically, unconscious bias refers to unconsciously classifying an individual into a group and then making a stereotypical judgment about the individual based on their group and then making decisions based on the stereotype. They also suggest that with increased time pressures and increased patient acuity, so too unconscious bias increases as health practitioners rely more on intuition or instinctive thought processes. There is an emerging body of research from a New Zealand perspective that indicates there is a positive correlation between health provider bias and poorer health outcomes (Houkamau & Clarke, 2016; Huria et al., 2014; Smedley, Stith & Nelson, 2003; White-Means, Dong, Hufstader, & Brown, 2009). Further to this evidence are the findings of the Health Services and Outcomes Kaupapa (WAI 2575) Waitangi Tribunal inquiry, which found Treaty breeches related to funding, governance and structural issues which contributed to the poorer health outcome of Māori (Waitangi Tribunal, 2019).

The effects of unconscious bias, racism and stereotyping in health can be generalised into other settings where social interaction occurs where there is a power imbalance, such as, in education or employment situations. The media provides a further example of this. In

Aotearoa New Zealand it has been demonstrated that a deficit approach in the media, where Māori are portrayed as sicker and poorer due to lifestyle choices is mirrored by stereotypes in the health system (Houkamau & Clarke, 2016). Health care professionals in New Zealand are thought to be culturally safe and culturally competent, however, there is evidence that racism and unconscious bias are negatively influencing care. This is reported in the 2002/03 New Zealand Health Survey where, "Māori reported the highest prevalence of ever experiencing racial discrimination in their interactions with care provides compared with non-Maori" (Houkamau & Clarke, 2016, p.116). Likewise, in education, students report feelings of bias, stereotyping, marginalisation and discrimination and a key finding of a Children's Commission report children experience and report racism (New Zealand School Trustees Association & Office of the Children's Commissioner, 2018b). As Bevan-Brown (2006) suggest, it is not only individual attitudes that need influencing, but also society.

There are a complex range of factors that influence Māori health and education inequities. Houkamau and Clarke believe that, interpersonal forces at work contribute to this (2016) and go on to state that, "some health care providers may hold stereotypes that inhibit their ability to connect effectively with young Māori" (p. 117). In a recent New Zealand study of Māori nurses' experiences of the Nursing Entry to Practice programme, themes related to being Māori, doing things the Māori way and issues with racism were apparent (Foxall, Forrest & Meyer, 2017). Although this study was limited by its size, it is significant as there is little New Zealand research exploring this currently. Additionally, the negative effects of this in the first year of professional practice may not motivate Māori new graduates to stay in nursing.

Internationally, minority nursing students who identified as Native American, African American, and Hispanic experienced racism in their institutions, in classrooms, from teachers and peers (Metz, et al., 2010). Similarly, racism and discrimination were reported as barriers to Māori achieving in everyday life, in education and in health settings. (Harris et al., 2006; Harris, Tobias, Jefferys, Waldegrave, Karsel & Nazroo, 2006a; Huria et al., 2014; Ratima et al., 2007; Savage et al., 2011).

There is evidence racism exists within the health sector and that it is a contributing factor to health inequalities for Māori. Harris et al. (2006a; 2006b) studied the effects of racism on health outcomes and, in their survey over ten thousand Pākehā and Māori provided data regarding interpersonal and institutional racism. Their findings suggest, experiences and perceptions of racism contribute to inequalities in health outcomes for Māori (Harris et al., 2006b). This research is significant because it is perhaps the first of its kind in New Zealand and the finding suggest strong association between discrimination and poor health for all minority

groups, independent of socioeconomic position (Harris et al., 2006a). More recently an update on this research was published. Harris, Stanley and Cormack (2018) studied racism and health and wellbeing measures over a ten-year period. Unsurprisingly they found that non-European people experience higher levels of racism in New Zealand. Asian people reported the highest levels of racism followed by Māori and Pacific people. Direct links between racism and health and wellbeing were demonstrated and was described as the root cause of racial /ethnic health disparities (Harris, Stanley & Cormack 2018). Not only does this research demonstrate breeches of human rights occurring in everyday life in Aotearoa New Zealand but also within healthcare, where individuals are arguably at their most vulnerable.

Given the evidence from Harris et al. (2006a; 2006b) it is unsurprising that nurses and nursing students also report occurrences of racism. Māori registered nurses reported racism in their nursing education and in their workplaces (Chittick, 2017; Chittick, Manhire & Roberts, 2019; Foxall, Forrest & Meyer, 2017; Huria et al., 2014) which in some cases lead to nurses leaving the profession. In a study by Huria et al., (2014) Māori registered nurses described experiences of discrimination prior to their nursing education, during their education and then within their professional practice environments. Interpersonal racism was evident between peers and at times Māori students felt they were "singled out as Maori during their training; no other nurses in the training program were marginalized in this way" (Huria et al., 2014, p.367). Institutional racism was also apparent across institutions and within schools of nursing where at times nursing practices were, "contrary to usual Māori cultural protocols" (Huria et al., 2014, p. 367).

An unpublished master's thesis explored factors Māori perceive as essential for success in undergraduate nursing education in New Zealand (Chittick, 2017). This descriptive study developed five themes that are not dissimilar to the literature:

1. motivation to become a nurse
2. support
3. the importance of relationships
4. what is described as cultural nurture and connectedness in the learning environment
5. developing resistances in the face of racism and unconscious bias

Several aspects of the findings from this study, both positive and negative, are directly relevant to teaching practice. Aspects that had a negative impact on learners included staff inability to correctly pronounce names and the Māori language. The cultural content essential in undergraduate nursing in New Zealand such as the Treaty of Waitangi, and Māori models of

health where content was poorly delivered, made participants feel not well understood and not valued as Māori. This also exposed negativity from classmates related to Māori, where harmful comments such as, 'why do have to learn this', 'we all have culture' were voiced. The fact that a theme regarding racism and unconscious bias was present was concerning. This was evident in the classroom, from staff and student colleagues and in the clinical environment amongst registered nurse preceptors. Although this is a small study, this finding is genuinely concerning. The subtle and not so subtle messages the Māori nursing student participants received had a negative impact on the learning experience for them at the time, but also was described as a motivating factor to develop resilience, to do well as a nurse and to combat these attitudes for others. Conversely, the learning environment had a positive impact on Māori learners when there was the presence of Māori academic staff, perceived protection of culture in the learning environment, and a feeling of connectedness to the Māori world, as one participant stated, "the need to feel culturally cherished, or feel free to speak as Māori in the classroom" (Chittick, 2017, p.74).

In Australia the student perception of discrimination by staff on clinical practicum is described by one nursing student, "I was speaking to one of the girls today and she said that once they find out that you're Aboriginal they're going to watch you closely…just wait for you to make a mistake and then they'll use that against you" (Lindsay et al., 2005, p. 4). It appears that Indigenous nursing students need to learn to navigate several cultures, their own, the educational institutions culture and the culture of nursing. Without support and a strong sense of identity this will no doubt be a further barrier to their educational success.

The evidence suggesting that racism exists amongst academic staff in nursing is particularly alarming given that all nurses in Aotearoa New Zealand are required to be culturally safe and competent (NCNZ, 2016b). Wepa (2003) discussed the need for Cultural Safety education within nursing curricula to be safe for teachers and students however, she identified institutional racism and unsupportive colleagues hindered this occurring. This is of concern as participants in this study were nurse educators who should have competence in Cultural Safety and who were delivering culturally specific content.

Culturally Responsive Teaching Practice/Models of Education

> In order to achieve widespread and permanent improvements for Māori learners…there needs to be ideological changes at societal level. (Bevan-Brown, 2006, p.227)

The search terms culturally responsive Māori education and culturally responsive pedagogy were employed to explore what is known about culturally responsive teaching practice and models of culturally responsive education. Results related to special education (Bevan-Brown, 2005), literature from secondary schools, early childhood, gifted learners and professional development for teachers (Bishop, 2008; Bishop, Berryman & Wearmouth, 2014) and a review of New Zealand research related to Māori student success were found (Sciascia, 2017).

A commonality in the literature and a critical factor in Indigenous student success is pedagogy coupled with teacher capabilities (competence) to be culturally aware, culturally responsive, and to value culture. Culturally responsive pedagogy is not a new concept and can be defined as, "teaching to and through students' personal and cultural strengths, their intellectual capabilities, and their prior accomplishments" (Gay, 2010, p.26).

Ako Aotearoa is a significant funder of research related to tertiary education in New Zealand. Multiple studies have been funded by Ako Aotearoa over the past decade that focus on Māori student success, or Māori learner success. In 2017 a report was collated that summarised this research presenting the main findings and pertinent points for consideration (Sciascia, 2017). This report acts as a resource for institutions and teachers and provides an overview of recent relevant literature that serves as background content to this study. Gaps in the literature are also identified in this report. In total forty-five projects were funded and were published between 2003 -2016.

The report begins with a definition of Maori learner success, while acknowledging that a single definition from the literature is difficult as it can be expressed in many ways. Success is broadly defined as the, "contexts, environments and tools that can foster, support and develop Māori learner success across the various forms it may take" (Sciascia, 2017, p.5). Success for Māori is often referred to as Māori 'fully realising' their potential, being self-determining in their education and holistic in nature (Lowitja Institute, 2018). For Māori the learner cannot be separated from the concepts of whānau/hapū/iwi (family/ tribe/ sub-tribe), and likewise a holistic approach to success needs to be taken into consideration. This includes factors leading up to tertiary study as well as the actual learning journey such as the learning environment, teacher, resources, curriculum and assessment and support services. The key themes from Ako funded research projects were engagement with Māori pedagogies, the values that underpin practice, and how values can underpin and guide practice.

The report concludes that institutions need to take greater responsibility in ensuring that education enables Māori student success, that particularly Māori ways of being (knowing and

thinking), are honoured. This can occur through pedagogical change and ensuring teachers have appropriate resources, professional development opportunities to understand and know how to integrate te ao Māori values into the teaching and learning context. The recommendations for future research include, practitioner reflection and evaluation in relation to supporting Māori learner success, more research related to technology and Māori, such as the role of social media, e-learning, mobile technologies, and the final area is more research into learning environments. This includes learning spaces that, "nurtures cultural diversity, identity, protocols, practices and language" (Sciascia, 2017, p.45).

Indigenous content is important in all the literature related to Indigenous student success. Bevan-Brown (2006) suggests the inclusion of seven areas within New Zealand curricula: Treaty of Waitangi, the effects of colonisation, Te Reo language education, understanding the dominant cultural influence, tikanga, strategies for working with whānau and community, and the causes and impacts of unequal power relationships, such as prejudice, racism, social injustice, inequality and poverty (Bevan-Brown, 2006). Whilst Bevan-Brown speaks from the secondary school education perspective, specifically for Māori with special needs, her recommendations are echoed in the Ako review report (Sciascia, 2017). Her suggestions can also easily be applied in the undergraduate nursing education context.

Bevan-Brown (2006) suggests strategies for overcoming barriers to education access, and barriers to providing culturally responsive pedagogy, that appear straightforward in that government policy, and strategies support much of what she suggests. However, there are larger challenges related to the enactment of policy and deeper issues of changing attitudes and beliefs both in society and in individuals which hampers equity of outcomes. She asserts that getting it right early in childhood education is paramount to having a positive impact on societal attitudes. Her research provides evidence that what takes place in schools, classrooms and early childhood centres can considerably affect what happens in society (Bevan-Brown, 2006).

Pacific tertiary students in Mayeda et al. (2014) describe a paedagogical approach that is culturally aligned as helpful to success. This approach being one that values "collective learning over individualistic, competitive learning" (Mayeda et al., 2014, p. 174). Savage et al. (2011) assert that, school culture needs to have some relation to student culture in order for students to be engaged.

Perhaps the most noteworthy model of culturally inclusive education practice in New Zealand literature is Te Kotahitanga (Bishop, 2008; Bishop et al., 2014; Bishop, Ladwig & Berryman,

2013). Te Kotahitanga was a research project funded by the Ministry of Education, which aimed to implement a culturally responsive pedagogy into classrooms (primary and secondary school sectors) through professional development and mentoring of teachers (Bishop, et al., 2013). The goal of Te Kotahitanga ultimately is to "improve the educational achievement of Māori students in mainstream classrooms" (Bishop, 2008, p. 446). The model aims to achieve this through teaching that occurs in a whānau (family) context within classrooms, where there are close relationships between teachers and learners and a sense of whanaungatanga (connectedness) (Bishop, 2008; Bishop et al., 2013). This model holds Māori world view at the core of its philosophy and Māori right to be self-determining within a dominant culture. The model takes time and extensive resource to implement effectively, however, the core principles echo the Indigenous student enablers described within the literature internationally. These being the philosophy, leadership, teachers, curricula and support mechanisms being focused on and culturally relevant for Indigenous students. The importance of family and community are also emphasised.

The classroom is the daily lived experience for students. In nursing education there are two dominant classroom cultures that students learn to navigate within. One where nurse educators have relative influence over (within the educational institute) and one where there is less control or influence (within the professional setting, hospital, or community practice setting) where students undertake practical nursing experiential learning. Traditional nursing hierarchical structures and paternalistic biomedical ways of knowing and working still exist and can be incredibly challenging for students and new nurses to navigate. Added to this is the Eurocentric approach of most organisations (Huria et al., 2014, Lindsay et al., 2005; Metz et al., 2010, Williams, 2011; Wilson, et al., 2011). This is arguably more challenging then, for Indigenous nursing students who not only are learning to adapt to the culture of nursing but also navigating their way through the culture of an educational system and various health care institutions where values may conflict with their culture.

It stands to reason that an institutional culture congruent with Indigenous world views should be overarching in institutional philosophy and practices, and pedagogically through appropriate cultural content threading through curricular that is delivered by culturally competent practitioners. Within nursing education specifically, the concept of Cultural Safety as a model for teaching practice could be further explored. Models such as Te Kotahitanga (Bishop, 2008; Bishop et al., 2014) are useful in informing this in an overall educational context, however, there may be room to adapt this to better serve the unique challenges nursing students and nurses face.

Cultural Safety

> Given that the first health professional consumers see when they enter a health care facility is likely to be a nurse, it is vital that contact with that facility by Indigenous people is a culturally sensitive experience, or they are not likely to return (Lindsay et al., 2005, p. 1).

Background and definition

Cultural Safety is a socio-politically situated concept (Richardson, 2010). Cultural Safety is contextualised by the events prior to and during its implementation in nursing. The inter-related socio-political events leading up to Cultural Safety are well documented by Ramsden (2002) and later by Richardson (2010). Notable events include the passing of the Treaty of Waitangi Act (1975) which legally recognised both versions of the Treaty as legal documents and established the Waitangi Tribunal. Following this, throughout the 1980's growing protest movements relating to Treaty or Tiriti breeches and the health status of Māori came to the collective attention of many in Aotearoa (Durie, 1998; Ramsden, 2002; Richardson, 2010). Richardson posits that the identity politics of Indigenous and feminist movements played significant roles in collective consciousness-raising making social inequities more visible (2010). It is against this rich and turbulent landscape of unrest that Cultural Safety originated.

Key reports and literature from 1990-2001 were analysed to put together a timeline of the evolution of Cultural Safety from its origins. The political, regulatory, and professional influences that have occurred over time and the current views and issues that are evident in the literature have been explored. From the inception, the introduction of Cultural Safety into nursing was surrounded by controversy, with close media attention, public scrutiny, including a parliamentary inquiry (Papps & Ramsden, 1996). In 1992 the Nursing Council released the first guidelines on Cultural Safety in nursing education which were subsequently reviewed in 1995 in response to the parliamentary inquiry (Murchie & Spoonley, 1995). The parliamentary inquiry was avoided as the Ministry requested review into nursing education and Cultural Safety recommendations were actioned by the Nursing Council, which resulted in the revised 1996 guidelines for Cultural Safety in nursing and midwifery education (NCNZ, 1996). The current guidelines were first published in 2002 following the last comprehensive review of nursing education by KPMG in 2001 (KPMG Consulting, 2001).

Defining Kawa Whakaruruhau – How is this Different to Cultural Safety in Nursing?

The English translation of Kawa Whakaruruhau is commonly interpreted in nursing as Cultural Safety. The Māori dictionary translates the two words more fulsomely as:

Kawa: custom, ritual, protocol

Whakaruruhau: safety, shelter, protect

In order to define Kawa Whakaruruhau as it was intended for nursing reference to Irihapeti Ramsden's original work for the Ministry of Education in 1990 and her thesis (2002) is essential. Initially Cultural Safety was about Māori. As Papps and Ramsden describe, "Cultural safety was born of the pain of the Maori experience of poor health care" and it was developed during a time of bicultural development (1996, p. 38). Kawa Whakaruruhau focused on two concerns when it was first applied to nursing in the late 1980's. These were, the safety of Māori students and nurses and the safety of Māori receiving care (Ramsden, 2002). As Cultural Safety became part of the nursing regulatory domain in the early 90's the meaning shifted to a broader definition of culture and moved away from association with ethnicity and Māori studies. Over time due to public, political, and professional influences the meaning of Cultural Safety has morphed.

Contemporary rhetoric indicates Kawa Whakaruruhau is about Māori. Specifically, the rights, protection, respect, and commitment to positive health/ nursing outcomes for Māori that are guaranteed under the te Tiriti o Waitangi or Treaty of Waitangi. Whereas Cultural Safety refers to the provision of culturally safe care to all health/nursing consumers. This distinction is important from many perspectives but importantly for Māori as Tangata Whenua Indigenous people of Aotearoa). However, a contemporary definition of Kawa Whakaruruhau separate from Cultural Safety is difficult to find in literature due to the dominance of the current regulatory definition of Cultural Safety by the Nursing Council of New Zealand (2011).

The concept of Cultural Safety or Kawa Whakaruruhau arose from a nursing education hui (meeting) held in Christchurch in 1988 where a student attending, Hinerangi Mohi, coined the name which has remained (Ramsden, 1990; Ramsden, 2002; Ramsden in Wepa, 2015). In 1990 the Nursing Council of New Zealand included Cultural Safety in its education standards (Papps & Ramsden, 1996). Colonisation and the long-term impacts of colonisation on Māori health were the reasons for the development of Cultural Safety (Ramsden, 2002), the term though coined in 1988, didn't come into widespread use as a model in nursing until 1992. Irihapeti Ramsden was instrumental in the development of Cultural Safety and her doctoral thesis (2002) explored the history, implementation of, and the negative public, political and media attention Cultural Safety received over the 1990s. As a New Zealand nurse, it is not possible to explore issues of Māori student retention and success and approaches to cultural issues without also examining Cultural Safety.

Cultural Safety principles were adopted to address the effects of power imbalances and discrimination of minority groups in the health care (nursing) context (Arieli, Mashiach, Hirschfeld & Friedman, 2012). Cultural Safety is not about the Treaty of Waitangi or Māori health needs, it is about the recipient of nursing care. Cultural Safety can be defined as, "The effective nursing practice of a person or family from another culture and is determined by that person or culture" (NCNZ, 2011, p. 7). Cultural Safety relates to the experience of the individual receiving nursing service or care, and it, "extends beyond cultural awareness and cultural sensitivity" (NCNZ, 2011, p. 7). The process of achieving Cultural Safety in nursing practice is a three-step process beginning with cultural awareness, cultural sensitivity and finally Cultural Safety. The Council defines, "Cultural Safety is an outcome of nursing education that enables a safe appropriate and acceptable service that has been defined by those who receive it" (NCZN, 2011, p. 8).

Nurses are required by the Nursing Council under the Health Practitioners Competence Assurance Act (2003) to be culturally safe practitioners. This is measured against the Council's Competencies for Registered Nurses (NCNZ, 2016b), specifically competency 1.5 which requires the nurse "Practises nursing in a manner that the health consumer determines as being culturally safe" (NCNZ, 2016b, p. 13). Cultural Safety is regarded internationally as a pioneering innovation in culturally appropriate care (Arieli et al., 2012).

Cultural Safety and white privilege in Australia

More recently, the Nursing and Midwifery Board of Australia (NMBA) updated its code of conduct for nurses and refers to the acknowledgement of 'white privilege' in its definition of Cultural Safety (Nursing and Midwifery Board of Australia, 2018, p.16). This caused some outcry in the media and amongst some nurses who described the new code as 'eyewatering' and interpreted it as a need to announce and apologise for their white privilege (Haycroft, 2018). The perceived fear and lack of understanding conveyed in this opinion piece from a founding member of the Nurses Professional Association of Queensland, reinforces the NMBA's decision to overtly describe white privilege and state clinical and cultural competence are of equal important to nursing practice. Leading Australian professional bodies hit back at Haycroft's public comments, clarifying the consultation process around the new code of conduct, and requirements of Cultural Safety (Chlopicki, 2018).

This controversy is reminiscent of the New Zealand experience in the 1990's when the New Zealand media reported Cultural Safety in nursing education as political correctness and the public case of Christchurch Polytechnic student, Anna Penn, who failed the nursing programme

for being culturally unsafe. Whilst Cultural Safety is now a mainstream concept in New Zealand nursing education and practice, the recent Australian experience serves as a reminder that nursing and nursing education is situated in a wider social context of values that are not always shared by all member of the profession. It also illustrates that understandings of and therefore, practices of Cultural Safety may in fact vary amongst nurses.

A range of national and international literature related to Cultural Safety has been published over recent decades. In 2012, to celebrate twenty-one years since the Nursing Council of New Zealand required Cultural Safety to be included in undergraduate nursing education, a bibliographic timeline was released of notable articles and media events related to Cultural Safety (Nursing Council of New Zealand, 2013a). Articles from this timeline have been reviewed and subsequent publications and sources of information critiqued since that period.

This next section presents key issues arising from Cultural Safety literature which arise from, the experiences of teaching Cultural Safety, the dominant Western context of nursing education, and challenges within the workplace. Cultural Safety is described as a decolonising model of practice, and the unique contribution Māori nurses can make in providing culturally safe care for Māori is explored. Finally, research based on undergraduate cultural competency education in New Zealand schools is explored.

Teaching Cultural Safety sometimes means the classroom can become unsafe

There are a range of undergraduate nursing curricula nationally, and schools may place varying degrees of emphasis on subject matter such as Cultural Safety and Māori health. There has not been a New Zealand study of the content, teaching methods and assessments of how this content is represented in nursing curricula. Guidance on how programmes should manage this is not included as part of the NCNZ education standards, though standard 2.5 loosely refers to programmes being required to articulate a philosophy, "congruent with the planning and delivery of the learning experiences" that are based on the guidelines for Cultural Safety, Treaty of Waitangi and Māori health, among other Council guides (NCNZ, 2015, p. 6). Additionally, the literature is largely silent regarding best practice related to content and pedagogy in teaching Cultural Safety, and Indigenous content, in nursing programmes nationally. There are, however, tensions described in the teaching of Cultural Safety.

Ariel, Friedman and Hirschfeld (2012) present a case study of Cultural Safety education experience from educator's perspectives in Israel. They state that socio-political contexts of society are reflected in nursing classrooms. This study takes place in a Jewish and Arab classroom where the socio-political context was extreme (active war conflict between these

two groups) and therefore, the authors suggest that Cultural Safety is crucial to the classroom (Ariel, Friedman & Hirschfeld, 2012). The education sessions related to Cultural Safety were delivered in a bicultural model with both an Arab and Jewish nurse educator involved in the teaching sessions. Educators in this school found that teaching Cultural Safety is a 'paradox' in that the goal of teaching Cultural Safety is to create a safe teaching and learning environment to discuss identity, differences, and values however, they found, that discussing deeply personal and often emotive issues related to Cultural Safety caused tension, conflict and may have resulted in students feeling unsafe in the classroom.

The challenge of how to frame Cultural Safety in the classroom is not new and was common when New Zealand schools of nursing first introduced it to the curriculum. Although not widely studied in recent years, it is a fair statement that this subject area remains one that provokes emotion in the classroom. The poor delivery of Māori and Indigenous content and management of class dynamics has been identified earlier as a barrier to Māori student success (Chittick, 2017; Chittick, Manhire & Roberts, 2019; Wilson, McKinney & Rapata-Hanning, 2011).

Western paradigms dominate nursing education and practice, hinder Cultural Safety

Harding (2013) challenges that deeper issues exist in nursing education related to nursing ethics and the entrenchment of Western paradigms in nursing education which to some extent creates further paradox with Cultural Safety principles. He argues that nursing ethics are global in their approach and are based on Western concepts from the individualist culture, that disregard cultural influence of ethical norms. He suggests that in New Zealand, nursing ethics education is likely to be delivered by someone from the dominant culture and it is unlikely that students will have an authentic Māori worldview incorporated into nursing ethics education. He challenges that it is time for nursing education to extend Cultural Safety into ethics education to account for the multicultural worldviews of the profession and the increasingly diverse society which are recipients of nursing care.

Harding's call, while truly relevant, may be late in coming. The effects of the increasingly diverse nursing workforce are in fact already having implications in practice. Ion, DeSouza and Kerin, (2018) echo Harding, but also state the evidence of poor care, racism and sexism that is present suggests that in some cases, nurses are not meeting the standards set by the profession. They state that changes in undergraduate education is not enough, and that practitioners need help in understanding the increasingly complex environment in which they

practice. While Ion et al. write from an international perspective, evidence of similar issues is found in New Zealand.

Cook and Brunton (2017) explore in depth the interpersonal cultural challenges nurses face in practice. They describe moral emotions as essential components to the judgement which leads to clinical action in nursing practice. They surveyed and interviewed internationally, and New Zealand educated nurses working in New Zealand. They maintain that multicultural nursing teams are the new reality, as globally, there is reliance on a multicultural mobile workforce. This, however, does not mean that the multicultural workforce will inherently, "generate intercultural understandings" (p. 3) and in fact it increases the cultural complexity of teams.

Their findings support Harding (2013) in that overall ethical frameworks accepted in health are guided from a monocultural framework, yet the moral emotion guiding moral judgment is often incongruent between cultures. Cook and Brunton found nurses from the dominant culture were invisible to their own cultural lens which lead to an 'othering' of their internationally educated nurse colleagues which may lead to many negative consequences including, a lack of collegiality, higher staff turnover, poor teamwork and communication which in turn effects care delivery and patient satisfaction (2018). They found that leadership had an essential role to play in influencing the team and that it needed to be culturally inclusive to role model, guide and influence team dynamics and communication. The ethnocentrism and racism reported was concerning and participants commented on the need for cultural education not just for nurse-patient but also nurse-nurse interactions.

Cook and Brunton comment however, on barriers to achieving cultural understanding between nurses including the neoliberal driven constraints around time, cost and staffing inhibiting investment in what may be considered less important (2017). Evidence to the contrary has been around for decades in the United States magnet hospital model, where investment in staff development and teams reduce costs such as recruitment in the longer term (Aiken, Clarke, Sloane, Sochalski & Silber, 2002).

Brunton and Cook (2018) published more in-depth findings from formal interviews with the same sample as their 2017 study. This study found significant differences in perceptions of nursing practice between internationally and New Zealand educated nurses, with the former being described as task based and unable to challenge hierarchy and the later, person-cantered, advocates in their care. This resulted in feelings of not being valued by the international nurses or under scrutiny from their colleagues. There were distinct separations between New Zealand (dominant) worldview and 'other' minority worldviews which may be

from a range of international perspectives, but concerningly were also reported by a Māori nurse participant who reported at times feeling like a minority amongst colleagues. This inability to appreciate cultural difference created numerous challenges with communication, collegiality, racism, and a general feeling of exasperation with the effort needed to create a harmonious team in a 'care-rationed' pressured environment (Brunton & Cook, 2018). The findings conclude that the intercultural tensions within the nursing profession are ultimately a risk to patient safety as, most sentinel events in healthcare settings result from breakdowns in communication (Brunton & Cook, 2018).

Literature has reported that investment in cultural development, and strategies to promote cultural understanding has been undervalued and seen as not as important as other technical knowledge and skills (Huria et al., 2018) yet this data demonstrates that cultural difference impacts significantly on communication and teamwork and thus patient safety. The Accident Compensation Corporation (ACC) has made multi-million-dollar investment in training to improve teamwork and communication using high fidelity simulation education to reduce the incident (and cost) of treatment injury in New Zealand (Accident Compensation Corporation, 2018). This training appears to focus on the cultural difference between professional teams e.g. medicine with nursing, theatre teams with recovery or emergency teams rather than focusing on personal cultural differences that hinder individuals to function effectively within those teams.

Cultural Safety: A de-colonising model

Investment in culturally responsive and cohesive multicultural nursing teams are only part of the equation toward Cultural Safety in practice. Nurses in New Zealand work within organisations and systems whether in academia or practice, that mirror a society which is Eurocentric. The dominant Eurocentric paradigm is not unique to New Zealand, and international research presents similar issues. Whilst Western education has played an important role in colonisation, Cultural Safety may be a key strategy in decolonisation of education and health systems.

Blanchet-Cohen and Richardson, (2017) present ideas from a series of articles related to Cultural Safety from a Canadian Indigenous perspective. A central theme explored is Cultural Safety and its relationship with colonisation. They assert that Cultural Safety requires de-colonisation of systems to include Indigenous views, an entire paradigm shift which requires a transfer of power to promote equity. They state part of this will require health professionals to undergo further education to reduce stereotyping, increase awareness of racism and

unconscious bias in order to transform practice (Blanchet-Cohen & Richardson, 2017). They stress, “moving towards Cultural Safety means that many professionals will need to transcend their privilege and leave their zone of comfort” (p. 139).

Racism, marginalisation, and inequities are present in nursing education and practice

Racism and unconscious bias are explored earlier, however, this section specifically explores racism in nursing, how issues of racism in nursing may in fact contribute to persisting health inequities. Barton (2008) undertook a master’s thesis exploring Māori perceptions of hospitalisation. Her results while not directly exploring Cultural Safety, demonstrate that Māori in her study did not feel safe as recipients of care in hospital. Participants describe the hospital as a Pākehā (non-Māori) environment, foreign, where culture needed to be put aside. The hospital culture was described as frustrating, hierarchical, difficult to navigate and paternalistic (Barton, 2008). This was experienced when dealing with doctors and nurses, where Māori needs were ignored and questions unanswered because they did not fit within hospital norms. Māori also perceived they received poorer quality care because they identified as Māori. Compounding this was the assumption that Māori preferred to provide care for their whānau, while in many instances this was true, it was not true for all participants, which meant personal care was sometimes not done by nurses. Barton’s findings were grouped into three interpretations:

- Maori are marginalised in the health system
- Māori do not believe hospital is conducive to healing and
- Māori experiences in hospital contribute to them wanting to leave as soon as possible (Barton, 2008).

This study provides evidence that nursing care is not always deemed by the recipients of care as culturally safe. It suggests that the dominant (Western) hospital culture and the culture of nursing trumps (or hinders) the provision of culturally safe care. In a recent opinion piece, Barton (2018) challenges that the persistent health inequities of Māori are a failing of nursing. She suggests that nursing needs to change ways of knowing and doing and challenge systems they work within to ensure inequities improve. She goes on to state that until that happens, nurses are not actually culturally safe. She raises racism and unconscious bias as contributing factors to persisting health care inequities and also suggests that the current NCNZ competence assessment framework (competencies) does not effectively measure culturally safe practice or, ‘effectively evaluate nursing’s contribution to maintaining disparities in health care” (Barton, 2018, p.18).

Māori nurses make a unique contribution, but it is not without challenges

Three masters theses explore Māori nurse's experiences of being Māori and being a nurse. Two are from a mental health perspective (Baker, 2008; Te Hiini, 2011) and one from the experience of new graduate Māori nurses on a Nurse Entry to Practice (NEtP) programme (Foxall, Forrest & Meyer, 2017). All speak to the additional responsibilities involved for Māori as advocates for Māori, which is often unrecognized, misunderstood and/or not valued. All recommend additional support for Māori nurses such as cultural supervision and refer to this being an integral aspect that needs addressing as part of undergraduate education.

Baker (2008) undertook a master's thesis to explore the cultural differences of the Māori world and the culture of nursing for Māori mental health nurses. She undertook focus group interviews with Māori nurses and the central theme that came out was interaction with two worlds and bridging of tension which occurs from this (Baker, 2008). She describes the unique contribution Māori nurses bring to nursing through their knowledge of te ao Māori (the Māori world) which is the foundation of health and the Pākehā (non-Māori) knowledge and skills they have obtained as a nurse. The tension experienced is the bridging of the two worlds Māori nurses needed to do to navigate between each world. This is described as two main themes, going beyond, and practising differently. Within these themes the following were recognised: the challenges to meet needs of Māori, personal strength and resilience that is required to navigate and shift between two paradigms, the ability to incorporate Māori values and practice into nursing, observance of tikanga (protocol), advocacy for wairua (spirituality)[9], relationships and whānau (family) connections.

Baker's work states that this process of using self (as Māori) and learning to navigate two cultural worlds begins for Māori as nursing students and that this is an additional responsibility for Māori to be both a nurse and proficient in managing Māori issues. She states, "there is a vulnerability amongst Māori, when there is an expectation from the Māori world, that they may not feel equipped to fulfil or if the Māori nurse has not defined their own Māori identity…" (p.85). Māori nurses may also have an increased burden from Non-Māori nurse colleagues where they are asked for advice and seen as a resource person to respond to Māori client needs.

[9] Not a direct translation. This is a Māori concept that does not fully translate in English.

In conclusion Baker makes a number of recommendations for practice, education, and policy. These are, recognise and value the dual responsibilities of Māori nurses, provide cultural support, networks and resources for Māori nurses, work to eliminate racism in the workplace, provide support and education to undergraduate Māori nurses to prepared them for the dual competencies required to be a Māori nurse, affirm Māori knowledge and model of practice in undergraduate education and strengthen service and workforce around Māori health and practice (Baker, 2008).

Te Hiini, (2011) similarly studied Māori mental health nurses to describe their practice. Her central points relate to being Māori, survival, independence or interdependence, adaptability and resilience and incorporating tikanga (custom) in practice. Participants cultural identity as Māori could not be separated from their identity as a nurse, as their upbringing, whakapapa (genealogy) and values heavily influenced and informed their nursing practice. Survival refers to having to 'survive' in a Western world where practice may not align with Māori values, the experience of racism, and having to adapt within the two at times, opposing worlds of te ao Māori and te ao Pākehā (Māori and non-Māori worlds) (Te Hiini, 2011). The theme independence and interdependence refer to the concept of autonomy, which is valued within a Western paradigm, but conflicts with Māori values of whānau, working together and within relationships, kinship and connecting with others. Adaptability and resilience refer to participants descriptions of the strength it took to become and continue to be a nurse. Finally, the importance of incorporating tikanga into practice was acknowledged. She concludes that Māori nurses competently navigate both cultures and are driven not by the, "clinical nursing requirements but the expression of tikanga Māori practices of whanaungatanga (connectedness), manaakitanga (support), aroha (love); that form the basis of the therapeutic relationship" (Te Hiini, 2011, p.47).

There is little published regarding the idea of dual competencies for Māori nurses that is, Māori nurses meeting both the NCNZ competencies for nurses and meeting other, additional cultural competencies as defined by Māori nurses. Te Rau Ora, a Māori health and wellbeing agency, have developed a dual competence accreditation programme for Māori nurses however, detail regarding the Māori competencies is not publically avaliable. Describing the contribution Māori nurses make is important to the provision of culturally safe care of Māori, to promote and advance Māori nursing and to ensure appropriate support is provided for nursing students to develop this aspect of their practice.

Equity through education – Undergraduate medical experiences

In 2004 the Council of Deans of Australian Medical School (now called Medical Deans Australia and New Zealand) released an Indigenous health curriculum framework as a guideline for all medical schools in Australia and New Zealand for the development and delivery of Indigenous content in undergraduate programmes. The Universities of Auckland and Otago then wrote similar hauora (health) Māori graduate outcomes based on this framework (Jones et al., 2010). The justification for including a specific Māori curriculum as part of medical education was in response to the persistent health inequities of Māori and acknowledgement that health professionals contribute to these through biases. Health professional's education is critical to equity of outcomes (Jones et al., 2010).

Jones et al., (2010) also suggests that cultural competency is often focused on race or ethnicity more so than other cultural dimensions. This is supported from a nursing perspective. In a recent master's study of nurses understanding and articulation of the NCNZ competency 1.5, *(practises nursing in a manner that the health consumer determines as being culturally safe*), Fogarty found many nurses chose a Māori client example to demonstrate meeting Cultural Safety (2018).

Jones et al., state while cultural competence education needs improving in medicine, Māori academics should not be relied upon to teach this aspect of the curriculum and Māori health should be its own distinct aspect of the curriculum (2010). They recommend within the medical curriculum there are multiple opportunities to learn about Māori health and apply it, that it should be a thread throughout the curriculum and students should also have other opportunities to learn in immersive experiences (e.g. marae based), demonstrate their learning in practice, and be formally assessed on their learning.

Huria et al., (2017) continued research into the New Zealand application of the Indigenous health curriculum at the University of Otago. They evaluated the curriculum over 2006-2014 which included over 500 student responses. Their approach involves situated learning, interaction with Māori, assessment of Māori using the hui process and Meihana model (Māori frameworks for clinical assessment) and guided learning through exploration of unconscious bias, stereotyping and te ao Māori. This occurred through an immersive learning experience at a marae. In summary, students valued the learning and they recommend, "multiple pedagogical approaches, faculty role-modelling and peer interaction during teaching" to engage learners, increase skills and confidence (Huria et al., 2017, p.7).

Some of the challenges identified in their study include the strong focus on 'traditional' science and decreased value placed on humanities and Indigenous content, lack of Māori academics and staff capacity to resource the content, a lack of Māori leadership within the faculty and the need for whole of faculty buy-in to the curriculum. The philosophy that Indigenous content is the responsibility of the whole of the faculty was identified in an earlier study (Huira et al., 2010) as critical to positioning the content for students. If there was not strong leadership and support from the whole of faculty, the Indigenous content could easily be undermined.

The medical profession is actively researching the role they play in reducing inequities. The role of undergraduate medical education in reducing inequities has been explored over the past decade by Huria et al., (2010) at both of New Zealand's medical schools. Recent research has explored health policy and health systems, where literature was explored using a conceptual model impacting health inequity (Chin et al., 2018). This was a comparative study of New Zealand and the United States contexts. Overall, they found that both countries had few policies that were strong or explicitly designed to achieve equity for minorities or those in low socio-economic groups. While New Zealand undergraduate medical education is legally required to include cultural competence, the extent that, "trainees and graduate are required to demonstrate competence in Māori health and health equity is limited" (Chin et al., 2018). In the United States undergraduate/graduate cultural education is voluntary. Four recommendations are made to promote equity including ensuring health care services are accountable for outcomes related to equity, ensuring health services work collaboratively across services, power is shared with Indigenous including promotion of Indigenous leadership and self-determination and ensuring that 'free, frank and fearless' conversations occur about institutional racism, colonisation, white privilege and unconscious bias (Chin et al., 2018).

Culturally competent to culturally safe doctors in Aotearoa New Zealand

More recently the Medical Council of New Zealand worked with academics and members of Te Ora, the Māori medical practitioners' group to revise their position around cultural competence for doctors. As part of this project, Curtis et al., (2019) undertook a comparative literature review exploring literature and definitions of cultural competency and cultural safety. Following this review, they concluded that the Medical Council should revise the definition to be one of Cultural Safety rather than competence. They draw heavily on Ramsden's work, particularly the critical theory underpinning it and the notions of power inequities in health care relationships (Curtis et al., 2019). They also posit that Cultural Safety

definitions need to move beyond focusing on individuals, and instead be extended to organisational cultures and processes that may perpetuate inequities.

The resultant statement on Cultural Safety released by the Medical Council of New Zealand in October 2019 reflects the shift in language from competence to safety and has a focus on health equity. This brings the medical and nursing lexicon more closely aligned, which could have benefits in more clearly articulating the knowledge and skills the public should expect from health professionals. Heke, Wilson and Came (2018) analysed the regulated New Zealand health professions definitions of cultural competency standards. They found the variations presented an inconsistent picture of how many of the professions enacted their standards and recommend regulators across health professions align in order to better "support practitioners to deliver an improved health care experience for Māori" (2019, p. 1).

Chapter Summary

Although the concept of Cultural Safety arose from conversations in nursing education and the feelings Māori students had in experiencing nursing education and nursing, (many of which have been described in the literature as common internationally with Indigenous students in dominant culture educational settings), there appears to be a disconnect between the theoretical concept and the application of Cultural Safety in nursing practice. Recipients of nursing care and nursing students report feeling unsafe. Nursing environments, workplaces and teams are permeated by racism and unconscious bias which present serious issues for patient safety and hinder nursing's potential to decrease health inequities.

The concepts described in the literature related to Cultural Safety lend themselves easily as transferable to the educational environment for Indigenous students in general. Richardson (2011) describes how identity and culture are important resources during times of vulnerability and stress in health and that through the development of a trusting nursing relationship, "these resources can be fully realised" (p. 45). This could easily be applied to the needs of an Indigenous learner and the student-teacher relationship. Richardson (2011) suggests the Nursing Council should advance the concept of Cultural Safety to move beyond the individual nurse's responsibility and move to an institutional responsibility[10], which the Medical Council have now articulated in its latest statement on Cultural safety (Medical Council of New Zealand 2019). Indeed, it should be a collective responsibility for all involved in the health and education sectors. Health and education operate within a politically shaped environment and if

[10] The Nursing Council, however, did not enact this recommendation, nor have they significantly revised their definition related to Cultural Safety for some years.

these environments are not reflective of culturally safe values, then culturally safe practice, be it in health or education cannot be fully realised.

Literature from a range of disciplines including education, psychology, social sciences, medicine and nursing have been drawn upon in order to develop a picture of what is known about Indigenous student success in education, predominantly in the tertiary setting and in nursing baccalaureate programmes. The literature identified common themes to Indigenous success and similar models across sectors in use to promote this. Transferable concepts are seen in education and health especially regarding Indigenous within a dominant culture, and it appears that success for Indigenous as individuals can have a much wider ripple effect of positive influence on families and communities.

Following this review, it can be determined that there are a multitude of models and evidence about what works for Indigenous students, but little recent research specific to nursing education. In particular, there is little about the perceptions and practices of non-Indigenous teachers working with Indigenous students. Nurse educators need to be competent as both culturally responsive educators and culturally responsive practitioners and it appears that there is a gap between the theory of Cultural Safety and its application to nursing practice and particularly in its application in nursing educational practice.

Chapter Three

The Research Design and Process

He nui maunga e kore e taea te whakaneke, he nui ngaru moana mā te ihi o te waka e wāhi

A mountain cannot move, a giant wave can be broken by the canoe's prow

Introduction

This research investigates how New Zealand tertiary education institutions, schools of nursing and nurse educators respond to Māori nursing students' learning needs. The purpose of this study is to explore how New Zealand tertiary educational institutes prepare for and work with Māori nursing students.

The previous chapter reviewed the literature, which provided a background, context and a rationale for the study aim and the research questions which are:

- What are institutional and school strategies that seek to support Māori nursing students?
- What are nurse leaders' and educators' perceptions of barriers and enablers in providing nursing education to Māori nursing students?
- How do nurse educators understand and interpret cultural safety in nursing education?
- How do nurse educators' practice and apply the concepts of cultural safety in nursing education?

This chapter begins by identifying the intrinsic assumptions in the research, locating me as a researcher within the work. I describe how this work is informed by my identify, the experiences I have had and the values and beliefs that motivate me and guide my practice. Formal theoretical perspectives of the research are then outlined, including Critical Theory, Freire, and Kaupapa Māori principles. Following this, the mixed method research design is outlined, and the approach to ethical issues are detailed. The chapter concludes by describing the research processes that have been undertaken including the data analysis approaches.

Epistemology

Crotty (1998) suggests epistemology, theoretical perspectives, methodology and methods are interrelated. Defining the epistemological approach informs more than the, "overarching structure of the research including the kind of evidence that is being gathered, from where,

and how it is going to be interpreted" (Gray, 2009, p. 18.). Figure two depicts the epistemology, theoretical perspectives, methodology and methods which provide the context for this study and the approaches used in undertaking the research.

The epistemological stance is one of constructivism, where meaning comes from our interactions with each other in the world, where meaning is constructed, not discovered (Crotty, 1998). This study explores socially (and politically) constructed educational institutions and the people that work within them. The assumption about knowledge in a constructionist sense is that "meaning is constructed by the individuals thinking about and engaging with the realities they are engaging with" (Crotty, 1998, p. 43). Individuals interpret, construct and understand meaning in different ways according to their worldview and experiences, because of this, individuals may perceive the same phenomenon differently (Crotty, 1998).

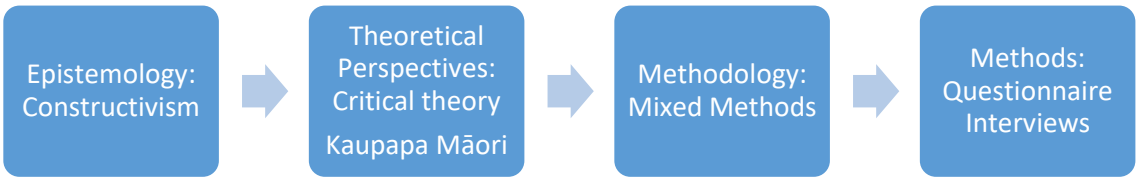

Figure 2. Relationship of knowledge, theoretical perspective, methodology and methods (adapted from Crotty, 1998).

Although it is suggested that pragmatism is a 'best fit' for mixed methods research, it can be reasonably argued that multiple philosophical worldviews may appropriately inform mixed methods research (Creswell & Plano Clark, 2011). Essentially, the epistemological approach is one of constructivism however, elements of pragmatism provide a rationale for the choice of the study design, for example, mixing methods is considered the most practical method in gathering information (i.e. what works) to answer the research questions (Creswell & Plano Clark, 2011).

In any research it is important to acknowledge the assumptions and values the researcher brings to the study. I have provided an outline of who I am and how I came to this topic of study in the introductory chapter, however, my theoretical stance is informed by who I am, my position in society, my education and career, and my personal beliefs and interests. Who I am, informs how I have approached this work, which is described as the philosophical assumptions, worldviews or the theoretical approach that provide the foundation to the study (Creswell & Plano Clark, 2011; Crotty, 1998).

I am a Pākehā (non-Māori) woman, born into a middle-class family with tertiary educated parents who were career focused. I view education as transformative because it has shaped my life, afforded me a highly rewarding career, enabled me to study further extending my thinking, helped me to have independent financial security and provided me opportunities to meet people and see places I would not have without it. As a nurse, I believe strongly in social justice and that healthcare and health outcomes should be equitable. I first became aware of my position of privilege in the world during my study to become a nurse. As a nursing student and later as a nurse in practice, I saw many examples of socio-culturally driven inequities that impacted people's health. As a nursing educator I saw these same inequities, but in the classroom setting, impacting on students' abilities to achieve.

As a nurse and an educationalist who has also worked in leadership and policy roles, I draw on different theories for different situations. As a nurse in clinical practice, I may draw on theories of human development and theories of nursing care for example. In mixed methods research, drawing on a range of theories is characteristic of the method, and is called paradigm pluralism (Teddlie & Taskakkori, 2011).

Theoretical Perspectives

Essentially, the overall notions underpinning this research are based on values of social justice, and the belief that outcomes of research, education and health care may all be transformative. Thus, the worldview informing the research is a transformative paradigm, which is informed by and draws on the principles of Critical Theory and Freire's Pedagogy of the Oppressed (Freire, 2017/1970). Kaupapa Māori and social justice principles are also drawn upon throughout this work.

Given the context of this study, exploring experiences of working with Māori nursing students, it seemed logical to align with Critical Theory. I draw on Freire's theory, Pedagogy of the Oppressed (Freire, 2017/ 1970), because this study is situated in an education context and relates to students that may be considered 'oppressed', or marginalised[11] because of colonisation, overall lower education participation and achievement statistics. Additionally, I outline concepts of Kaupapa Māori theory and describe how these concepts underpin the theoretical stance of the project and locate it in the context of Aotearoa New Zealand.

[11] I do not like either term oppressed, or marginalised in reference to people, as they seem to be negative labels. However, the literature has not offered alternative terminology to describe the inequities in groups where there are power differences at play.

Critical theory

While epistemology defines "how we know what we know" (Crotty, 1998, p. 8), theoretical frameworks provide perspectives with which to look at the research. Critical Theory is concerned with the principles of equity and of justice (Reeves, Albert, Kuper, & Hodges, 2008) and therefore, seemed a logical fit for my social justice lens. Social justice when applied to an educational setting, refers to the pursuit of a just, human, and civil society, where all people are treated with respect and dignity. Jorgenson (2015) says where those not of the dominant culture are valued within the education environment, all people benefit, and education is enhanced for all. This is often referred to in New Zealand as, 'what's good for Māori, is good for everyone', or a universal design principle (Higbee & Goff, 2008).

"Critical theorists study how the construction of knowledge, and the organisation of power in society generally…can lead to subjugation or oppression of particular individuals, grounds or perspectives" (Reeves, Albert, Kuper, & Hodges, 2008 p.633). The intent of Critical Theory is described as political, meaning that its goal is the emancipation of people and groups in an equal egalitarian society (Cohen, Manion, & Morrison, 2011). Critical Theory argues that social structures and behaviours are the outcome of dominance and repression by those that hold power. The dominant power, and thinking is not representative of all, particularly those who do not hold power, whose knowledge and ways of being are seen as legitimate by the dominant individuals/society (Cohen, Marion, & Morrison, 2011).

The role of Critical Theory and critical inquiry is:

> …not merely to give an account of society and behaviour but to realise a society that is based on equity and democracy for all its members. Its purpose in not merely to understand situations and phenomenon but to change them. (Cohen, Manion, & Morrison, 2011, p. 28).

In this respect it is described as transformative or emancipatory, where the application of critical theory seeks to bring about change (to dominant ideals) and therefore give power to those whose interests are not being served or are repressed (Cohen, Manion, & Morrison, 2011; Crotty, 1998). This study seeks to understand the educational setting and practices of those within it, and challenge the knowledge-power interplay, in seeking to define how practice can be changed to better serve the needs of Māori nursing students.

Freire's Pedagogy of the Oppressed

Paulo Freire's theory Pedagogy of the Oppressed is a branch of Critical Theory. As a critical theorist Freire's work is specific to educational settings and disadvantaged (oppressed) groups.

The Pedagogy of the Oppressed is based on experiences in Brazil in the 1960's post-Portuguese colonialism, when political and religious power thrived with little regard for the poor (Darder, 2018). While Freire's theory clearly speaks to that time in Brazil, other colonised and minority people have experienced similar consequences of dominant culture hegemony. The lasting impacts of colonisation in Aotearoa New Zealand have been well documented and are still evident amongst Tangata Whenua (Indigenous people of Aotearoa) today (Huria, Cuddy, Lacey & Pitama, 2014).

Similarities in Freire's theory and the ways in which I view education practice in Aotearoa New Zealand made it a logical framework for this study. Freire's theory provides a framework for analysing, interpreting, and explaining the research findings where there are similar power differentials and inequities in education, driven by pedagogical approach.

Freire's theory is critical pedagogy, an approach to education that is designed to be transformative for people that have been marginalised (oppressed) by dominant cultures, structures, and systems. Freire's theory speaks to the power differences in educational settings between 'oppressed' or marginalised groups and the dominant culture in education. It is premised on the idea that minority students within an education system that is dominated by a culture different to theirs, cannot achieve until the power differences, systems, teaching methods and structures have been understood and dismantled. When this occurs, it is transformative (Freire, 2017/ 1970).

There are two distinct stages in the Pedagogy of the Oppressed, first, "unveiling the culture of domination" and the second stage, begins when "the reality of oppression has been transformed" (Darder, 2018, p.104-105). There are key concepts of Freire's theory that are important to explain, in order to understand the process of transformative education that the theory espouses. This next section explains those concepts.

Conscientização

Freire uses the term conscientização to describe the development of critical consciousness. It is necessary to develop critical consciousness in order for the oppressed to develop understanding of the impacts and processes of oppression in order to rise above it, affirm their world view and autonomy. In a Māori context this could be described as tino rangatiratanga (self-determination). The development of conscientização goes two ways, in that, the oppressor must also develop self-awareness and critical consciousness in order to understand their power, and importantly, how to relinquish it in order to empower the oppressed (Darder, 2018; Freire, 2017/1970).

Freire describes conscientizaćão as necessary for transformative praxis in education. Drawing connections to nursing education in Aotearoa New Zealand, there are parallels in the process of conscientizaćão with Cultural Safety. The process of gaining self-awareness or insight, and understanding one's own culture, and power, is part of the process of Cultural Safety education.

Figure three depicts the Cultural Safety process in nursing, which begins with individuals developing an awareness of differences, followed by what Ramsden termed cultural sensitivity (Nursing Council of New Zealand, 2011). Here, students begin to develop the beginning of critical consciousness or as Freire named it, conscientizaćão. The process to becoming culturally safe in nursing, moving through the processes of developing cultural awareness and sensitivity is a transformative process, like Freire's theory.

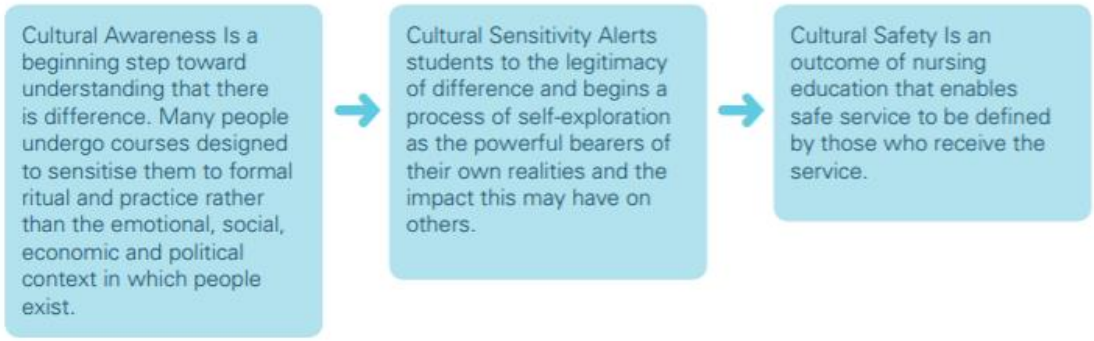

Figure 3. The process toward achieving Cultural Safety in nursing practice (Ramsden, (1994) in Nursing Council of New Zealand, 2011, p. 8).

Banking education and problem posing education

Freire describes the concepts of banking education as a mode of education that perpetuates colonisation and that operates as an instrument of oppression (Darder, 2018; Freire, 2017/1970). Banking education is characterised by, the teacher as an expert, as holding power, and whose knowledge is seen as the absolute truth. Teaching is seen as an act of bestowing knowledge onto others who know nothing. Students are seen as passive recipients of knowledge, who are lesser, and who need to adapt and accept the ways of knowing and doing of the dominant culture. In effect, banking education aims to 'conquer' students to assimilate to dominant ideals, ways of thinking, doing and being.

Darder describes the teacher's role in a model of banking education as, "to fill the students with their narration, without concern for who the students are, or what they bring to the classroom" (2018, p. 110). Historically, nursing education could be compared to a model of banking education. Students worked as apprentices in a culture where education and practice

were based on tasks, rituals, and following instruction. The nurse was not seen as having any personal or cultural agency that could legitimately inform their practice. While this is no longer the case in nursing education today, it could be argued that to some extent the cultural agency of students is not valued in the classroom/practice setting because the dominant cultures within education and nursing are unaware or do not recognise this as legitimate knowledge.

Conversely, Freire's theory suggests problem-posing education as a method to break the cycle of banking education. Problem posing education is the opposite to banking education. Problem posing education positions relationships as central to the process of education, where students and teachers share power and knowledge in order to be 'free' (Darder, 2018; Freire, 2017/1970). Freire refers to the importance of equal relationships in problem-posing education as humanising praxis. He describes two types of relationships, vertical and horizontal. Vertical relationships occur in banking education, where the dynamic between student and teacher is one where the teacher holds authority and power. Horizontal relationships are necessary in a problem posing model of education, where trust, humility and respect occur and are underpinned by people's right to be self-determining. Freire maintains that self- determination is," not the privilege of an elite, but the birth right of all" (Freire, in Darder, 2018, p.123).

In problem-posing education, horizontal relationships occur, and students are active participants, encouraged to be free thinkers and develop critical thinking skills. These relationships support the development of conscientização, where both teacher and students' question, reflect and share culture, knowledge, and power. Freire calls this dialogue, and dialogical praxis (Darder, 2018; Freire, 2017/1970). Through dialogical praxis, the development of conscientização, authentic sharing of power and transformative education occurs. Freire's methodology of conscientização is affirming of individuals cultural as a critical component in education to achieve transformative outcomes (Darder, 2018).

Cultural revolution, revolutionary leadership

The final concept that needs to be explained relates to transformative action. Freire describes transformation as cultural revolution. During the revolution, people learn and grow together in solidarity, with ongoing dialogue (Darder, 2018). However, revolutionary leadership is required to maintain the cultural revolution. Freire states that leadership is necessary to maintain relationships, dialogue, and freedom from paternalistic patterns of banking education and thought. He asserts in order to maintain a cultural revolution, that is, transformative thought and praxis, revolutionary leadership is required of the collective. Revolutionary leadership

maintains the revolution/transformation by ensuring collective conscientizaćão and ensures a move away from thinking about people to thinking with them, a move away from power hierarchies to authentic collective praxis.

Kaupapa Māori Theory

The literature describes Critical Theory and Kaupapa Māori Theory as two theoretical approaches that go well together, as they both refer to concepts of critique, struggle, and emancipation (Eketone, 2008; Mahuika, 2008; Smith, 2003). Critical Theory is also said to have informed the development of Kaupapa Māori Theory, so there are some synergies in these approaches (Eketone, 2008; Smith, 2003). However, Kaupapa Māori Theory cannot be used as the underpinning theory of this research because I am not Māori.

New Zealand is a bicultural society and nursing and education are underpinned by commitment to bicultural practice and te Tiriti o Waitangi or Treaty of Waitangi. While, Critical Theory provides the underpinning structure to the conceptualisation and undertaking of the research, the principles of Kaupapa Māori Theory locates the research in the unique Aotearoa New Zealand context.

Kaupapa Māori literally refers to 'the Māori way' and refers to being Māori, Māori philosophies, principles, language, and culture, and is a way of being that affirms Māori as the norm (Cram, n.d.; Smith, 2003). Cram describes, as an analytical approach, Kaupapa Māori, "is about thinking critically, including developing a critique of Pākehā (non-Māori) constructions and definition of Māori and affirming the importance of Māori self-definitions and self-valuations" (n.d. http://www.katoa.net.nz/kaupapa-maori).

The principles of Kaupapa Māori Theory as defined by Smith (2003) and Pihama (2001) are outlined in table two. The potential of Kaupapa Māori as a transformational theory for Māori is based on these principles being enacted (Cram, n.d.). These principles provide an ethical and analytical framework for undertaking the research by offering a number of concepts on which the conduct of the research is based upon, a number of concepts on which the analysis will draw and provide a point of reference to Māori values in this study.

Table 2

Kaupapa Māori Concepts and Explanations

Concept	Explanation of concept
Tino Rangatiratanga	Self-determination
Taonga tuku iho	Cultural aspirations
Ako Maōri	Culturally preferred pedagogy
Kia piki ake I nga raruraru o te kainga	Socio-economic mediation
Whānau	Extended family
Kaupapa	The collective philosophy
Te Tiriti o Waitangi	Defining document between The Crown and Māori, "provides a basis through which Māori may critically analyse relationships, challenge the status-quo, and affirm the Māori rights" (Rangahau, n.d.).

Navigating being 'Tangata Whenua' and 'Manuhiri'

The uncomfortable feeling I have in drawing upon Kaupapa Māori research as a non-Māori researcher stems from the tension of being unable to uphold the core value of 'by-Māori for-Māori' (Moewaka Barnes et al., 2008; Smith, 2003, 2005). As mentioned earlier, the fundamental elements of Kaupapa Māori research are Māori ways of knowing and seeing the world, and therefore identifying as Māori (via whakapapa) is often described as a necessary component. However, given that a primary aim of this project is to critically analyse relationships, challenge the status-quo, and affirm and acknowledge the relevance and success of Māori in nursing education, acknowledging Kaupapa Māori principles was deemed essential. To help in articulating the tension in this binary of being non-Māori but drawing on Kaupapa Māori principles, the pōwhiri analogy becomes useful. The pōwhiri process is commonly described as a welcome ceremony that involves two main groups; Tangata Whenua (hosts) and Manuhiri (visitors). When I think about my position as an experienced nursing educator, I feel deeply connected to that aspect of my professional identity as Tangata Whenua and as an absolute insider (see further in this chapter). However, when expressing the conflict of wanting to draw on Kaupapa Māori principles for this project, I am most definitely Manuhiri. As such, I am aware of the debate over the role of non-Māori in Kaupapa Māori research, however, it has become more acceptable that non-Māori "should be involved in Māori research (particularly 'Research involving Māori'; and 'Māori-centred research') for many reasons" (National Ethics Advisory Committee/Kāhui Matatika o te Motu, 2012, p. 38). Yet, this comes with a caveat and

caution “as long as it is consistent with a Kaupapa Māori approach” (G.H Smith, 1995; 2003; L.T Smith, 2000, 2005). To this end, and as an ally of Kaupapa Māori research strategies, I adopted a set of principles (table 2) that have been discussed at length (Cram, 2001; G.H Smith, 2003; L.T. Smith, 2000) to help guide me as ‘manuhiri’ in the application of Kaupapa Māori principles in this study.

For instance, in attempting to uphold tino rangatiratanga, as a knowledge gathering exercise it was important to ensure that by relinquishing my role as researcher and assuming the role of teina acknowledged my position as a learner. I viewed this as essential in developing relationships of trust and shared understanding. Acts of reciprocity, accountability and responsibility to give back were completed by the continual sharing of transcripts, analyses and results and findings - an empowering process that sustained participants position as proprietors of the knowledge they shared with me ensuring that their views and knowledge were valued. One of my supervisors acted as an advisor to ensure that if required, the space was mediated appropriately commensurate with physical, cultural, knowledge-base and spiritual dimensions adhering to notions of taonga tuku iho. This also provided a culturally safe way in which to engage with my participants.

This project aims to expose the systemic marginalisation of ‘Māori ways of knowing and seeing the world that occurs inside nursing education institutions and attempts to address the concept of ako. Consequently, this project therefore extends beyond the parameters of influencing pedagogy or the deficit attitudes of nursing educators, but will also assist in achieving both translational outcomes (see recommendations) and transformational change that advocates for power-sharing and empowering outcomes (Smith, 2003) for Māori pursuing a nursing career and vital contribution to ‘kia piki ake i ngā raruraru o te kainga’ and the overall ‘kaupapa’.

Methodology

Mixed methodology

This study uses mixed methods. Various definitions of mixed methods research have evolved as the method itself has evolved in recent years (Creswell, 2015; Creswell & Plano Clark, 2011). A contemporary and accepted definition of mixed methods research is:

> An approach to research in the social, behavioural, and health sciences in which the investigator gathers both quantitative (closed-ended) and qualitative (open-ended) data, integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems (Creswell, 2015, p. 2).

Creswell (2015) further describes the method as an approach that combines quantitative data, such as statistical trends, with qualitative data describing experiences. Mixed methods is an appropriate method where one method of data collection may be insufficient to explain or explore a particular phenomenon. Mixed methods have been chosen in this study because the combination of quantitative and qualitative data create the broadest and most complete picture of the phenomenon being studied. Quantitative or qualitative data alone could not fully answer the research questions. Therefore, combining quantitative and qualitative data provides a not only a holistic picture of the phenomenon being studied, but also more evidence about the research problem which could not be achieved by either method on its own (Creswell, 2015; Fraenkel, Wallen, & Hyun, 2012).

The advantages in using mixed methods are in the combination of the strengths of both quantitative and qualitative research methods, the ability to generate more evidence to answer questions that a singular approach cannot and the ability to approach the research using multiple worldviews (Creswell & Plano Clark, 2011). Creswell and Plano Clark argue that the strengths of mixed methods, "offset the weaknesses of both quantitative and qualitative research" (Creswell & Plano Clark, 2011, p.12). In short, mixed method research can answer research questions that "cannot be answered by quantitative or qualitative approaches alone (Creswell & Plano Clark, 2011, p.12).

The literature describes the disadvantages, or challenges of mixed methods as the skills, time and resources that may be required of the researcher to successfully undertake and interpret research data using both qualitative and quantitative methods (Creswell & Plano Clark, 2011).

An explanatory sequential design

The method selected for this study was ultimately determined by the purpose and the context and by the questions this study aimed to answer. The mixed methods design in this research is an explanatory sequential design (Figure 4). Creswell (2015, p. 38) defines the purpose of this design as, "to begin with a quantitative strand and then conduct a second qualitative strand to explain the quantitative results". In this research, the first phase informs the second phase of the data collection (Figure 3). While a mixed methods design is proposed, qualitative data forms the largest part of the research collection, (quan → QUAL) (Creswell, 2015).

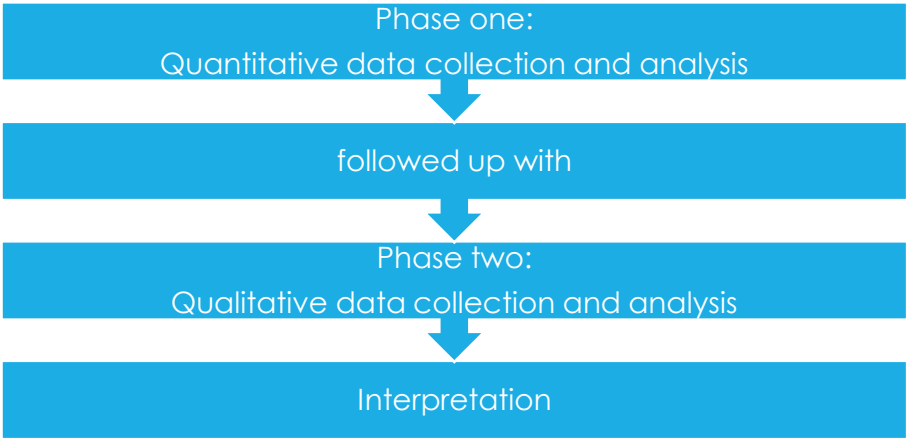

Figure 4. Explanatory sequential design adapted from Creswell (2015).

The rationale for choosing a mixed methods design is to gain an understanding of the nature of the overarching institutional and school level practices related to the preparedness and experiences in working with Māori nursing students. The intent is also to understand nurse educator's perspectives and experiences of those practices and of the barriers and enablers in the classroom, school, and institutional settings.

This project is designed and conducted in two phases (Figure 5). In the first phase, quantitative data was collected. Data was obtained by an electronic, anonymous questionnaire. A process of quantitative data analysis followed, where descriptive statistics are used to make meaning of the data (see chapter 5, Findings of the questionnaire). The rationale for commencing with the questionnaire in phase one of the research was to gain a broad overview of leaders' and teachers' perspectives, and current institutional policy and education practice related to Māori learner teaching and learning. The questionnaire collected demographic information, quantitative data and explanatory comments. The primary mixing of data in this explanatory sequential design occurred in informing and connecting the two phases, or data sets, that is, the quantitative results are used to "make decisions about qualitative research questions, sampling, and data collection in phase two" (Creswell & Plano Clark, 2011, p.75).

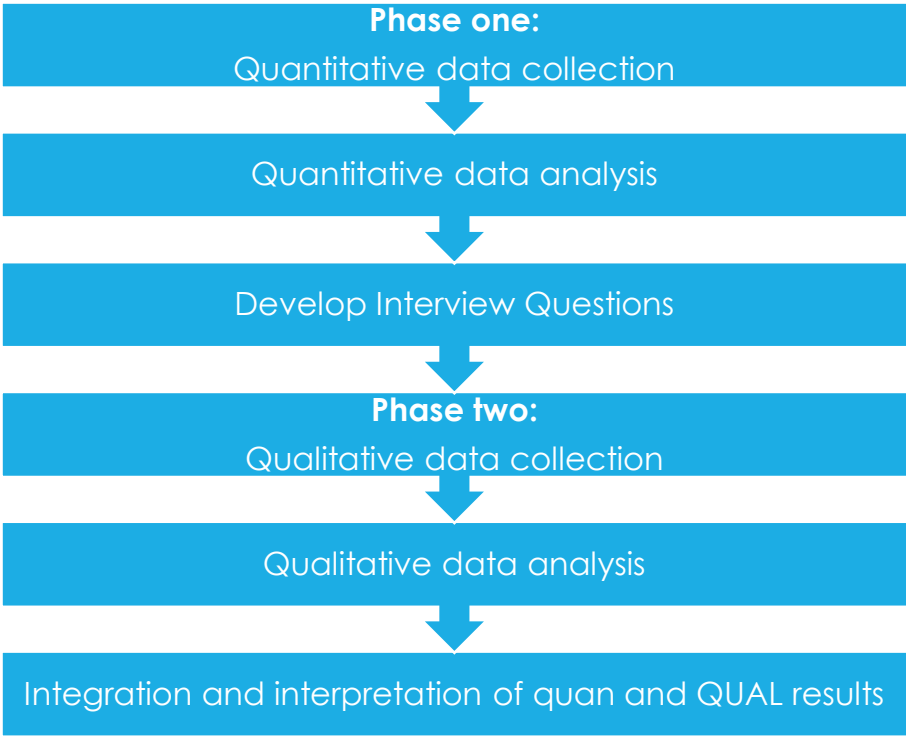

Figure 5. Stages of explanatory sequential design in relation to project.

Phase two of the research followed the analysis of the questionnaire, where semi-structured individual interviews were conducted, to explore, in more depth, educator practice, understanding of, and experiences with Māori learner success. Questions or areas requiring more detailed exploration arose from the findings of the quantitative phase. Although some qualitative data was gathered from the open-ended questions in the questionnaire, the subsequent in-depth interviews provided much more detailed data to help explain the findings of the questionnaire, as well as develop a more comprehensive picture of the phenomenon.

The final aspect of the research involves the integration and interpretation of the data sets from both phases (quantitative and qualitative results). This process of integration involves, 'integrating all data into a coherent whole" (Creswell & Plano Clark, 2011, p.214). Here discussions and implications of the findings occur, and recommendations will be made at the conclusion of the project.

Ethical Considerations

Any research requires consideration of ethical issues. Prior to commencing the research, approval to conduct the research was required and subsequently obtained from the Massey University Human Ethics Committee (See appendix A). "Ethical and legal issues in research are concerned with the protection of human participants for whom there are ethical codes and

legal regulations to ensure the absence or minimisation of harm, trauma, anxiety or discomfort" (Schneider, Whitehead, LoBiondo-Wood & Haber, 2016, p. 81). Undertaking research requires responsible and ethical practice on the researcher's part, and the following section details how ethical issues were addressed, including the role of the researcher as an insider, the ways in which participant protection was assured and how the research was conducted in a bicultural manner in line with Tiriti o Waitangi or Treaty of Waitangi responsiveness.

The role of the researcher – An insider

When a researcher identifies as part of the group that is the focus of the study, it is referred to as insider research (Polit & Beck, 2012). As a nurse academic with experience in both teaching and leadership and management of undergraduate nursing education, I am considered an inside researcher. When I commenced this study, I was employed in a school of nursing in a management position, so I was particularly aware that there may be a perceived conflict of interest or power imbalance. As it turned out, by the time I was ready to interview participants, I was no longer in this position, and had some distance from the schools of nursing in my new employment position in policy. However, I was still an insider researcher as someone still involved in the oversight and regulation of nursing education.

Insider research has both strengths and limitations. As an insider, there is an intrinsic awareness and understanding of the subject studied and a relationship based on common understandings with the participants as colleagues in education and in nursing. This understanding is critical to the ability to not only ask the right questions, but also to interpret the data and in the ability to construct meaning from the findings.

Polit and Beck (2012) recognise advantages of insider research. They describe it can bring an ease of access through a researcher's cultural capital; it can also avoid participant or context disturbance; and an insider researcher has a wealth of implicit and explicit knowledge. Bonner and Tolhurst (2002) describe another advantage of insider researcher as ease in gaining trust and acceptance from participants. Conversely, it is important to acknowledge disadvantages of being an insider. There may be the potential for researcher bias and predetermined views about the subject and the possibility that participants perceive a power imbalance or coercion issues (Bonner & Tolhurst, 2002; Polit & Beck, 2012).

These issues can be addressed using appropriate strategies including the identification, acknowledgement, and management of potential issues. As an inside researcher, it was important to be conscious of these potential issues and plan to manage them as part of the

ethical consideration of this study. Throughout this study, I have carefully reflected on myself and considered my worldview and position. I have used reflexive strategies to separate ideas to reflect and clarify whether ideas arose from my experience of were those of the participants. Examples of how reflexivity occurred include journaling, mind mapping and critical discussion with the supervisory team. Issues of power and coercion were managed through a process of informed consent, additionally, the participants were not considered a vulnerable group. During the interview data collection, I was careful to seek clarification from participants to ensure I understood their experiences and not compare these with my own. Researcher bias, however, was somewhat of an inevitability.

Denzin and Lincoln (2011) state that "all research is interpretive: guided by a set of beliefs and feelings about the world and how it should be understood and studied" (p. 13). Researchers are aware that as their beliefs and feelings impact on the study this becomes a bias, that they have a duty to acknowledge and then moderate this effect (Denzin & Lincoln, 2011). This is particularly relevant as an inside researcher. As an inside researcher, I am upfront about the way that I view things, and in that respect, I own my biases. The findings need to be viewed with my position in mind. However, through the study process, I have reflected on the findings, and reflected on my beliefs, and any potential willing on my part to find pre-determined outcomes. However, this was not the case. The findings challenged my thinking and presented many unexpected findings. The process of academic supervision additionally offered many opportunities for guided reflection throughout the study.

Protection and respect for participants

The Massey University code of ethical conduct for research, teaching and evaluations involving human participants (the code) (2017) has provided a framework for considering ethical principles in this study. Coupled with this, the theoretical frameworks guiding the study reiterate many core ethical principles and position this research as bicultural in the unique context of Aotearoa New Zealand. The ways in which participants have been protected and respected through all steps within this research are outlined using the ethical principles and research values detailed in the code.

The Massey University ethical principles include:

- autonomy
- avoidance of harm
- benefit
- justice

- special relationships
- whakapapa (relationships)
- tika (purposefulness)
- manaakitanga (cultural and social responsibility)
- mana (justice and equity)

In addition to these principles, research values outlined in the code relate to the bicultural context of Aotearoa New Zealand. The values are specifically concerned with the researchers approaches to relationships and communication with participants, particularly respect for and a humble approach to others knowledge and views.

In this study, individuals, their personal beliefs, values, and their right to make autonomous decisions were respected. Their right to participate, withdraw from the research, or not to participate in the research was upheld. All interactions with participants were of a professional nature, and communication was respectful of the privileged nature of the researcher-participant relationship. Establishing trust, particularly in phase two interviews, was an important part of communication, and how this occurred in described in more detail in chapter 5, the findings of the interviews.

By using Massey University templates for participant consent and information forms, I was sure that comprehensive information was provided, including participant rights, so that informed consent could be given. Further surety of these process was given as all participant information and forms were reviewed prior to the study commencing by the university ethics committee.

The sample are not considered vulnerable participants, and participants exercised their free will to informed consent to participate. The consent process (both prior to questionnaire completion and interview) was free from coercion, outlined the purpose of the research, the participant's role and how the data was to be used. The right to withdraw at any point was evident in participant information. Information provided for participants stated that any details that were potentially identifiable would be deleted or obscured. To maintain the confidentiality of the information gathered, identifiable features of the participants were removed from data while maintaining the overall context. Pseudonyms where appropriate were used, and institutions were not named. All interview participants had their right to view, edit and have a copy of their interview transcript. All participant information was anonymised. No identifying information was included in the writing of the research findings nor will be included in subsequent publications that have the potential to negatively impact participants

or educational institutions included in the research. Institutions and participants are anonymous throughout the write up of the data. Storage of data was secure with only the researcher and a professional transcription service having access to raw data. Prior to undertaking the transcription, a confidentiality agreement was signed (see Appendix B).

Tiriti o Waitangi or Treaty of Waitangi principles and responsiveness

Consideration for Māori and Tiriti O Waitangi or Treaty of Waitangi responsiveness are key ethical, legal, and social obligations in Aotearoa New Zealand and are of critical relevance to this research. Tino rangatiratanga (self-determination) and achieving at least equitable health and education outcomes for Māori, are the primary motivations for undertaking this study. However, as a non-Māori researcher, I am clear about my limitations concerning te ao Māori and the importance of ensuring Māori are protected throughout the process of this research. This is a researcher responsibility in Aotearoa New Zealand, to ensure research is guided by and upholds the principles of Te Tiriti O Waitangi or Treaty of Waitangi. Within this research, I have approached this responsibility in two ways. First, through formal academic supervision of this study and second, in the theoretical and ethical approaches to the study.

The Massey University Code of ethical conduct for research, teaching and evaluations involving human participants (2015) states, “In cases where non-Māori researchers are proposing research about Māori or Māori health, researchers should consider carefully their proposal in light of the principle of participation and the need to protect Māori participants” (p.6). As a Pākehā researching things concerning Māori, cultural supervision, guidance, and discussion during the research process was required to ensure the research was culturally safe. One of the academic supervisors of this project is Māori, whose role was to provide cultural supervision, oversight, advice and manaaki (support/protection) throughout the study process. Māori concepts were discussed during cultural supervision, my understandings, interpretations and limitations were guided through this formal process.

The theoretical approach that has been taken to the research has been explained as informed by Critical Theory and that it is cognisant of Kaupapa Māori principles. Through this approach, the imbalance of intrinsic power relationships is acknowledged within the educational system. The perspective of this research is one which aligns with Kaupapa Māori principles and seeks to promote Māori aspirations and views, “to restructure power relationships to the point where partners can be autonomous and interact from this position rather than from one of subordination and dominance” (Bishop, 2008, p.440).

Methods

Phase 1: Questionnaire

The questionnaire, design, and pilot

An electronic questionnaire using software such as SurveyMokey, has several advantages which were considered prior to choosing this method of data collection. Electronic questionnaires are a low-cost method (no printing or postage); are easy to distribute to a wide range of potential participants; use a standard format; and participants may feel a greater sense of anonymity when answering (Wood & Ross-Kerr, 2011). Disadvantages of this method of data collection are that responses are limited to the questions that are posed in the actual questionnaire; participants may interpret questions differently; answers cannot be clarified, and the response rates may be low (Wood & Ross-Kerr, 2011). Responses may also not be fully representative as, those who choose not to respond may have differing viewpoints or be atypical of the subject group (Jones, Murphy, Edwards, & James, 2008).

In this study, the electronic questionnaire was chosen as a data collection method for a number of practical reasons. There was no cost associated with developing and using the survey tool and the software was made available to the researcher as a doctoral student. The software was easy to use and enabled me to design, distribute and transfer data to other software programmes for the analysis. Ease of distribution was also a key factor considered, it was very easy to distribute the questionnaire nationally attached as a link within an email and it was considered probable that most potential participants would be familiar with the survey software as it is frequently used in education settings in New Zealand.

The questionnaire was designed following extensive review of national and international literature. The literature provided context about what was known about the research area and where gaps existed in knowledge. There were no previous studies of this kind in the New Zealand context and therefore, a specific data collection tool needed to be developed. Questions were designed in consultation with the research supervisors. The questions were formulated to specifically gain information related to the research questions.

Prior to extending a formal invitation to potential participants to participate in the research, a draft questionnaire was developed that was then piloted amongst volunteers from the researcher's workplace academic colleagues. The pilot study was undertaken to test the questionnaire as a data collection tool (Schneider, Whitehead, Elliot, LoBiondo-Wood & Haber, 2007). Thirteen volunteers responded to the pilot questionnaire. The participants in the pilot questionnaire were nurse academics or non-nurse academics experienced in research and

survey design. Testing the questionnaire amongst colleagues enabled any errors or ambiguity in the tool to be identified (Schneider, et al., 2007). Specific feedback from the pilot survey helped to refine the final questionnaire with suggestions around the clarity and consistency of question wording, deletion of some repetitive questions, improvements in the numerical scales and general flow of the questionnaire. Following these revisions from the pilot feedback, the final questionnaire was prepared.

The final questionnaire, '*An investigation into the preparedness for and experiences in working with Māori nursing students among New Zealand tertiary institutes, schools and nurse educators*', (Appendix C) consisted of thirty-nine questions in seven sections:

1. Demographic information (six questions)
2. Education (six questions)
3. Current employment (three questions)
4. Institutional approaches to Māori student success (five questions)
5. School of nursing approaches to Māori student success (six questions)
6. Preparedness for working with Māori nursing students (eight questions)
7. Professional development and other education (four questions)

Once the questionnaire was finalised a process of obtaining ethical approval to conduct this study then occurred and was subsequently obtained (see Appendix A). Participant recruitment then began.

Recruitment and data collection

The sample were a purposive group of registered nurses who were either in a position of leadership responsible for staff and an undergraduate nursing programme or were academic staff teaching within undergraduate nursing programmes. Eligible staff from all schools of nursing that had an undergraduate nursing programme were invited to participate.

Participants were recruited via email. Identification of potential participants was through publicly available email contact lists on institutional webpages (for example, www.massey.ac.nz) and also from Nursing Education in the Tertiary Sector (NETS), Aotearoa, a national group of nursing school leaders in the ITP sector of which at the time, the researcher was a member. Permission to use NETS as a method of distributing the email invitation was obtained (see Appendix D and E).

The invitation to participate was sent to all heads of schools that had undergraduate nursing degree programmes in New Zealand in June 2017. Contained in the email was the electronic embedded link to the SurveyMonkey questionnaire, along with information about the

research, the researcher and participant information sheets (Appendices F and G). The email invitations were sent to all heads of nursing schools who were members of NETS (14 out of 17 schools) through the NETS Chairperson. Direct emails from the researcher were also sent to the remaining three heads of schools who were not NETS members (three of 14 schools). Within the email invitation, heads of school were asked to distribute the invitation to their relevant academic staff teaching in undergraduate nursing programmes.

It was anticipated that the survey would be open to responses for a period of four weeks, with reminder emails sent one week before the survey was due to close. Initial responses came in within the first week of the invitation being extended, however, responses slowed significantly after 9 days. Reminder emails were sent at week three and four, which obtained further responses, however, this was not considered enough to be significant, as the expected target was for fifty responses.

Further recruitment strategies were then explored, and two additional avenues were considered. First, potential participants could be identified through most institutional websites where staff profiles were listed along with email contact details. A second strategy suggested by one of the researcher's supervisors was to contact Nursing Review, a national nursing publication to run a short article about the research along with contact details of the researchers and a link to the survey. Further ethical approval was required in order to progress these recruitment strategies and was subsequently obtained.

In total the survey was open for 14 weeks and was closed one week following the online release of the Nursing Review article in October 2017 (Cassie, 2017). A total of fifty-eight responses were obtained.

Data analysis

The results of the questionnaire are presented in detail in chapter four: phase one findings. Data gathered from the questionnaire included demographic information, responses to questions on Likert, nominal scales, and ordinal scales. Some questions included space for participants to provide comment and elaboration. Descriptive statistics are used to, "describe and synthesize data" (Polit & Beck, 2012, p.379). In this study, descriptive statistics were used to describe the participants responses to the scaled questions.

Survey data was exported from SurveyMonkey Inc (San Mateo, California, USA) into both Excel and SPSS formats. SPSS (Released 2016. IBM SPSS Statistics for Windows, Version 24.0. Armonk, NY: IBM Corp.) was used to perform descriptive statistics to characterise the respondents. Insufficient response numbers prohibited any advanced statistical analyses.

Comments provided as free text were collated into an excel document, and the content was analysed by looking for trends in information and key statements of intertest to the research questions. The results from phase one, the questionnaire, provided an overall picture of what was known about the topic, where there were gaps in information and helped to identify areas of interest that needed further investigation in phase two.

Phase 2: Interviews

In keeping with the sequential study design, following the first phase of the research, data obtained were analysed. This revealed some insight into respondents' understanding of institute and school strategy, experience, feelings of preparedness and areas of further development related to teaching and learning practice for Māori nursing students. Further questions were raised through the course of analysis of the questionnaire data which formed the basis of the development of the indicative interview question guide (see Appendix H) Areas where more detail was required such as greater understanding regarding particular practices such as cultural safety practice in the classroom, examples of and barriers to supporting Māori learner success, and understanding of and experiences of curriculum content related to mātauranga (knowledge) Māori.

Interviews are advantageous as they enable in-depth data to be obtained, clarification can be sought, further information, examples or more detailed elaboration can be drawn out by the interviewer (Wood & Ross-Kerr, 2001). Disadvantages of interviews are that they require significant time, interviewer skills, and participants may feel less anonymous than in a questionnaire (Wood & Ross-Kerr, 2001). Individual, one-on-one interviews with participants were chosen over focus groups. The rationale being that some of the information offered by participants may be deemed sensitive and, which they may not wish to divulge in front of colleagues. One to one interviews also allowed for rapport (whanaungatanga) to be developed between the interviewer and interviewee.

Participant recruitment for the qualitative stage two interviews occurred at the same time as the initial invitation to participate in the questionnaire. The email invitation invited participation in both the questionnaire and interview phases. Those who were interested in participating in the interview phase were asked to contact the researcher directly via email. Additionally, at the end of the questionnaire, the researcher's contact details were listed along with an invitation for potential interview participants. To maintain anonymity of the questionnaire data, those who were willing to be interviewed were directed to email the researcher directly. The selection criteria for interview participants centred around the desire

to ensure a national spread of participants, to get a picture about practice across New Zealand schools and to identify regional differences (if any), particularly knowing the Māori student demographic is varied between the schools of nursing in New Zealand.

As with the questionnaire, the draft interview schedule of questions was developed in consultation with the researcher's supervisors and it was then piloted with a volunteer nurse educator colleague. Following feedback from the pilot, minor revisions were made to the order and the wording of the interview questions. The final interview question guide consisted of 18 questions and focused on the following areas:

- Describing participants, their role, and their experience in nursing education
- Experiences and examples of what worked to support Māori nursing students
- Professional development and support related to te ao Māori
- Engagement with Māori stakeholders and how this informed practice
- Opinions and experiences of Māori as priority learners
- Awareness and experiences of racism and unconscious bias in nursing/education
- Understandings and practices of Cultural Safety and Kawa Whakaruruhau

In total, eleven participants volunteered to be part of the semi-formal interview phase, however in the end only ten interviews took place. The final potential participant eventually declined to participate due to workload issues. Participants were in a range of roles as, academic staff members, academic staff members with specific Māori student support roles such as Kawa Whakaruruhau leaders, programme coordinators and a head of school (see chapter 5 for details of participant demographics).

Prior to the arranged interview time, signed consent forms were received (Appendix I). The indicative interview schedule was provided to participants one week before the interview and an offer was extended to participants to ask questions or seek clarification prior to the interview date. The interviews were conducted at a mutually agreeable time, using the video conferencing platform Zoom for the convenience of both interviewee and interviewer. A virtual face-to-face meeting was the preferred medium since the interviewees were based in various locations around Aotearoa New Zealand, ranging from the far north to the far south of Aotearoa New Zealand. Additionally, in keeping with Kaupapa Māori principles, this enabled the ability to 'see' participants, kanohi-te-kanohi (face-to-face), albeit at a distance. Having a face to face connection also allowed for the processes of whanaungatanga (connections) to occur, creating a more personal connection, and an opportunity to interpret body language and facial expressions.

The interviews took place over two months in late 2018. All the interviews were audio recorded, with the consent of participants, for the purpose of transcription. Additional notes were made by the researcher throughout the course of the interview. Interviews ranged in length, from 30 to 80 minutes. Interviews were transcribed verbatim by a professional transcription service who signed a confidentiality agreement. All participants were offered the opportunity to review, validate and modify their transcribed interview. Of the ten participants interviewed, two reviewed a copy of their transcript and made minor changes.

Thematic analysis of interviews

Thematic analysis is described as a "foundational method for qualitative analysis", that is useful across methodologies (Braun & Clarke, 2006, p.4). Braun and Clarke state, "Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, p.6).

It is important to note as an insider researcher, that themes did not arise or emerge from the data, nor does the research 'give voice' to participants. That is, analysis of data did not occur within an, "epistemological vacuum" (Braun and Clarke, 2006, p.14). The theoretical perspectives upon which this research is based, (critical theory and Kaupapa Māori theory) and the knowledge I have brought to the research has informed the thematic analysis undertaken. Themes have been constructed from the data by the researcher to have meaning in relation to the research questions. Braun and Clarke refer to this as a theoretical thematic analysis (as opposed to inductive) which is driven by the research questions and analysed with a theoretical lens and the experience of the researcher.

The process of thematic analysis followed Braun and Clarke's framework of six steps. Each of the steps are now discussed in turn.

Phase 1 Familiarisation with data

Initially, I felt close to the data, having freshly completed each interview, I reviewed my notes, and made summaries of the key points that stood out from each interview. Once the interviews had been transcribed, I then listened back to the recordings, while checking each transcription for accuracy and to fill in any areas where that transcriber had difficulty interpreting, particularly nursing jargon. During this process, I was familiar with each interview, each participant's context and it was a rewarding aspect of the research process, hearing participants experiences and unique perspectives.

Phase 2 Generating initial codes

During the process of familiarisation with the data, it became apparent that I needed to organise the data before I could begin to analyse it. I had not asked each participant questions in the same order, because in some interviews the discussion flow reached questions at different points during the interview. Therefore, I needed to organise the data. I collated the participant responses to each of the questions in one document per question, so all of the responses to the question were collated together. This enabled me to begin looking across the data for initial codes.

After reading and highlighting sections of data that stood out as important to the research questions, I developed a coding process to visualise responses to each question. For each of the interview question categories, I collated a table of codes, basic themes, organising themes, and then global themes for each question. An example of a coding table developed in this part of the analysis is provided in table three. In this phase I was attempting to describe what was said, and initial themes were constructed.

Table 3

Example Coding Table – Thematic Analysis

Q 2 What do you think works well to support Maori students; How do you support Maori students?			
Codes	***Basic themes***	***Organising themes***	***Global theme***
whanaungatanga	whanaungatanga	Whanaungatanga (knowing each other, connecting with individuals)	Maori values and world view are important to Maori student support
Recognising the individual			
Recognising Maori have specific needs that are different to non-Maori			
Supporting students with specific needs often beyond the classroom/programme	Ensuring culturally appropriate support happens	Manaakitanga (extending aroha, helping, supporting)	
Maori nursing staff with specific role to support students			
Māori content/ culturally inclusive practices	The nursing school, staff and programme are bicultural	Kotahitanga (oneness)	
Te reo, tikanga, karakia, marae, pōwhiri, hui		Tikanga (practicing what is correct)	
Giving students time and space to be Maori	Being valued and autonomous as Maori	Rangatiratanga (self-governance)	

Phase 3 Searching for themes

After coding the data within each question category, it became evident that similarities were apparent across questions. I continued reading and rereading the data and began interpreting it at a deeper level of understanding. I then revisited my coding and initial impression of themes and I was able to interpret this as the significance of themes became clearer, and how they were related as a whole. To do this, I needed to visualise how the themes were

interrelated. I created a mind map to extract major ideas from across the data set and I drew connections between ideas to demonstrate their interconnectedness.

Phase 4 Reviewing themes and phase 5 defining and naming themes

Data saturation was evident when no new information or themes were able to be identified within the data. Once I had a visual representation of the initial themes I had developed, I checked in with my supervisors, working through my thematic analysis. I was challenged to revisit my themes, and data. Defining and naming themes (phase 5 in Braun & Clarke's framework), overlapped with phase four. The process of refining themes, moving themes around, naming and re-naming themes occurred several times, and continued as I began writing up the findings. The final number of themes was determined by the data and the main concepts constructed from this. The names of the themes either originated from words participants used, or from the analysis of central concepts described by participants. Throughout this phase, an understanding occurred of not only how data should be organised, but deeper interpretation of what the data meant in the context of the overall study began to be constructed. Here I began to draw upon the theoretical principles guiding the study to create meaning from the findings.

Phase 6 Producing the report

As themes were constructed it prompted further research into ideas that had not been considered previously, such as, ideas around colonisation in education and nursing and conversely decolonisation. Braun and Clarke describe this reengagement with literature as a necessary process in a theoretical approach to thematic analysis (2006). The process of writing, in bringing together the narrative within the themes and subthemes then prompted further analysis. It became evident that initial coding of some data no longer fit, and some subthemes did not have adequate evidence to be justified. After several drafts, the final analysis of the data was complete and is presented in chapter 5.

Chapter Summary

Research questions from disciplines such as nursing, and education lend themselves well to mixed method research as they depend on both quantitative and qualitative approaches to understand often complex social contexts. In this chapter, my background, values, and theoretical perspectives have been described. The role of Critical Theory, specifically Freire, and how Kaupapa Māori Theory have informed this work has been explained. Key ethical

considerations, particularly, participant protection principles and the role of specific bicultural values and the Tiriti o Waitangi or Treaty of Waitangi to this research have been outlined.

The research design, an explanatory sequential mixed methodology, has been justified and a detailed account of the research processes undertaken has been given. In the next three chapters findings from the phase one questionnaires are presented followed by the phase two interviews.

Chapter Four

Phase One: Findings of the Questionnaire

E kore e ngaro, he tākere waka nui

We will never be lost we are the hull of a great canoe

Introduction

The findings from the questionnaire (phase one) and the interviews (phase two) of the research are presented in the next two chapters, concluding with the integration of the two data sets where discussion is generated. In this chapter, the findings from the first phase of the research, the questionnaire, are presented in this chapter under seven headings that align with the seven sections of the questionnaire:

- Demographic information
- Education
- Current employment
- Institutional approaches to Māori student success
- School of nursing approaches to Māori student success
- Preparedness for working with Māori nursing students
- Professional development and other education

The questionnaire findings initially describe the demographics of the participants and then describes the participants' understanding of and opinions of institutional and school approaches to Māori student success. In some questions, ranking scales were used to gather understanding of the participants' preparedness for working with Māori nursing students. Finally, participants were asked what further professional development they would like related to Māori nursing student success.

Demographic Information

Demographic information was collected to create a picture of the participants and the tertiary nursing education sector in general (figure 6). The majority of nursing academics identified that they were aged between 45-64 years (77.59%), with the largest groups identifying as aged between 55-64 years (41.3%). This is unsurprising given that the nursing workforce in New Zealand is aging (Nursing Council of New Zealand, 2020) coupled with the time requirement to achieve the requisite clinical experience and postgraduate education to work in education.

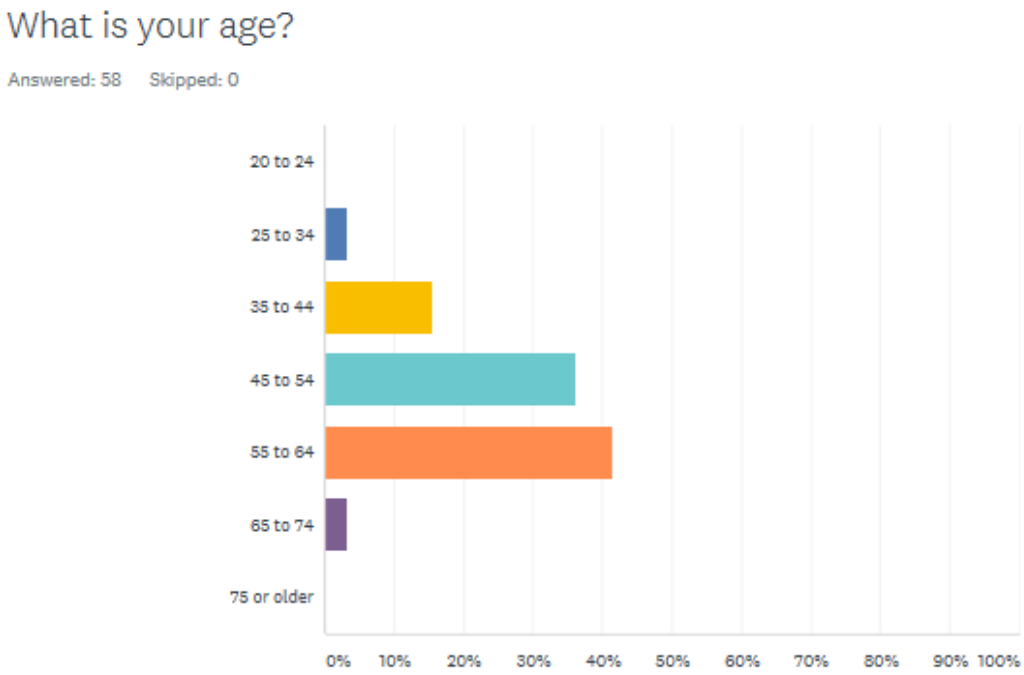

Figure 6. Age of participants.

Men were a small group represented in the participants at 3% which is less than the overall nine percent in the nursing workforce (Nursing Council of New Zealand, 2018). Participants mainly identified as New Zealand European/ Pākehā (79.31%), with Māori and European the second highest ethnicity of participants (13.79%). Three participants recorded 'other' for their ethnicity, and specified American, Canadian, and English. There is a higher number of Māori respondents in this study in comparison with the general population of nurses (7%) which may be due to the subject of this study being important to them, hence the higher participation rate (Nursing Council of New Zealand, 2018).

Age is not entirely representative of participants experience as a nurse, so a question was asked to determine the length of time participants had worked as nurses. There was a range of experience reported (see figure 7). Almost half (46.55%) of the participants had greater than 31 years of experience. All had more than 5 years' experience.

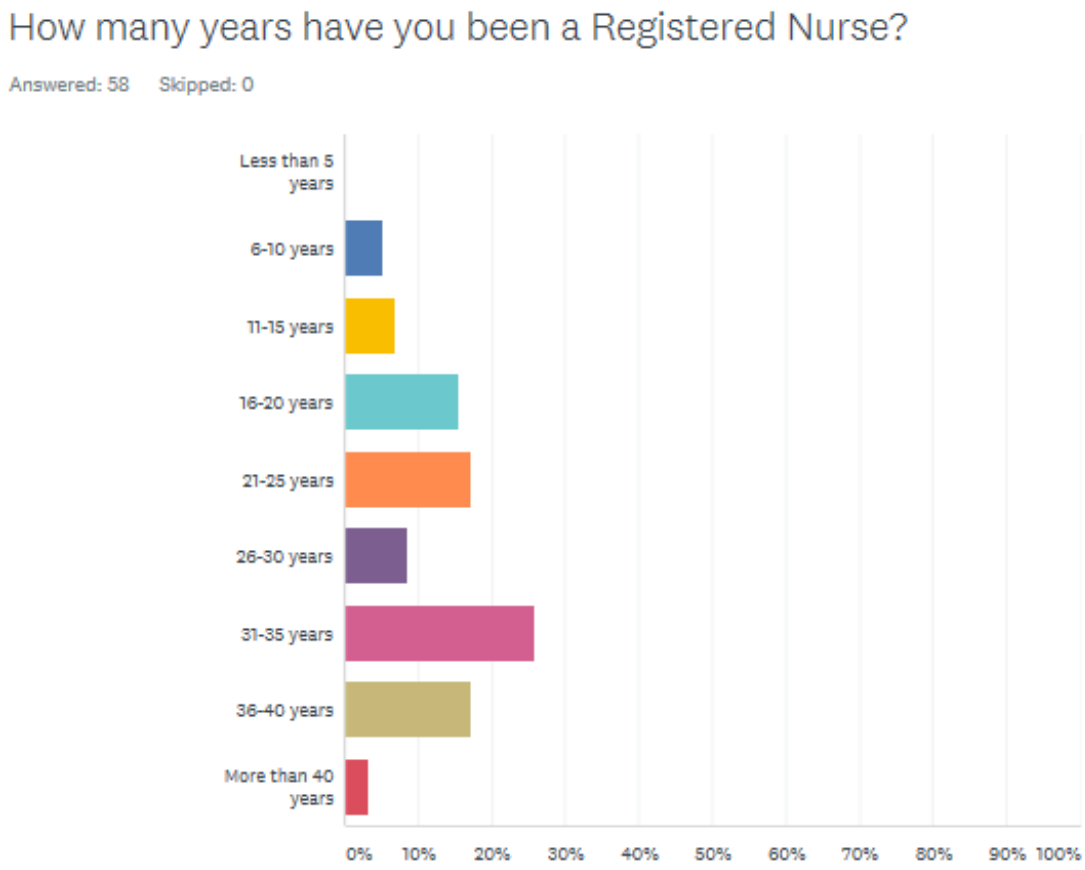

Figure 7. Length of time as registered nurse.

Participants first registered in New Zealand as a nurse between 1970 (earliest) and 2011 (latest). Ten participants first registered in another country. Countries of first registration included England, The United Kingdom, United States of America, and Australia.

Education

Nursing staff in tertiary education in New Zealand are required by the Nursing Council of New Zealand (NCNZ) to be appropriately qualified for their roles. Requirements for academic and clinical teaching staff are outlined in standard three of the NCNZ education programme standards (Nursing Council of New Zealand, 2015). The standards require academic staff to have a relevant master's degree or to be in progress to complete one within four years of their appointment. In addition to this, a qualification in adult teaching and learning is required within two years of appointment. Clinical teaching staff need to have an undergraduate degree or higher as well as have sound understanding of the curriculum and experience in the practice setting they are working within (Nursing Council of New Zealand, 2015).

A series of questions were asked about participants initial nursing education, their highest educational qualification and about their education preparation for teaching. The majority of participants had either hospital-based education (34.5%) or a Diploma in Nursing (43%) as their initial nursing education. This is not surprising due to the length of experience most participants had, (almost half had greater than 31 years' experience) and degree nursing education in New Zealand did not become required until the mid-1990s (Jacobs, 2005). Just under a quarter (22.4%) had an undergraduate degree as their initial education preparation for nursing. Participants initial nursing educational qualifications were obtained between 1970 and 2010, from a variety of countries including New Zealand (84.48%), the United Kingdom (5.17%), England (5.17%), Australia, the United States of America and the Netherlands (1.72% each). Figure eight depicts the range of participants highest educational qualifications. Over 80 percent have a master's qualification or higher.

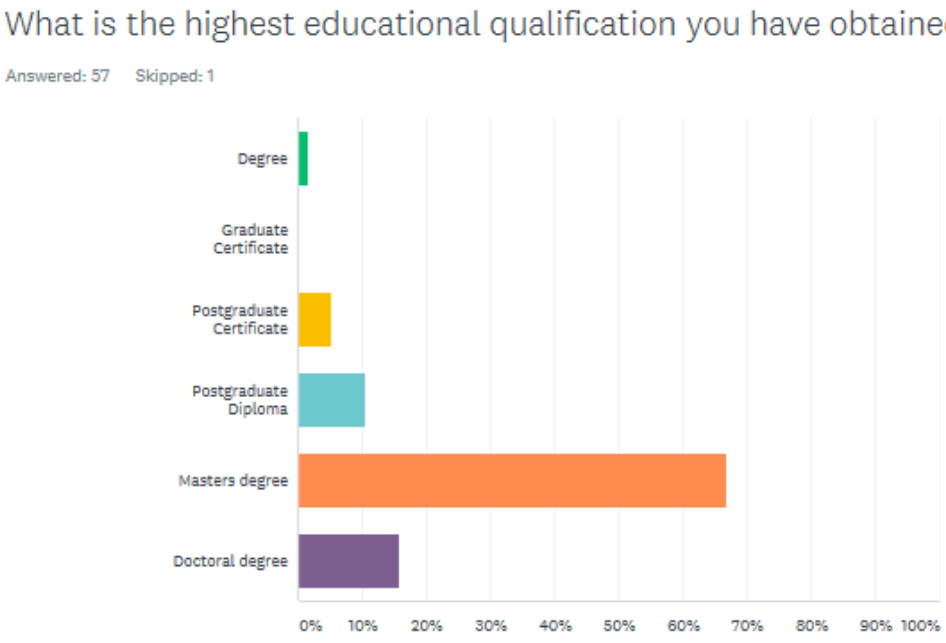

Figure 8. Highest educational qualification.

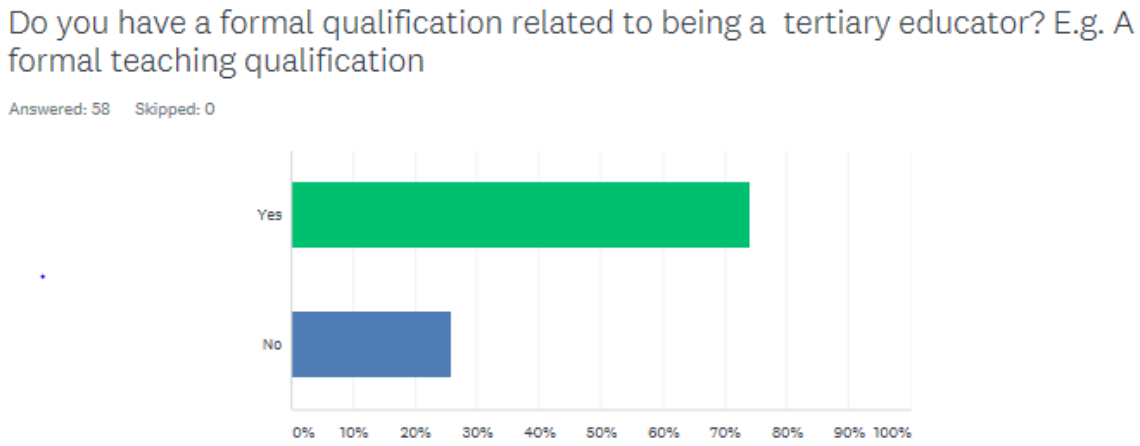

Figure 9. Teaching qualifications related to tertiary education.

Question 12 asked participants whether they had a formal qualification related to being a tertiary nursing educator. The majority did (74.14%) and these ranged from Certificate (level 5) or Diploma (level 6) programmes in 'adult education' or 'tertiary teaching' (see figure 9). One respondent had a Bachelor of Education. Postgraduate Certificate or Diploma qualifications were also common, while three are Masters of Education. Just over a quarter of participants did not have a formal qualification related to teaching. It is unclear whether these staff are working towards this requirement, whether they do not require one for their role, for example, a clinical teacher or for another unspecified reason.

Current Employment

This section of the questionnaire asked about the participants current role and the Māori student population in the school where they work. It is known that the Māori student population varies amongst schools of nursing, mostly due to a reflection of the regional Māori population, but also due to other factors such as, specific Māori curricula, active recruitment programmes for Māori, staff champions and iwi and scholarship incentives for nursing.

Certain schools are potentially identifiable based on providing exact percentages of Māori student cohorts, therefore, this question was designed to maintain confidentiality. Participants were asked to identify within a range of answers from very low Māori student population (0-10%) to very high Māori student population (greater than 30%). Figure ten shows the range of responses. The majority (65.5%) of participants worked in schools with low or very low Māori student populations. Just over thirty-four percent came from schools with medium (21-30%) to high (greater than 30%) Māori student populations. Based on ethnicity breakdown by school, approximately half of the schools of nursing in New Zealand have student cohorts that are less

than 10% Māori and there are four schools with high proportions of Māori students (Ngā Manukura o Āpōpo, 2014).

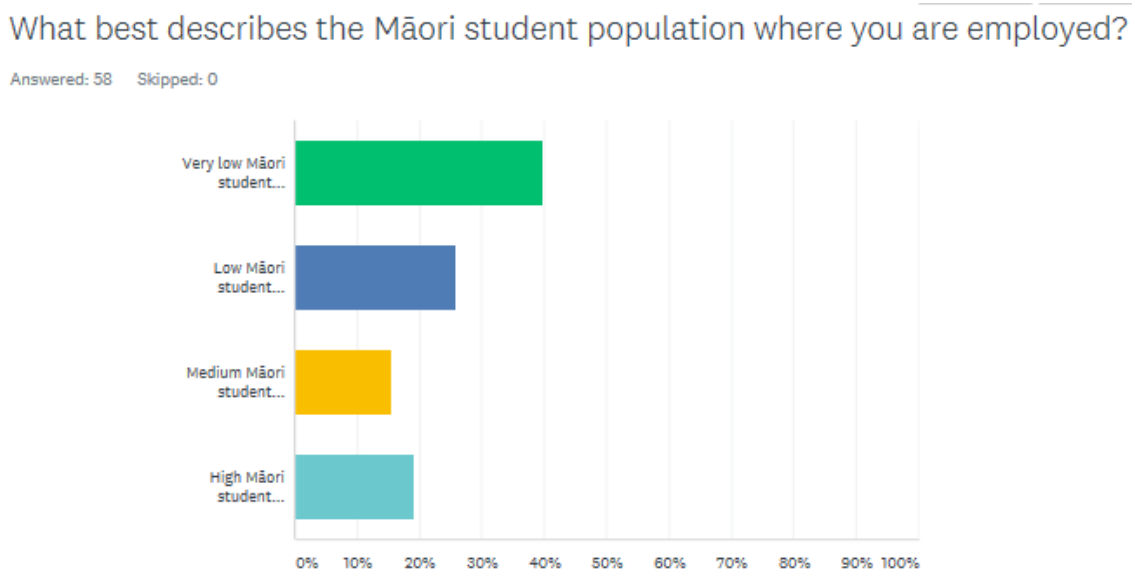

Figure 10. Māori student population of schools.

Participants were asked what best described their current role in the school of nursing (figure 11). Most participants (72.4%) work in academic roles in their schools. It is unclear whether academic roles encompass classroom and clinical practice, as schools have different teaching models. It is likely that these respondents work in both setting because most of undergraduate nursing occurs in Institutes of Technology and Polytechnics (ITPs) where nursing lecturers usually undertake a mix of classroom and practical teaching. Management were the next largest group of participants (13.79%), followed by clinical staff (8.62%). Three indicated their role as 'other'. One commented they worked in clinical practice with students, one participant specified 'academic and clinical' another held a role leading cultural safety in their school.

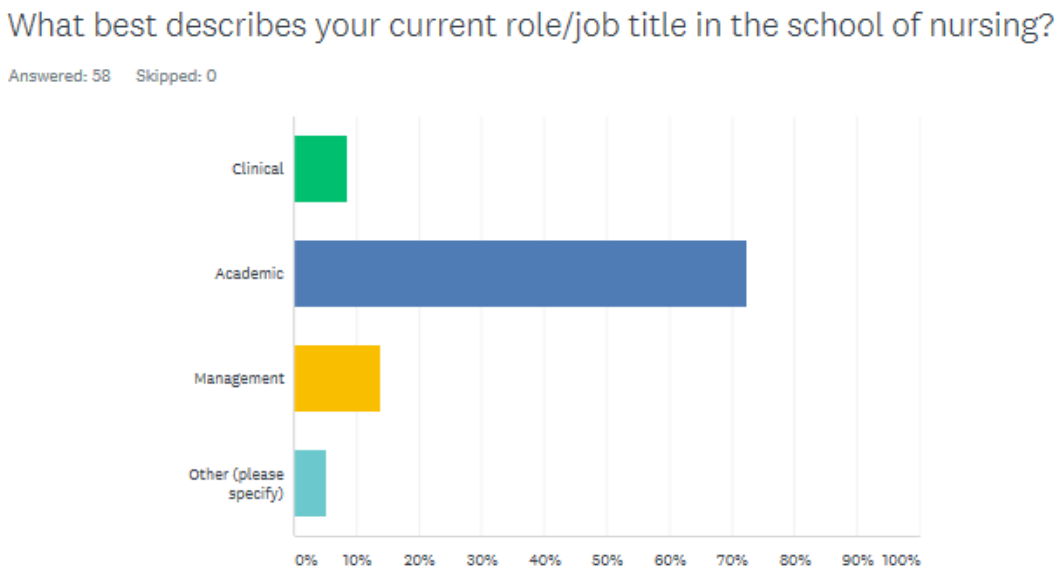

Figure 11. Roles of participants.

Whilst there was a vast amount of nursing experience amongst the participants, over half had been in nursing education between 0-14 years (67.25%). The range of education experience is depicted in figure twelve.

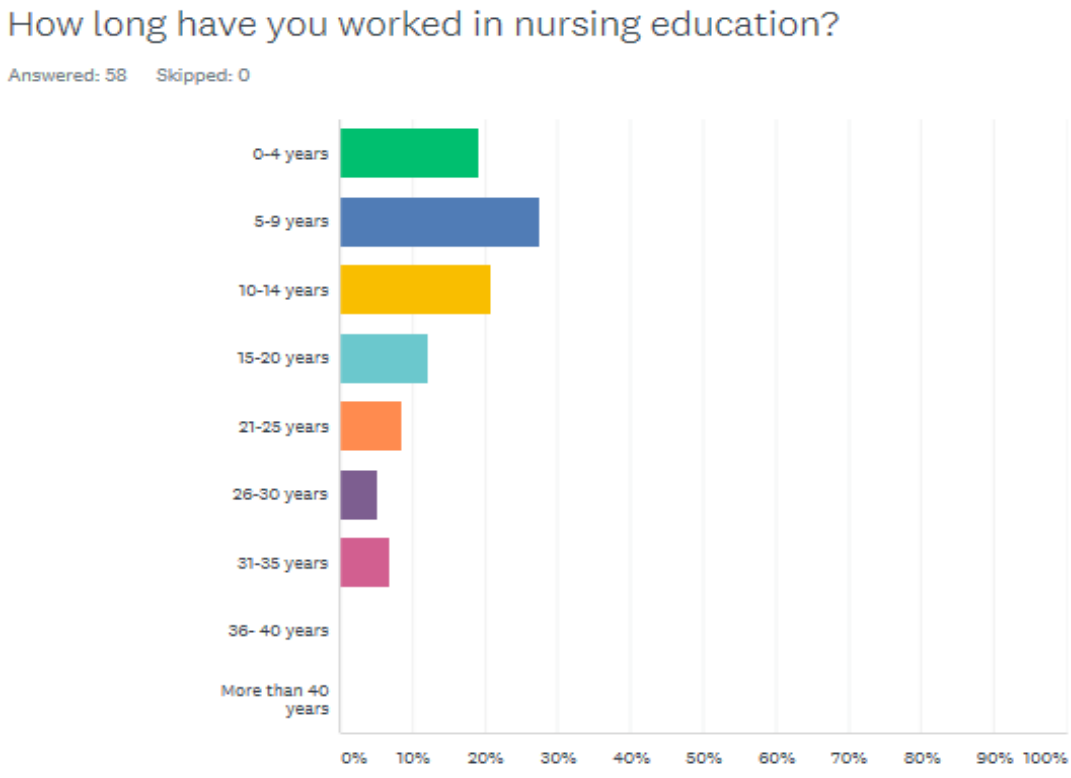

Figure 12. Length of time in nursing education.

Institutional Approaches to Māori Student Success

The Tertiary Education Strategy 2014-2019 describes the areas that are considered priorities for educational performance, funding, and long-term benefit for society through educational outcomes (Ministry of Education, 2014). Boosting achievement of Māori is one of six key priorities of the strategy and as such, many educational institutes have implemented their own more explicit plans on how they intend to contribute to this. The following two sections questions were designed to explore what nursing staff understood about their institutional strategies and their own school strategies related to Māori student success.

Participants were asked whether their institution had a strategy related to Māori student success. 87% responded yes, no one answered no and 12.96% were unsure (figure 13). If they answered yes, they were invited to describe this in a free text box. Twenty-five provided answers naming a specific institutional strategy or other descriptive comments. These ranged from naming the strategy, the types of support and roles offered institute wide for Māori students, such as pastoral, cultural and academic support, Māori recruitment strategies, development of staff competence, reporting on student performance to a full immersion whare wānanga (Māori immersive university) educational environment.

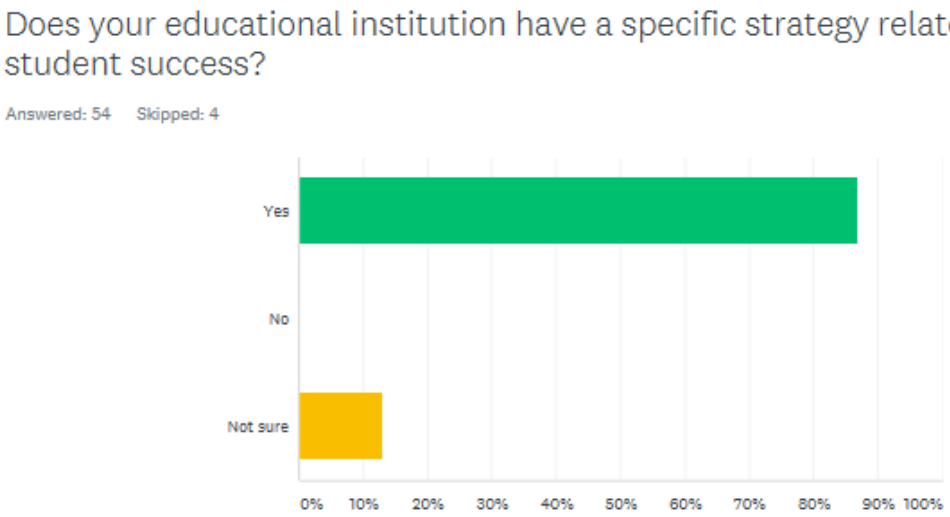

Figure 13. Institutional Māori strategies.

Five could not describe an institutional strategy or were unsure of what it was, as these participants wrote, "*I am pretty sure there is one, however I do not see it at the course level*", and, "*A framework has been developed but I do not think it has been implemented*". Twenty-six did not comment.

The next question asked participants their opinions, on how at an institutional level, the strategy influenced practice. Forty-six responses were provided, and the following themes were extracted from the responses:

Environment

Creating an environment conducive to Māori, appeared to be the overall aim, and intended influence of the strategies described by the participants. Overall, expectations around Māori student's success appeared to be clarified by the institutional strategies, "*It provides clear expectation of how, what, when and who will facilitate the success of Māori students*". Additionally, the institutional culture created by the principles of the strategies were evident in the descriptions, "*The framework sets a standard that success for Māori students is achievable, creating a pattern of success as cultural norm for the organisation rather than the exception*". Another respondent described their institutional strategy, "*… helps us to create a culturally safe and responsive environment with a focus on Māori students but it benefits all cultures".* Two respondents described where Māori staff were in leadership positions this was important to student success, promotion of institutional strategy and the environment where Māori was norm.

Resources such as a whānau room, sponsorship for students to attend hui, provision of free printing and refreshments, greater use of tikanga and te Reo (protocol and Māori language) were also described as was the provision of formally or informally welcoming new students with pōwhiri (Māori welcome) or similar.

Achievement

Achievement, student success and retention and completion rates were also evident in the responses. Achievement and success were quantified by some as positive retention and recruitment of students, *"EPI targets set same as non-Māori"*, and "*pressure to achieve*", while others described this as greater accountability for learners, *"Staff are held accountable for Māori learners within their programmes"* and the strategies as promoting a greater sense of awareness amongst staff, *"High awareness of targets for Māori student success and need to meet or exceed overall success rates".* An environment with greater connectedness (whānaungatanga) to students was also described to be linked with Māori student success, "*The strategy encourages relationship-based learning, which has proven increased outcomes for retention & completion*".

Support for students

The strategies at the institutions also were said to drive the support available to Māori students. A variety of support methods were described such as, academic, pastoral, cultural, peer, and financial support. Dedicated staff and teams were evident for student and staff guidance. The presence of Māori teachers and dedicated support staff were also portrayed as strategic. One respondent was negative about the influence of their institutional strategy and described it as*, "inverse discrimination, Students feel 'picked on'".*

Staff development

Institutional strategies related to all staff development also were commonly described as illustrated in the following quotes, "*Provision of training in Tiriti o Waitangi for all staff, creation of an environment where Māori language and culture are celebrated so that Māori learners can flourish*". Another respondent stated at their institute, "*Non-Māori staff have completed a Māori course… however there is no obvious evidence of implementation of learning in day to day/academic processes by the staff*.

Some difficulties were also described, the strategy for one respondent was a positive influence however, they were not sure if this was a universal feeling, *"This influences my practice but uptake by other lecturers/clinical educators is very individual".*

Another respondent discussed perceived tensions where the needs of one group, Māori, were seen as prioritised over other groups, and the negative feelings this invoked in some staff,

> Difficult, large Pacific population, sometimes needs of the two groups are conflated, Treaty obligations to Māori first then Pacific and others not well understood. Some evidence of a need for better understanding of the rationale for targeted approaches, still hear from colleagues "it's not fair, if you do that for Māori (or Pacific) you need to do that for all students" - attitudes like that contribute to the maintenance of inequalities, so ok to have strategies but need to back up with professional development, resources and genuine commitment.

These three respondents stated their institutional strategy was either absent or unclear to them, "*can't comment about the wider organisation",* and "*it has not been implemented".* One respondent stated, while there was an institutional strategy, it did not affect practice at school level, "*At a University level there is a clear strategy, but this does not necessarily translate at a School of Nursing level".* One respondent felt there was little support for Māori staff, "*There is little support at an institutional level for Māori teaching staff".*

Question eighteen asked whether the institution's participants worked in, employed a specific Māori student support role or roles. Figure 14 illustrates the findings. 83.3% said yes, 12.96% were unsure and 3.7% said no.

Further comments were invited to this question, to gain a fuller picture of the types of roles around the country. Twelve comments were made describing specific support roles including Kaumatua, academic and cultural advisor roles. Some difficulties were reported regarding these roles, as not being sufficient for demand, "*the role has 0.4 FTE (full time equivalent) allocated to it and only functions. Has great potential, but a lot of what happens is invisible and not effective" or ineffectual due to other organisational issues, "The position is not visible or accessible to all teaching staff as they have positioned themselves outside of the department. However, accessibility for tauira (students) is evident. Problem: The position does not feedback to teaching staff the needs and requirements or outcomes regarding Māori student*s.

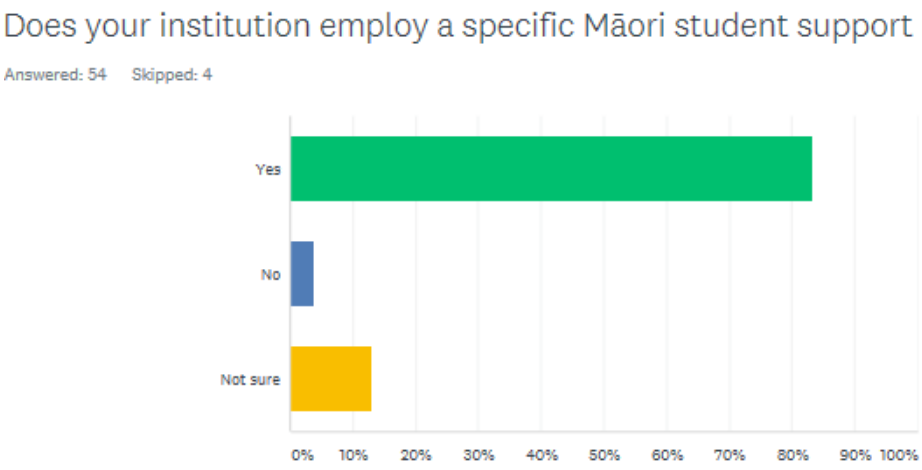

Figure 14. Institutional Māori student support roles.

Perceptions of overall institutional support for Māori students was then explored. Participants were asked to rate on a scale their opinion about the statement, '*within the institute there is plenty of support for Māori nursing students*'. The scale was from zero (totally disagree) to five (totally agree). The majority (72.2%) of responses agreed there was plenty of support answering either a three or four out of five.

The next question was related to agreement with the statement, '*within the institute, there is plenty of support for staff to enable Māori student success*'. The scale was the same as the previous question. Most (68.5%) felt the support for staff to enable Māori nursing student success was a 3 or below indicating that most disagreed with the statement. Of this, 33.3%

disagreed or totally disagreed there was plenty of support for staff. Conversely, 31. 5% agreed there was plenty of support for staff.

School of Nursing Approaches to Māori Student Success

The questionnaire then focused more specifically on examining the school approaches to Māori nursing students. Figure fifteen depicts the responses related to school strategies for Māori student success. 63.4% said their school had a strategy, 19.23% were unsure and 17.31% said their school did not have a strategy.

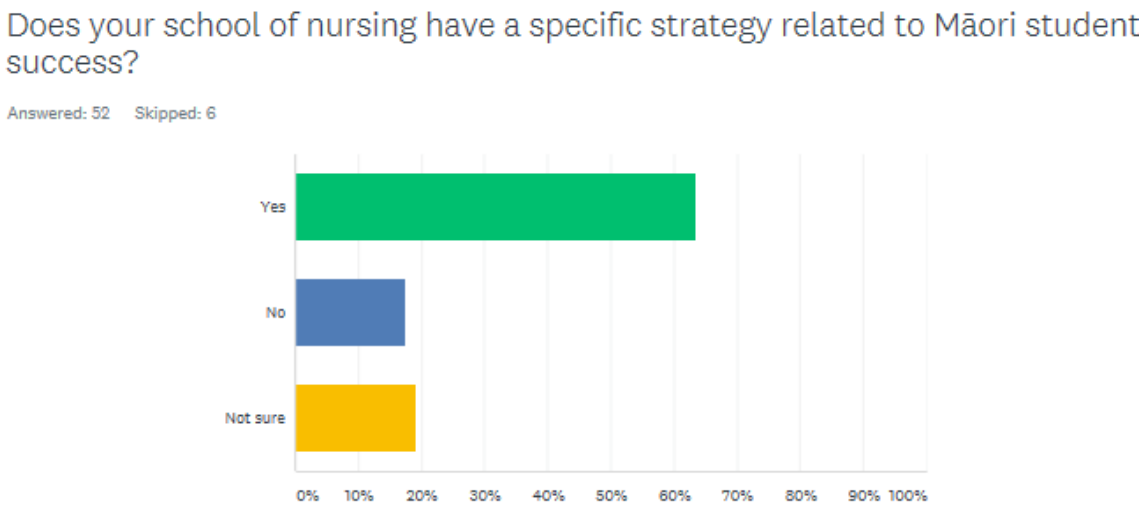

Figure 15. School Māori strategies.

If schools had a strategy, participants were invited to describe this in a text box. Twenty-five respondents provided descriptive comments about their school strategies. Some referred to needing to follow the institutional strategy, one respondent described Kaupapa Māori principles as their school strategy which, "*underpins all teaching and learning".* Several respondents described process of identifying Māori students upon enrolment, to then provide targeted support. Another described their school strategy as, "*To increase the number of Māori registered nurses in the workforce",* and two stated the tuakana-teina approach was utilised. The tuakana/teina approach is a model of mentorship that refers to the relationship between an older (tuakana) person and a younger (teina) person and is specific to teaching and learning in the Māori context (Tūruki Māori Workforce Strategy, no date). Overall, there appeared to be less clarity around school of nursing strategies related to Māori student success as compared with participants' previous answers related to strategy at the institution level.

The next question asked participants to describe, in their opinion, how their school of nursing strategies influenced teaching practice. Thirty-two participants responded to this question and the following themes emerged from their descriptions.

Awareness and expectations

There appeared to be a strong sense of ownership over professional practice and ensuring a positive student experience within the individual schools. Cultural Safety was described by some respondents as one stated, "*Increases awareness amongst staff. However, as academics we are keenly aware of culturally safe educational practices. Personal Practice: I am keenly aware of being culturally safe for ALL my students irrespective of their ethnic background".* The school strategy was also described as serving as a reminder, "*The strategy keeps me conscious of influencing Māori outcomes".*

Further to the awareness school strategies invoked, the idea of success as the norm for Māori was described as an outcome of strategy, "*The framework encourages Māori success to be an expectation not an exception, it describes the aspects key to Māori success with associated strategies to achieve this. Thus, encouraging an organisational norm of success".*

One participant's description spoke of the strategy within their school as being focused on student achievement and having "*course completions being greater than 80%*". Regarding the influence this had on their practice they stated, "*It's something to report on, but doesn't necessarily influence teaching practice or teacher understanding of student needs*".

Support

Like the overarching institutional strategies described early in this chapter, at a school level support was also provided in the way of financial support for hui attendance, awards, and academic, pastoral, and cultural support. Staff in positions of responsibility within the school were seen to be supportive of students and staff however, in some cases it appeared to fall upon Māori staff to provide the majority of support to Māori students. The following two responses illustrate this issue,

> Dean supportive, lecturers seek advice from Māori colleagues, promote and refer Māori students to the support programme in the Faculty and to external support services recommend/refer Māori students to from existing

Another participant also described,

> There is support from BN management and a few non-Māori staff. Departmentally, there is evidence that staff are required to enrol in courses that should support Māori

student achievement, however outcomes are followed through by upper management and there is an expectation that the problems will be resolved by Māori teaching staff.

Valuing students

Extending beyond support strategies described was the notion of the school placing a vested value on Māori students. Achieving equity for Māori, celebrating student successes, and taking a holistic approach to education within the school were all described, "*We also celebrate student success with shared kai and acknowledging other protocol. We involve the individual student's whānau in celebrations and also if there are difficulties*", another participant responded, "*We consider our Māori students to be taonga".*

Staff as role models

The responsibility to act as role models and demonstrate a willingness to learn were identified as important by some respondents. Examples of this was learning Te Reo and demonstrating an awareness of Māori worldview and learning needs. One participant described how this influenced their practice, "*For me it heavily influences my practise. In pronunciation, knowing protocol and attending pōwhiri and generally supporting Māori*".

Specific support roles have proved to be valued by students. The next question was aimed to determine whether schools of nursing in New Zealand had a specific role to support Māori nursing students and to describe them. Figure 16 illustrates that 44.23% of schools in this study did have a specific staff role for supporting Māori nursing students, 7.69% were unsure and 28.85% did not. Some described this as part of their academic workload, where time was allocated to the staff members to provide support to Māori students, two responses indicated they had not been able to recruit into the role, one response indicated a number of Māori academic staff had mentor groups they followed, one indicated they has a Faculty Leader Māori, a kaiāwhina (assistant) and one response said their student support person was not visible/accessible to the teaching staff, '*staff member positions themselves outside the department'.*

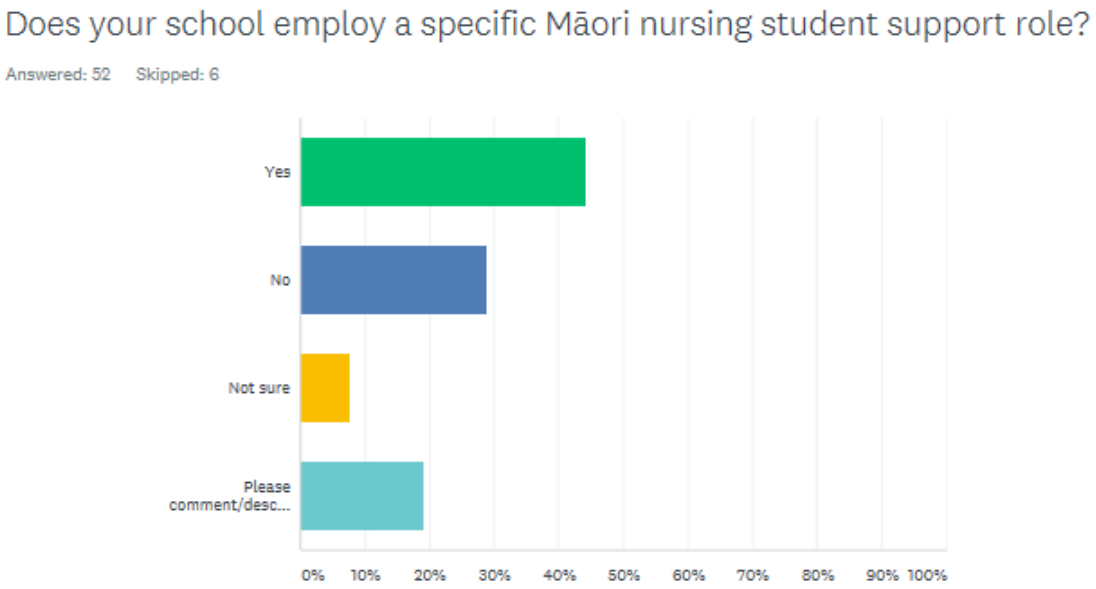

Figure 16. School Māori student support roles.

Question 24 asked how actively participants felt their school engaged with Māori stakeholders. The question required participants to provide an answer on a scale with zero being not at all engaged and five very engaged. 57.7% answered that engagement with Māori stakeholders was average or below average with 48.8% being below average. 42.3% rated engagement as above average.

The next question asked about perceptions around the level of support for Māori nursing students. Support for Māori nursing students within schools was split with 50% of respondents rating Māori nursing student support as average or below average and 50% above average. Question 26 focused on the support for staff in supporting students. Support for staff however, was rated poorly, with over 60 percent (61.5%) rating this as below average. By comparison, 38.5% stated this was above average.

Preparedness for Working with Māori Nursing Students

This next section of the questionnaire focused on staff preparedness for working with Māori nursing students. A series of questions aimed to explore staff preparedness in the classroom, in clinical practice and whether there were any perceived barriers in meeting the specific needs of Māori nursing students. In question 27 participants rated overall their preparedness in meeting the needs of Māori nursing students. Half of the responses were above average in their feelings of preparedness, but the other half rated their preparedness as average or below average. A quarter (25%) rated their overall preparedness poorly as a 2 out of 5.

Given that undergraduate nursing education is situated either in a classroom or in clinical practice, questions were focused on each of these areas to determine if there was a difference in staff feelings of preparedness in either setting. Firstly, staff were asked to rate their preparedness in the classroom for working with Māori nursing students. 48% rated their preparedness as above average and over half (51.9%) rated their preparedness as average or below average. Over a quarter of respondents (26.9%) rated their preparedness as below average.

Feelings of preparedness in clinical practice were slightly less than in the classroom with 46.9% stated they were above average and 53% rating preparedness as average or below average. Most questionnaire participants described their role as academic (72.41%). There could have been some confusion in how to answer these questions however, as staff may have been in roles that were limited in their classroom and/or clinical practice teaching due to the range of teaching models throughout the 17 schools in New Zealand. There may also have been participants that had no teaching contact with students in their positions as programme leaders, heads of school or other leadership positions. There were 8 (13.8%) participants in leadership and management positions.

Question 30 sought the opinions of participants regarding the level of emphasis put on Māori student success. Participants were asked to rate overall their opinion regarding the emphasis placed on Māori nursing student success. Answers included too much emphasis, not enough emphasis, at the right level. Responses are illustrated in the following figure (17).

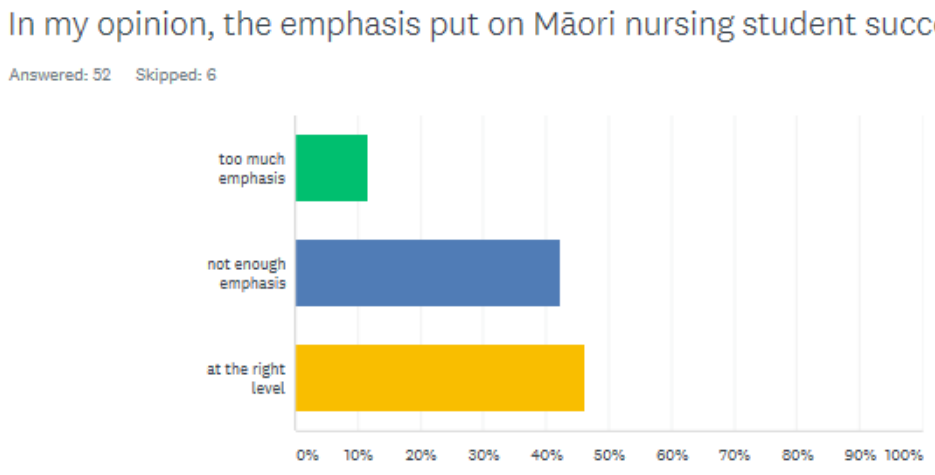

Figure 17. Emphasis on Māori nursing student success.

A free text area inviting comments to this question followed. Fifteen responses were given. These ranged from elaborations regarding how things could be improved for Māori, to comments that were neutral, negative, or comparing Māori learnings to all learners.

Some participants noted, the emphasis placed on Māori student success was at the right level, but the focus needed to be on recruiting more Māori into nursing, "*About right. Issue I see is not supporting success, but getting more Māori students to apply for nursing"* as this participant also explained they felt it was also,

> At the right level in our institution, some of the clinical placements could be well improved, overall in Aotearoa not enough emphasis is placed upon Māori nursing student success hence the low percentage (7%) of Māori in the nursing workforce.

Some positive comments included the feeling that the emphasis placed on Māori student success was well supported by Māori staff, "*strong support from Māori academic staff*". At other schools, it was thought that having fewer staff negatively influenced the staff ability to provide the appropriate support, "*relative to our capacity; good but could be a lot better. It comes down to FTE (not enough)",* this comment was echoed by another respondent, "*We know they are needed and not succeeding. We are working to address this, but there is limited support to assist with this*".

Some respondents believed Māori students were no different to other learners that required the same support in order to achieve,

> It is a very important issue, and there are many students that need support. There are also students from other cultures that need as much support. Many students regardless of culture struggle with learning, it is these challenges that need to be supported whilst ensuring respecting culture.

Another participant elaborated on their experiences,

> I am interested to know what different learning needs Māori students have to non-Māori students. After many years of teaching undergraduate students, I have not identified any specific learning needs Māori students have, over non-Māori. As an undergraduate-student, academic success comes down to the individual, not their ethnic background. I have seen huge success for Māori students and for non-Māori. It always comes down to how much time, effort and plain hard work as to how successful students are.

Following further analysis of the comments there appeared to be some concerns amongst staff that Māori were receiving extra support, or that standards of assessment were in fact lowered for Māori. This participant described, "*I am concerned about the overt identification of Māori students and would hope that support is available to all students",* and this participant stated

there was, "*conflict when standards are compromised as they frequently are, will do nothing for Māori health long term".* Conflict and a sense that this topic may be uncomfortable to discuss openly between colleagues was clear in this participant's response, "*I'm not really sure there is a right answer to this....but I am inclined to think that Māori and non-Māori faculty may disagree about this".*

One of the research questions in this study was to identify nurse educator's perceptions of barriers that they may face in ensuring Māori student success. This question asked participants about barriers, options for answers included yes, no, not sure. Half of the participants reported no barriers to ensuring Māori student success, 30.3% reported they did and almost twenty per cent were unsure. Responses are illustrated in the following graph (figure 18)

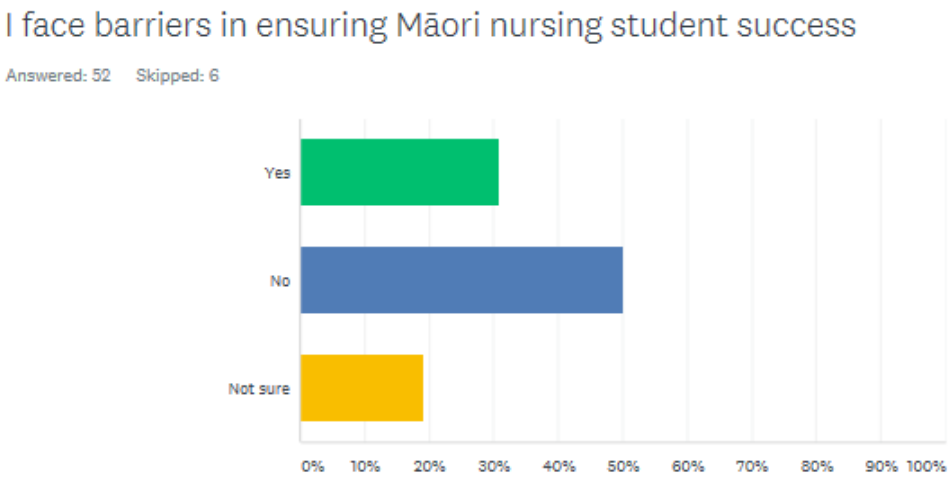

Figure 18. Barriers to Māori nursing student success.

A text area inviting comments to this question followed. Sixteen responses were given. The responses indicated a perception that a level of discrimination of Māori exists in clinical practice, within institutions, schools of nursing, and amongst staff. Three respondents describe this,

> Finding clinical placements that provide a culturally safe learning environment for our tauira (students). Most clinicians are delighted to have our tauira, however there is a certain degree of prejudice evident from some nursing staff (education and retirement will hopefully sort this).

Which this respondent elaborated on,

> Lack of Māori staff to work with to engage Māori innovation in teaching. A lack of focus from my colleagues to address specific Māori centred learning. Poor cultural competence of staff, particularly international staff.

Working to inform ideas around Māori student support as 'special' was described by this participant, "*working to improve recruitment and enrolment process, addressing attitudes such as "why the special treatment*".

Other barriers staff within schools of nursing identified in ensuring Māori student success included, workload issues, knowledge of te Reo, "*I would like to have a better command of Māori language and culture*" and student having competing or conflicting demands taking time away from their study. One respondent stated programme entry requirements and student attitudes influenced student success, "*I feel we have students that are let into the programme that do not have the academic ability or right attitude, often these are Māori students. They are therefore unsuccessful, despite efforts of both student and teacher they are unable to pass".* Another respondent described the competing pressures of international students as taking time and resource away from Māori, "*More emphasis placed on international students, not enough time to spend with Māori students, lack of institutional support and resources to support Māori".*

Similarly, as described earlier in this chapter, was the feeling that the responsibility for Māori students was placed on a few staff, "There *is a dumping of expectations on individuals, rather than a collaborative approach that might be more helpful"*. In some cases, student issues were not identified in a timely manner, "*everyone holds onto information, as the* [role of participant omitted for confidentiality] *at times I was unaware that Māori students were not meeting the requirements until too late, if earlier linking this could help with other supports & options for the tauira".*

Feeling prepared for working with Māori nursing students may also be influenced by confidence and vice versa. Question 32 asked staff overall how confident they felt in working with and meeting the needs of Māori nursing students. 61.5% of the participants answered they were above average in their confidence. 38.5% rated their confidence as average or below average. This is higher than participants reported feelings of preparedness which was 50% reporting above average.

Leadership within schools related to Māori student success was rated favourably with 61.5% rating this above average compared with 38.5% that scored this as average or below average. Teaching practice, in general, within the schools was not rated as strongly as leadership. 53.8% rated the school teaching practice as average or below average- a quarter of respondents felt teaching practice was below average (25%). Less than half (46.25) of the respondents rated the teaching practice as above average for Māori nursing students.

Professional Development and Other Education

Cultural safety is a key competence for nursing practice in New Zealand, an area all participants should be able to demonstrate competence (Nursing Council of New Zealand, 2007). This question aimed to gather data about cultural safety education amongst participants and how they applied or related this to their education practice. The question had three answers, yes, no, and not sure and the results are presented in the figure nineteen. The majority or responses confirmed that they had some form of formal or informal cultural safety education however, two respondents stated they had not had any education related to cultural safety.

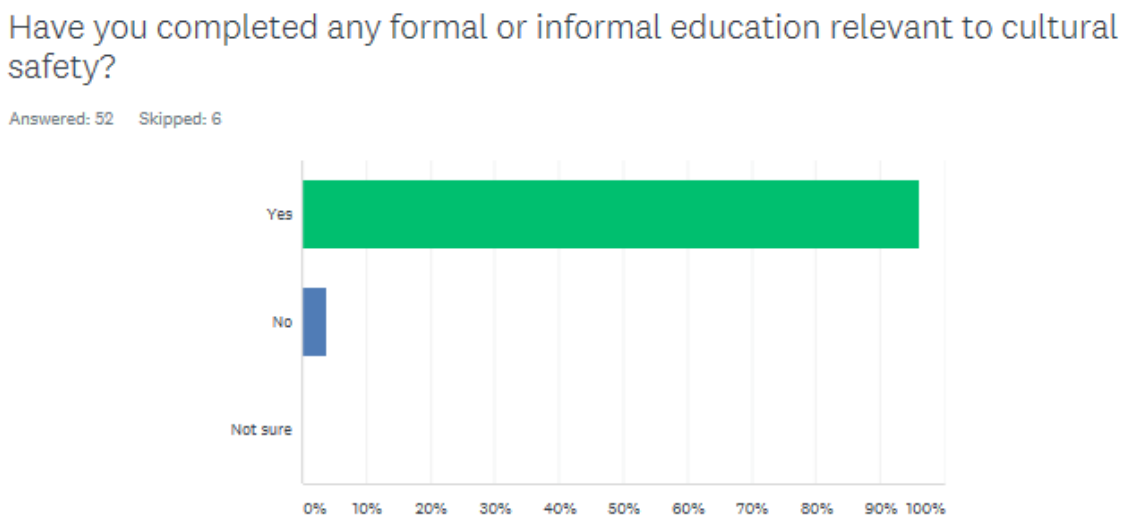

Figure 19. Education related to Cultural Safety.

Those that answered yes were invited to comment further about the relevance of cultural safety to their practice. Forty-two responses were provided. Some comments (seven) stated cultural safety was useful, but not overtly so. Comments ranged from finding cultural safety useful, not very relevant, "*was not specific to education*", somewhat relevant, "*built on previous knowledge",* to*, "not overtly relevant to education more to clinical practice for nurses*".

The majority of comments (twenty-one) stated that cultural safety was very relevant to all aspects of nursing including nursing education. One comment describing cultural safety as relevant, but also a continuum, "*Very relevant although I think it is (for want of a better word) a 'journey' and sometimes I think I feel confident and competent and other times neither".* Another respondent appeared to feel that having conversations around cultural safety might lead to judgements about them, "*Believe it goes both ways - I don't always feel safe to have these important conversations without assumptions being made about me".*

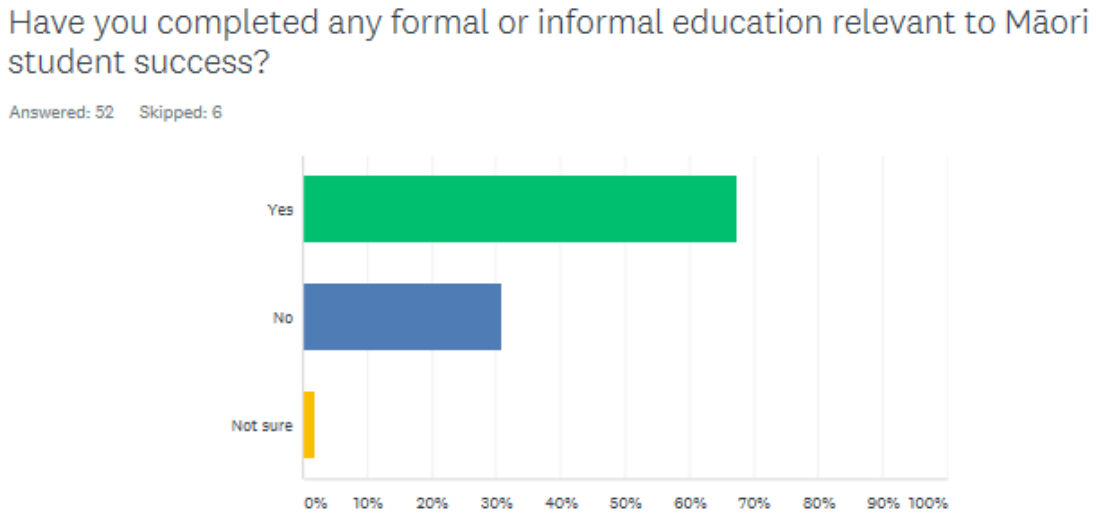

Figure 20. Education related to Māori student success.

Most participants had undertaken some formal or informal education related to Māori student success (67.31%), 30.77% had not, and one respondent was not sure (figure 20). Twenty-seven comments were made, some described the type of education they had undertaken, as being either in-house informal session or part of formal qualifications they had achieved. All respondents except one, found this education as highly relevant to their teaching practice, the one exception stating that they had learned about, "*Beginning ideas that are practical, but not sure how to implement them".*

Many participants had completed formal or informal education related to te Reo (figure 21) and they were invited to comment on how they felt this was applicable to their educational practice. Twenty-nine participants made comments. Most respondents (twenty-one) stated their education related to te Reo was useful or extremely useful to their education practice. Some stated that knowing some te Reo increased their confidence in the classroom, one respondent said that it was, "*Essential to AT LEAST get our vowels right! From there it's all goodness as capacity is increased".* A few participants (three) said they were not using te Reo enough and this negatively affected their confidence.

This was echoed in the responses to question 38. Whilst over 60% of participants had completed some education (formal or informal) for te Reo, confidence was rated poorly regarding the ability of nursing academics to say their own pepeha or mihi in Te Reo. Nearly half of participants were below average in their confidence and 76.9% rated their confidence as average or below average. 23.1% rated their confidence as above average.

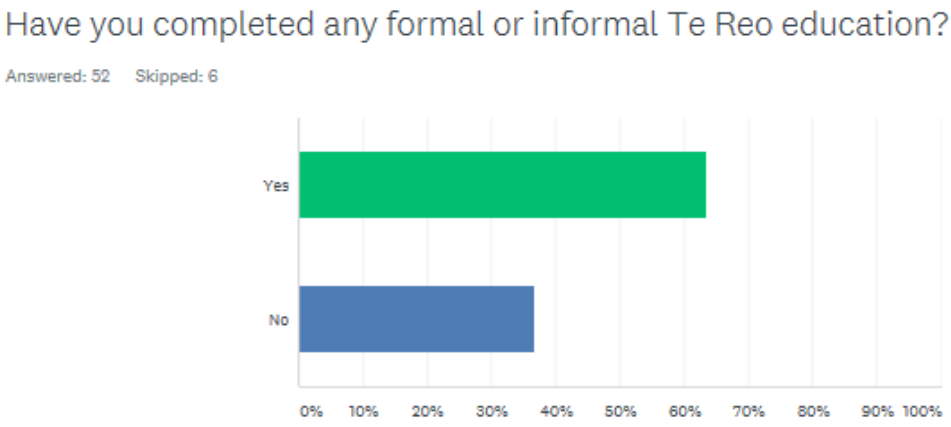

Figure 21. Education related to te reo.

The final aspect of the questionnaire was designed to elicit what professional development nursing academics would find useful in their practice related to working with Māori nursing students. Participants were provided with a list of further professional development categories and they could choose multiple options and make comments. The options included:

- Māori learning styles
- Māori student success strategies
- Māori world view
- Te Reo
- Tikanga
- Cultural safety related to teaching/ educational practice
- None

Responses are displayed in figure twenty-two. Most participants were interested in further professional development about most of these areas. Comments were also invited to this final question, however, there were very few (six). Most comments related to wanting to continue learning however, were not specific with what they wanted to learn. Two commented, "*Seems there is a danger of assuming all Māori students are the same, which would be unsafe",* and "*too simplistic to talk about Māori learning styles. Not all Māori students identify as Māori and that is OK and we should respect that".*

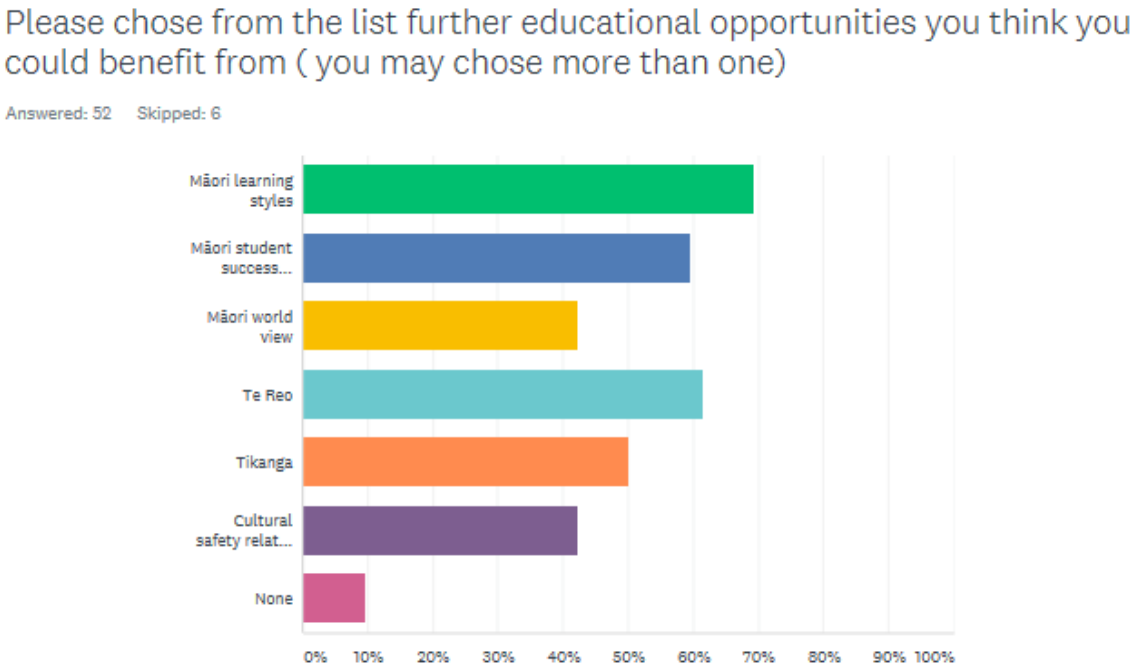

Figure 22. Professional development.

Analysis of Findings to Inform Phase Two – Interviews

The demographics of the participants were what was anticipated, based on knowledge of the nursing workforce. There were slightly more Māori respondents than expected. Respondents were very experienced in practice and education. From these findings, no further demographic questions are specifically required, though understanding the interviewee's experience and role will be important to establish context and the relationship between interviewer and interviewee.

The relationship of the Māori population of the school on perceptions and practice was unable to be fully established from the questionnaire alone. Engagement with Māori stakeholders was also rated as poor. Further questions regarding the influence of the local Māori population size, as well understanding engagement with Māori stakeholders will be designed. Support for Māori students and support for staff in supporting Māori students was split in response positive and negative- so elaboration around this will be sought.

A clear tension that arose from the findings of the questionnaire was related to Māori as priority learners. There was a sense that some respondents did not agree with support for Māori over other learners, and that this was inverse discrimination/ Māori privileging. There were also suggestions that there were lower standards for Māori, and evidence of racism and reluctance to openly discuss these issues amongst colleagues. Uncovering attitudes,

observations and practice related to this theme will be sensitive and difficult to do but necessary.

Confidence, teaching practice and leadership were all rated favourably, despite some of the issues that were apparent from the questionnaire that suggest otherwise. Seeking examples in these areas will be important to illustrate good models of educational practice.

A further area of interest that arose from the questionnaire related to Cultural Safety. There was agreeance that Cultural Safety was highly important, but some respondents noted tensions around being judged, assumptions or misunderstandings. Like the tension around Māori as priority learners, this was an area that respondents were concerned about having open dialogue in. Two of the research questions were not fully explored within the questionnaire:

- How do nurse educators understand and interpret Cultural Safety in nursing education?
- How do nurse educators' practice and apply the concepts of Cultural Safety in nursing education?

And the findings suggest, this is an area of tension and perhaps limited understanding for some nurse educators. The interviews aimed to explore these areas in greater detail.

Chapter Summary

This chapter has presented the findings of the first phase of this study, the questionnaire. Fifty-eight nurse educators from schools of nursing around Aotearoa New Zealand responded to the questionnaire. The findings have provided a picture of the respondents, their roles and experience in nursing education and their understandings and perceptions of institutional and school strategies that are used to support Māori nursing students. This first phase of the study has also provided a base of evidence that contributes to answering some of the research questions, and informs the second phase of the study, the participant interviews. The next two chapters present the findings of the interviews.

Chapter Five

Part 1 of the Interview Findings

Understandings and Practices of Cultural Safety

Ahakoa ko wai, manaakitia kia rongo I te reka o te aroha

No matter who it is nurture them so that they may experience the sweetness of love

Introduction

This chapter presents the findings from phase two of the research, the participant interviews. Ten individual interviews were conducted with nurse educators from a range of nursing schools around Aotearoa New Zealand. Data from the interviews were analysed thematically.

Table four provides an overview of all the interview themes. The findings are presented in two parts, over two chapters. The first part, understandings and practices of Cultural Safety is presented in seven themes. The second and final part of the findings is presented in chapter six.

Table 4

Overview of the Interview Findings

Part/Chapter	Themes
Part 1 (Chapter 5)	
Understandings of Cultural Safety	Cultural Safety is for all of us
	Kawa Whakaruruhau has a specificity and richness
Practices of Cultural Safety	Historical tensions
	Whanaungatanga-making connections
	Tikanga- custom and ritual
	Manaakitanga- to provide care and support
	Rangatiratanga-leadership
	Tino Rangatiratanga-self-determination, autonomy
Part 2 (Chapter 6)	
Challenges to teaching Cultural Safety	Challenging ground
	Making uncomfortable places safe(r)
Resistance to Māori as priority learners	Colonised thinking and structures
	Racism and unconscious bias

Describing the Participants

This chapter begins with an overview of the interview participants and their roles and experience in nursing education, to provide some context to their narrative which features throughout the chapter.

As outlined in chapter three (the research process), ten virtual face-to-face interviews took place over two months in late 2018 using the video conferencing platform Zoom. The interviews were conducted in a range of schools of nursing in geographic locations around Aotearoa New Zealand. This included both the north and south islands in city and regional areas. Participants came from eight of the seventeen schools of nursing offering undergraduate nursing programmes (47 percent). Two were employed within the university sector, seven in institutes of technology and polytechnics (ITP) and one participant was employed by a wānanga (Māori university).

Participant ethnicities were either European/Pākehā (non-Maori) or Māori. Four identified as Māori (40 percent) and six identified as Pākehā of European descent (60 percent). Of those, two achieved their initial nursing qualification and registration overseas (UK and USA) and had been registered in New Zealand between 6-10 years.

Participants' experience as registered nurses ranged between 10-40 plus years and their experience in tertiary nursing education ranged from 18 months to 20 plus years. All had experience as academic staff members in the role of nursing lecturer, three had additional Māori student support and/or Kawa Whakaruruhau responsibilities within their role descriptions, one had a combined academic and programme coordination role, and one was in a senior leadership position as a head of school (see table 5).

Table 5

Participants' Role Descriptions

Role	*n*
Academic staff member	5
Academic staff member/ Kawa Whakaruruhau leader	3
Academic staff member/ Programme Coordinator	1
Head of School	1

An overview of the background in nursing education of participants is provided in table six to give the reader some context to the participants while reading the narrative in this chapter. Some of the participant details are not provided in the profile in order to maintain anonymity,

for example, participant's roles are not aligned with pseudonyms due to being potentially identifying.

Table 6

Background in Nursing Education of Interview Participants [12]

Awhina identifies as Māori and has over 20 years of experience working in nursing education. She has allocated time within her academic workload to provide support for Māori nursing students.
Carl originally qualified as a nurse overseas, identifies as Pākehā and had approximately 6 years' experience in New Zealand nursing education.
Dannielle identifies as Māori and has 5 years' experience in nursing education. She has a dual role as an academic staff member and Kawa Whakaruruhau leader.
Erena identifies as Māori and has close to 20 years' experience in nursing education. She is an academic staff member and has had various responsibilities relating to Kawa Whakaruruhau over this time.
Kate is relatively new to nursing education and at the time of interview had 18 months experience in undergraduate nursing education. Kate identifies as Pākehā
Maria initially qualified as a nurse overseas and identifies as Pākehā. She had over 6 years' experience in nursing education in New Zealand.
Nicki has over 30 years' experience as a registered nurse in New Zealand. She is relatively new to nursing education and had approximately 18 months experience. Nicki is Pākehā.
Rob identifies Māori and has been working in nursing education in New Zealand for over ten years.
Sara is Pākehā and has worked in nursing education for over 20 years.
Tina has over ten years' experience in nursing education in a region with a high Māori student population. Tina identifies as Pākehā.

Establishing Connections with the Interview Participants

As part of the interview process, it was important to establish rapport and a sense of connection with interview participants. This was important in two ways. First, to ensure participants had opportunity to clarify the study purpose and to explain the study process to date, confirm confidentiality and informed consent. It was also important to help participants to feel at ease with the interviewer and to help the interview flow freely. In the Māori world, (te ao Māori) following greetings a process of whanaungatanga (connectedness) is customary, and although I am not Māori, it is part of my personal and professional practice to provide

[12] As outlined in chapter three, all interview participants were assigned a pseudonym to maintain the confidentiality of their identities.

some context to myself (my background, places of work etc) when meeting people and allowing them to also share what they wish.

The interviews commenced with greetings, introductions, whanaungatanga. Two of the participants were former colleagues of mine, and two further participants were known to me through professional networks. The remaining six participants I had not met prior to their interviews. Through the process of greetings and introductions, participants were thanked for their interest and participation. It became evident to me early in the interview process that all participants had a common motivation for participating in the study. Participants said they were enthusiastic about the topic and all participants expressed deep personal and professional commitment and a desire to be responsive to Māori. This was also described as a strong sense of social justice, and a sense of personal responsibility for Māori nursing student success. This motivation stemmed from participants' identity as Māori, their links with iwi and hapū (tribe/subtribe), or, as the remainder of non-Māori participants described, an affinity to te ao Māori and Māori values. This will be illustrated within the narrative throughout this chapter.

Personal identity was described as important in framing participants viewpoints, particularly for Māori. An overview of the descriptions that participants offered is provided to illustrate this. Three of the participants, Rob, Awhina and Danielle described who they were as Māori and how they identified with the local communities where they lived and worked. Rob described himself as a "*local lad*" and named his iwi and marae and Awhina shared her whakapapa at the beginning of the interview. Danielle had returned home to where she originally completed her nursing education and said she "*moved home for whānau purposes*". She described,

> I've got affinities with both iwi in the area and participate in whānau, hapū, iwi, so I'm very active in the te ao Māori world I suppose.

Kate, Sara, and Nicki talked about influences in their lives growing up and professionally that shaped their views. Nicki talked about growing up in an area which was predominantly Māori. She said,

> Well I'm lucky really because I grew up in (name of town) so I've been exposed to Māori culture most of my life. I'm Pākehā but my grandfather was fluent. He went to a native school. He was a working-class man, worked in the freezing works all his life and he spoke Te Reo every day. I'm not fluent because what happened to the Reo in our whānau was the same as what happened to a lot of Māori. My uncles got in trouble at school for speaking Te Reo and after that happened, my grandfather stopped teaching them.

Nicki went on to say,

> I've always had an affinity for Māori people and also the Māori worldview. It's partly exposure to the culture, it's also the awhi (guidance/care) that Māori colleagues and friends have shown me.

Kate, similarly, grew up in a small town that she described as predominantly Māori. She described how this influenced her professional view and employment. She said,

> I was the first Pākeha employed on the NEtP (new graduate nursing programme) in the Kaupapa ward[13]. I was told later the reason why was they thought I had some connection to Māori because I was from (named town).

Sara described a desire to want to learn more and how this informed her views. She said,

> I did my certificate in Te Reo. I was always interested in Te Reo and social justice, so I guess that's where I have tried really hard all my life in seeing others who are not in the best position. I think I have more and more of an understanding of the effects of colonisation and how it has affected more and more actually.

Sara went on to say,

> I've tried really hard from a white upbringing in the South Island…I've tried to be inclusive. I also know the feeling of displacement has helped a lot when I did the certificate (in Te Reo) because I felt displaced as a non-Māori and that gave me a really good understanding about what it feels like to be othered and not aware of all the cultural practises and how scary that is.

Carl and Maria were originally from overseas, and to them, acceptance and understanding of diversity was a clear part of their lives and of their nursing practice. Carl said,

> I'm from an incredibly multi-cultural place (city overseas) so I felt happy working with diversity already, it's kind of normal to me. It is abnormal not to have lots of diversity.

Maria said she was really surprised at the tensions that she perceived between Māori and non-Māori since immigrating to New Zealand. She explains,

> It just blows my mind. There is this ingrained bias that exists within New Zealand I have not ever experienced.

Maria said she could not understand why there seemed to be barriers for Māori students from staff or school processes that appeared punitive to her. She wondered why culturally specific support strategies were not "*normal already*".

[13] 'Kaupapa ward' refers to a specific hospital ward that operates using Maori values as core principles, designed to meet the holistic health care needs of Maori.

The opening section of this chapter has provided some description of the interview participants to give context to the narratives which they gave during the interviews. The remainder of this chapter will draw upon extracts from their narratives to present the themes of the first half of the interview findings.

Themes from the Interviews – Part One

The following section presents part one of the interview findings and the themes constructed from the analysis of the interview data (see table 7). This section of findings describes Cultural Safety in nursing education in Aotearoa New Zealand. The overarching topic of this section relates to educators' understandings and practises of Cultural Safety. Specific aspects of were explored with the interview participants, how educators defined Cultural Safety, how they described their practises related to Cultural safety and whether they made any distinctions between Cultural Safety and Kawa Whakaruruhau. First, participant understandings of Cultural Safety is presented, followed by their practises of Cultural Safety.

Table 7

Overview of Part One Interview Themes

Part 1	Themes
Understandings of Cultural Safety	Cultural Safety is for everyone
	Kawa Whakaruruhau has a specificity and richness
Practices of Cultural Safety	Historical tensions
	Whanaungatanga-making connections
	Tikanga- custom and ritual
	Manaakitanga- to provide care and support
	Rangatiratanga-leadership
	Tino Rangatiratanga-self-determination, autonomy

Understandings of Cultural Safety

The first three themes: *Cultural Safety is for everyone*, *Kawa Whakaruruhau has a specificity and richness*, and *historical tensions* describe how participants understand the concepts of Cultural Safety and Kawa Whakaruruhau. The findings demonstrate that there are differences in educators' understandings of Cultural Safety, and, that although Kawa Whakaruruhau is the commonly understood te Reo Māori translation of Cultural Safety, the two concepts are viewed by participants as distinctly different. The evolution of Cultural Safety in nursing has

not had a smooth path and participants describe how historical tensions still impact them today.

Cultural Safety is for all of us

Although the Nursing Council of New Zealand provides a definition and guidelines for Cultural Safety in nursing education, it was important to determine participants understandings. This theme, *Cultural Safety is for all of us*, provides descriptive narrative that describes how the nurse educators in this study, understood and interpreted Cultural Safety as a broad and inclusive concept.

A specific question was posed asking them how they defined Cultural Safety, and what it meant to them in their education practice. Most participants described Cultural Safety as a broad concept that applied to all people of all cultures. Nicki said,

> Cultural Safety I guess looking at it with Pākehā eyes, because that's what my eyes are, means ensuring that people of all cultures feel respected and feel that they can practice their own culture wherever they are, and that they are made to comfortable to practice their own culture.

However, Nicki said that it did not always occur. She said,

> Cultural Safety is a very much Pākehā term isn't it? I think that often it's reduced to a tick box, Cultural Safety. Like oh, we better be culturally safe, we'll get someone in to say a karakia (prayer), you know before we have our meeting.

Danielle's description echoed Nicki's. She said,

> Cultural Safety is for all of us-you don't have to be Māori to be practicing Cultural Safety.
>
> But cultural safety, just the pure simple understanding of that is really about respecting everybody's cultures regardless of your values and your beliefs. How you do that is not putting yourself first, you're always thinking of the patient, the resident, the whānau, yeah. That's my simplest understanding. There are many levels as you know.

Tina said Cultural Safety was a concept that you continue to learn more about. She said,

> My concept of cultural safety is so huge, and I think it's an ongoing learning, Cultural Safety. I don't think we ever stop learning about Cultural Safety.

Rob's understanding of Cultural Safety recognised the importance of empowering people. He said,

> Cultural Safety is understanding that you know those that you are working with are the vulnerable individual in the relationship the party that is empowered are the ones that

> are giving themselves to you to support them in care for them and to help them recover and get back to where they are or meant to be so you know that of course it is not about you it's about how you interact with those people.

Rob also described Cultural Safety as an ongoing learning process. He describes,

> Cultural Safety is gender blind, age blind, race blind, ethnicity blind and sexual orientation blind. To me Cultural Safety is blind it has no senses it has no sight, it has no hearing, it has no taste. It is what it is and is as long as a piece of string can be and its infinite. Cultural Safety is infinite there is no start point and no stop point it will be forever evolving and forever changing.

Erena talked about Cultural Safety origination in te ao Māori (the Maori world), and how as a concept it evolved to include a broader definition of culture. She said,

> What Cultural Safety is, the essence of it is manaakitanga (to care for), we need to manaaki someone – there is no power. There is no power in the relationship and Cultural Safety was about power relationships and as it related to the two Treaty partners. It then morphed into something that was about gender and religious affiliation and all of those things that the Nursing Council has on their website but which I don't think they've looked at in the last 15 years.

It is well-documented that Cultural Safety was contentious when it was first developed (Papps & Ramsden, 1996). Erena's dissatisfaction with how Cultural Safety changed to the current Nursing Council definition is raised later in this chapter, when historical tensions are described. In addition to historical tensions, the concept of Kawa Whakaruruhau was differentiated from Cultural Safety by the participants. This is described in the following section.

Kawa Whakaruruhau has a specificity and richness

Kawa Whakaruruhau is te Reo Māori that can be translated to mean Cultural Safety in English. In this study however, Kawa Whakaruruhau was described as a unique Māori concept, distinct from Cultural Safety. While not all participants gave comprehensive descriptions of their understanding of Kawa Whakaruruhau, they were all clear that it was different to what they described as Cultural Safety. Nicki understood that it was different to Cultural Safety but was reluctant to try and define it. She said,

> I think Kawa Whakaruruhau is quite different in that I think it goes deeper than just tikanga.

Carl was similar in his understanding. He said,

> I think Cultural Safety is broad and I think it is everybody, and Kawa Whakaruruhau that's specific to Māori.

Carl felt that it was essential for nurses to understand the differences between Cultural Safety and Kawa Whakaruruhau. He described these as different baskets of knowledge. Carl explains,

> Within Cultural Safety there is knowledge within all these different cultural areas, like baskets of knowledge. But the Māori basket of knowledge is a bit more special because of the Treaty, so you know, I think that is something all nurses must have a good grasp on, whereas the other baskets of knowledge they can have a looser grasp on those things.

Danielle felt that the key difference between Cultural Safety and Kawa Whakaruruhau was the focus on Māori students that Kawa Whakaruruhau has. She said,

> I suppose the biggest thing is that Kawa Whakaruruhau is looking after the students, Māori students.

Rob elaborates on what Kawa Whakaruruhau meant to him. He was clear about the separation of the two in their intent. Rob said,

> Kawa Whakaruruhau is defined as something to me that is fully Māori and based on a purpose and it is defined, its boxed and it's got context, history, purpose, sensitivities. It has sight, sound, taste and all those sorts of things and to me that's the difference.

He went on to say people will interpret the concepts differently. He said,

> The reality is that it is journey and people will find their own conclusion. A lot of people consider them (Cultural Safety and Kawa Whakaruruhau) one and the same, that they are opposite sides of the coin. I think that one of them is a coin and one of them is a paper bill.

Maria had never considered that Cultural Safety and Kawa Whakaruruhau might be different until this question arose during the interview. She explained that she had taught herself about the Treaty of Waitangi and Cultural Safety when she was new to New Zealand, and that she had to read about these concepts in nursing. She wondered if the differences between the two concepts was like the two versions of the Treaty of Waitangi. She said,

> It really reminds me of the Treaty translations, the English version and the Māori version. It's like, cultural safety is not specific enough, it could be for anybody, but the other concept (Kawa Whakaruruhau) has a degree of specificity and richness.

For Awhina, Kawa Whakaruruhau was what brought her into nursing education. She explained that she was approached to come and teach it and that as a concept it resonated with her. She said,

> When I was approached to come into the school to teach it was around that concept of Kawa Whakaruruhau. That was a word that from my own whānau I didn't need

> translated because that was a word that I understood. You know, kawa was about process and procedures, a way of being, and that whakaruruhau was about coming and sheltering and nurturing the individual.

Like Rob, Erena explained why Kawa Whakaruruhau is a distinct concept for Māori. She said,

> Kawa Whakaruruhau if nothing else provides that absolute single focus on things Māori and I think it's very clear, it's a Māori word, it's a Māori concept, it relates to things Māori. Cultural Safety relates to all. Kawa Whakaruruhau is just the same concept, but it has so many more inferences in it about how you shelter people, how you nurture them, all Māori.

This theme described how participants viewed Kawa Whakaruruhau as a distinctly Māori concept that differs from Cultural safety. It was described by Maria as having a specificity and richness relating to Māori that is not evident in the participants understandings of Cultural Safety. The origins of Kawa Whakaruruhau were particularly relevant to participants understanding of it as a concept and the historical tensions associated with the implementation of Kawa Whakaruruhau in nursing education were a source of harm to some participants. Participants passionately described how the regulatory changes to the meaning of Cultural Safety/ Kawa Whakaruruhau affected them and their ability to engage with the concept.

Historical tensions

The separation, interpretation, understanding and application of the two concepts, Cultural Safety and Kawa Whakaruruhau, were linked to historical media and political events that resulted in the Nursing Council redefining Cultural Safety education in nursing (Ramsden & Spoonley, 1994). Erena and Awhina both recalled the early implementation of Cultural Safety in nursing education in the 1990's and the subsequent backlash that occurred in the media that triggered the Nursing Council to review its definitions and standards related to it. For Erena and Awhina, the changes that occurred to the concepts of Cultural Safety were a loss for nursing and for Māori.

Awhina reflected on how the definition of Cultural Safety was broadened by the Nursing Council to include a more generic definition of culture, and how to her, it did not reflect the meaning of Kawa Whakaruruhau. She said,

> For me that extension of cultural Safety was for everyone else, Kawa Whakaruruhau should stay as a concept because, Kawa Whakaruruhau can only be Māori because it's in that sense of shelter and protection that relate to Māori. Culture Safety is generic.

The effect of the broadened definition Awhina described as a loss for Māori. She said,

> People then lumped everything together and it was just all one big ball of nice sort of stuff, and Kawa Whakaruruhau disappeared and so did that emphasis on being really sure that our nurses of tomorrow had a good sense of what mattered to the diverse group of Māori.

She went on to describe the negative public and political attention that Cultural Safety had generated, and what it meant for Kawa Whakaruruhau. Awhina said,

> 96 was brutal but I can absolutely see why Council at that time did it. It was too much, and so they had to say let's just have this sort of little sanitised version here, which again I think is absolutely core to what we do, but Kawa Whakaruruhau was a casualty.

Erena too described these historical events. She explains,

> What Kawa Whakaruruhau was about was Māori, but it was not palatable for the public. Suddenly the Nursing Council was on the map and having to answer to a government inquiry – what's going on in your nursing school?

Erena talked about how she felt the past impacts on Māori. She said,

> I've always had an issue with the whole concept of cultural safety having to be reshaped so that it includes everyone. So here we go again. Irihapeti (Ramsden) wrote about Kawa Whakaruruhau and it was a response to what was happening in nursing education, but it was also about - what are we going to do to improve our situation for Māori? So, you know it's all in the literature the backlash and the whole public outpouring of debate and dispute about -why is there so much emphasis on Māori in nursing education? So, it got reduced down to theory called Cultural Safety.

Both Awhina and Erena had experienced the turmoil surrounding Cultural Safety in the 1990's. For Erena, it had a lasting impression that made her no longer want to teach it. She said,

> I have been the one to teach Cultural Safety, but I refuse now because the current version of cultural safety, even though it's morphed into something generic, it's still seen as the domain of Māori to teach. Well no, I'm not going to teach cultural safety. If you're going to teach it, teach the history, teach the whakapapa, teach how it evolved into something that it actually never was.

She went on to explain her frustration and how she believed public acceptance was more important than safeguarding Māori. She said,

> I feel quite angry. I think I have supported my colleagues to understand better that Cultural Safety is something that everyone should teach now even though I don't like the form that it's in but it's still seen as a Māori thing and yet it was stolen off Māori and changed into something that was more acceptable for the general public.

In this section, educators' understandings of Cultural Safety in nursing education were described in nursing education through the themes: *Cultural Safety is for all of us*, *Kawa*

Whakaruruhau has a specificity and richness and *historical tensions*. Educators had different understandings of Cultural Safety and Kawa Whakaruruhau based on their personal and professional experiences. There was however, consensus that Cultural Safety is a broad concept that applies to all people and all cultural variations whereas, Kawa Whakaruruhau has a specificity and richness, and that it is a separate and distinct Māori concept that needs to have its own place in nursing. There were also historical tensions that some participants described as having contributed to a watering down or invisibility of Kawa Whakaruruhau as it was intended for Māori. These historical tensions were described by some participants as having lasting effects on the intent and practices related to Cultural Safety and Kawa Whakaruruhau, and as having caused lasting damage and mistrust among some Māori nurses.

Practices of Cultural Safety

The next section of findings describes participants' practices of Cultural Safety. Across the interview findings examples of te ao Māori, the Māori world and values were provided. The themes, whānaungatanga, tikanga, manaakitanga, rangatiratanga and tino rangatiratanga were identified from the data as values that underpinned teaching practices and educational environments in nursing that participants described as being important to Māori. This was evident across a range of questions that were asked of participants, particularly when they were describing strategies to support Māori nursing students, in where participants said they found their confidence in Māori specific teaching strategies and from where they gained support. Māori values also were found in organisational structures and when participants described the positive influences of leadership which enabled teachers and schools to effectively engage with Māori nursing students.

While initial analysis identified Māori support roles and strategies that educators had as being ways in which they practised Cultural Safety, following further analysis it became evident that it was the underpinning values behind the establishment of support roles for example, and values that motivated practices that held meaning for participants and this research. Participants did not overtly state te ao Māori concepts when describing their practises, rather, through the process of data analysis it became clear that what participants were describing were practises that align with te ao Māori principles. The next five themes are:

- Whanaungatanga-making connections
- Tikanga- custom and ritual
- Manaakitanga- to provide care and support
- Rangatiratanga-leadership

- Tino Rangatiratanga-self-determination, autonomy

Each of these themes illustrate educators' practises of Cultural Safety in the nursing education environment. These practises mainly relate to interactions with Māori nursing students, but they also extend to ways in which participants interact with nurse colleagues and to the school culture.

Whanaungatanga – Establishing connections

Whanaungatanga refers to connecting with others, establishing relationships, a sense of kinship or family. Knowing students' names, where they came from and establishing whanaungatanga was described as important to starting the learning relationship between teachers and students. Participants said this was important to them, and that they did this in several ways, by welcoming students and their whānau, having one to one meetings, designing specific class activities and by having multiple modes of communication available to students.

Rob and Carl talked about getting to know students and where they came from. Rob said,

> Knowing your students is important. How you support them depends on the background of the student and how they connect to their culture and upbringing.

Carl also said this was important, and although he worked with large classes, he still worked to ensure connections were made. He describes,

> Acknowledging where people come from is important. Trying to get to know the students, there were quite a lot of them, but it was still important to try and know them, their names. Trying to build activities straight away from day one into the classroom.

Knowing students' names was also highlighted by Kate. She said it was her responsibility. She said,

> I think straight away as an educator I have a responsibility to know everyone's name. I think for Māori in particular, me knowing their name means I know that they are sitting in my class and that starts an opportunity to build rapport.

Kate felt that beginning by knowing student's names, was how she established whanaungatanga. From there it set the tone of how they would work together. As she described, creating connections was more than knowing a name, but it also signalled students were valued. She said,

> I try to establish a relationship with every student, so they feel valued in my class and that we are kind of on this guided journey together to succeed in whatever it is. Like, if we are on clinical we are doing that together. So that's how it all starts".

For Danielle and Awhina, who had specific time within their role to work with Māori nursing students, they organised opportunities to connect personally with students. Danielle said,

> I meet with them weekly for the first two months, the year ones.

Awhina described official welcoming of students by the 'mana whenua' (people of the institute) of the institute and, how she tries to connect with students early through multiple methods. She said,

> Often if I know in advance they are here, I can contact them with an email just saying welcome to the programme, is there anything I can support you with? We have really active Moodle (online learning system) and Facebook for our Māori learners here within the organisation.

Nikki and Tina described the importance of connecting with students as like establishing a family among the class. Nicki said class size enabled whanaungatanga. She explains,

> It's more of a whānau (family) atmosphere and we're lucky we can do that because we have small classes.

Tina also talked about having a family atmosphere. She said,

> I support them as individuals and having a family-like atmosphere in the classroom.

She went on to talk about a whānau (family) evening recently introduced at their school. She said,

> We have an evening to welcome them in, we work with the new year ones bringing them together with staff, bring the whānau in, and children.

This theme described the ways in which educators made connections with students as one method of providing a culturally safe environment. The establishment of relationships, whanaungatanga, was described by participants as important to welcome learners, set the tone for students as being valued and recognised as individuals who bring their culture to learning. The next theme describes the use of tikanga, or customs and rituals in nursing education. Tikanga, the use of correct Māori protocol and practices in the class and wider educational environment was described by nurse educators as a method that also helped to establish connections. However, tikanga was also described as an important element of teaching practice and creating and educational culture that was conducive to Māori learners.

Tikanga – Custom and ritual

Tikanga can be defined as formalities, customs, ritual or the 'right' way to do things in the Maori world. Tikanga also encompasses the correct use of te Reo (Māori language). Though

particular Māori values have been listed separately as themes, aspects overlap and are interconnected. For example, the use of tikanga helped to create whanaungatanga between staff and students, but it was also described as a specific strategy of teachers to locate te ao Māori within nursing education. While specific content related to Māori health and the Treaty of Waitangi is required by the Nursing Council of New Zealand (NCNZ) to be included in all undergraduate nursing curricula (NCNZ, 2015), bicultural teaching practice, for example, practices that incorporate tikanga, are left to individual schools, or teachers to implement.

Interview participants described various aspects of tikanga as being enabling for Māori nursing students. Tikanga was described as important to the school culture and processes, and as an important way for nurse educators to role model biculturalism and demonstrate their enactment of Treaty of Waitangi or Tiriti o Waitangi principles in their practice.

Nicki described tikanga in relation to her students. She said in the classroom, tikanga was important in how she did things,

> As far as the academic stuff goes, to support them I think it's really important to weave tikanga through your teachings. To do so in a way that doesn't seem like lip service. So, we do karakia (prayers), we do waiata (songs)…being respectful of using Te Reo whenever I can.

She went on to say,

> To me sharing of kai (food) is a really important thing. Sometimes I'll say well we've got a lab tomorrow afternoon and I'm going to make afternoon tea for you. So, I'll bake for them and bring it in. I don't mind doing that, and they're so appreciative they'll often bring in food as well.

Carl described learning about te ao Māori was something he was self-motivated to do. He said he had made a conscious decision as a new nurse to New Zealand to learn what he could and incorporated it into his practice. An example he gave was,

> When I open a class, the first thing I do in the first session is a mihi. I try to put relevant whakataukī (Maori proverbs) into every lecture and get the students to think about connections to Māori. So, I do little things like that and try and keep a theme going.

Awhina said at her educational institute an official welcome was offered to all students, but also a specific pōwhiri (formal welcome ceremony) for Māori was an option. She said,

> Māori learners come, and they're given the opportunity to connect and identify and have support in regards to not only academic matters but if they want to get on a pathway of understanding more things about te ao Māori that that has always been the premise that we've worked from in the school. So, what does that mean? That means that our processes are that every learner (whether they're Māori or non-Māori)

> comes into our organisation with a mihi whakatau (Maori welcome), they're all brought in and welcomed by the mana whenua onsite, on campus. As a follow-up to that there is also an option for Māori learners to attend a pōwhiri (formal welcome ceremony) that is hosted at one of our marae (Māori meeting place).

Sara talked about observing tikanga in the classroom and the value she saw in that. She said,

> Witnessing karakia, I'm becoming more convinced about that, witnessing karakia and waiata (song) before lectures is really good.

Danielle talked about normalising Māori events for all students, for example, marking the school calendar with significant Māori events such as Matariki (Māori New Year). She explains,

> I kind of normalise those events and put them in our calendar so then our students see them, and they can celebrate what's happening here and what does it mean.

Erena described the importance of their whānau (family) room as central to many aspects of Māori student wellbeing. In relation to tikanga she said,

> The Tertiary Education Commission says Tertiary providers need to create environments where Māori can be Māori. Well that's what our whānau room had always been. When I describe it to people it was our marae and so yes, we take our shoes off when we go in there. We've used that space as we would use our wharenui because when we lost a student a few years ago who took her own life – we didn't have her in there, but we had our tangihanga (funeral) in there for her. You don't do that in a common room.

Danielle saw her role as Kawa Whakaruruhau leader as extending beyond students, to assisting non-Māori staff with their professional development around things Māori. She talked about an initiative she started, an annual staff retreat focused on te ao Māori (the Māori world/view). She said,

> So, we have a retreat, going away once a year to talk about Kawa Whakaruruhau, tikanga, te Reo Māori. I implemented that two years ago, we'll go away before we all come back into teaching, so it's a PD day. We just hired out a bach (holiday home) and were able to kind of go through what it is that we understand in regard to Māori learners. So te Reo Māori is one, that's really one that gets a lot of my peers is pronouncing it correctly. Names and words. I said part of that is participating, so you're already participating! Now all of them are doing a basic free course in te Reo Māori.

At the institute where Awhina works all staff were expected to engage in te Reo. This was part of their strategic framework which she felt had good buy-in from staff. Awhina said,

> All our academics have now completed an introductory course to the Māori world in te Reo Māori. That has been mandated by the Iwi governance group here as part of the

> strategic plan, it was that all fulltime academics would complete the course within 2 years of starting employment. We've managed to do that with all the current academics, so I think there's an understanding of what our commitment is to our learners.

As a result, Awhina said aspects of tikanga (Māori custom) were now normalised. She said tikanga was part of the school culture amongst staff. She describes,

> Having karakia (prayer), waiata (songs) for our staff- those things are all sort of seamless now.

Te Reo was a significant aspect of tikanga that participants discussed. Staff expressed commitment to learning more, particularly non-Māori participants, who talked about developing themselves as bicultural professionals. Many used their initiative to learn te Reo because they saw it as important to their teaching practice and to their students. It was identified as a tool that for some, gave them confidence in working with Māori. Carl, Sara, Maria, Tina, and Nicki shared experiences of learning te Reo and incorporating it into their teaching practice.

Nicki said her students at the wananga were supportive and encouraging to her. She said,

> I understand a tiny amount but I'm learning a lot more. The thing that helps me with the confidence to do that is when you're saying something to do with tikanga or I'm using the Reo in my classroom I ask the students. So, I also say is this correct, please tell me if I'm not following tikanga, I don't mean to cause offence to anyone. Is this the correct usage of this word, that kind of thing, until I'm confident with using the words.

Carl decided learning te Reo was important to his practice as a nurse in New Zealand after he immigrated. He explained this was not a workplace requirement, more his own want to understand better and to participate. He said,

> I have done a very basic a very basic te Reo course. It wasn't that I was being told to do it. But I think people should be told to do that stuff because it's the ones who don't, who aren't seeking it out are the ones who need it most.

Tina spoke of her own experiences and seeking learning with her colleagues. She said,

> We're always looking for opportunities to make that relationship (with Māori students) better and to become more informed. I'm learning te Reo at the moment.

Maria, also a recent immigrant to New Zealand talked of her admiration and respect for te Reo. She also expressed a lack of confidence in her pronunciation and said she did not want to cause offence. She explains,

> I mean Māori is such a rich descriptive language with purpose and there is timing and I just don't know if I'm going to say it in the right spot at the right time in the right way. So I have limited myself quite significantly because I don't want to offend. I think that would be the honest truth. But I have to apologise for my pronunciation because I cannot do those Rs and my rhythm is incorrect and it's just horrible, so I do my best.

For Sara, learning te Reo gave her insight to what it may be like learning in an environment where you do not know all the cultural practices. She said,

> I also know the feeling of displacement has helped a lot when I did the certificate actually, because I felt displaced as a non-Māori. That gave me a really good understanding about what it felt like to be othered or not aware of all the cultural practises and how scary that is- although people were always very supportive and forgiving. That's not saying that Māori students don't know how to negotiate our western culture because they do it all the time.

Tikanga, custom and ritual can be seen in this theme as serving to create a culturally safe environment by providing te ao Māori context for students in the educational setting. Educators used tikanga to help make students feel welcome and to make themselves as educators and the class content relatable to Māori students. The normalisation of te ao Māori through tikanga practices served to signal to all students that te ao Māori was valued and is a legitimate part of nursing education and practice. Having knowledge of tikanga, particularly te Reo Māori was identified as a key aspect to educators' culturally safe practice. The next theme, manaakitanga, illustrates the range of support strategies that educators used in the pastoral care of students, and in their interactions with each other.

Manaakitanga – To provide care and support

Understanding strategies used to support Māori nursing students involved identifying practices centred around supporting students as well as practices that enabled educators. Manaakitanga can be defined as a manner of showing respect, kindness, and care for others. In this theme, manaakitanga was observed in two ways within the data. First, in the various levels of support provided to students. Secondly, in the support given between colleagues.

Methods of student support, or manaaki that were expressed in the data were similar to the Indigenous student support methods that were identified in the literature in chapter two. In this study, manaaki (support; care) was described by participants as a range of academic, pastoral, and financial support methods that were provided to Māori nursing students. However, there appeared to be a deeper level of care, connection and understanding that participants expressed towards students and to each other.

Nicki talked about ensuring academic support was in place for students and described the structures of this at her school. However, she said the pastoral care she and her colleagues gave to students made a more meaningful contribution to their success. She said,

> We make sure that we help our students in practical terms as much as we can. There's lots of different hardship grants and things like that that they're encouraged to apply for. So I think that the support, just practical stuff to start with, is really important. Even you know making sure they've got enough kai to feed their children. Things like that.

She talked about everyone in the nursing team being aware of where students might need manaaki (support; care), and how they shared information to ensure students were holistically cared for. This example illustrates tauira (student) manaaki beyond academic matters. Nicki said,

> We talk to each other about our tauira, if one person is concerned, they'll share it with the rest of the team, and we'll make a plan on how we can best support that student. That might not be a concern about their academic progress, it might be concern about other things that might be happening to them. For example, one of our students recently had a home invasion and she and her husband were assaulted and lots of stuff was stolen and it was terrible. She also had a problem with her car, so we organised a hardship grant for car repairs, she was loaned a car. A whole lot of us went with our kaumatua and blessed her house.

Some participants described financial support that was provided, and provisions that were made to ensure students were able to attend external Māori specific events. Awhina said,

> I think it works really well that the school gives financial support in anything that our tauira want to do. Whether they want to go to the indigenous NZNO (New Zealand Nurses Organisation) student hui (meeting; conference) or whether they want to go to the National Council hui.

Tina said for her, it was important to show manaaki through celebration too. She said at her school they liked to acknowledge student success. Tina said,

> We celebrate success, we've got marae (Māori meeting place) on campus and we go there to celebrate.

Maria felt that the institute where she worked was not particularly enabling to her in providing support for Māori students, particularly some of the rules that created barriers. She said, as she gained confidence and knowledge as a teacher, she decided she could bend rules and make exceptions to provide the manaaki she felt students needed. She said,

> I've learned to sort of draw my lines in the sand and have established my own non-negotiables and realised that I have the power to actually allow for things to happen. It doesn't have to be dictated. We don't have to follow these rules as rigid as they are, and we can make exceptions. I recognise those that want to go to hui or whatever their individual needs are, and I make sure that I sort of raise the road up to meet them.

The other way manaaki was identified within the data was in the relationships staff had with each other. This was expressed within the school between nurse educators, in collegial relationships across schools and through examples of leadership.

Nicki spoke about the availability of kaumatua, kuia and Māori student support staff and how important they were for her. She said they extended their supportive advice to colleagues. She spoke of situations where she needed advice and guidance. She said,

> There are people outside our team that I go to. There's a really wonderful woman in the student support centre, who is just amazing. I'll go to her and ask if I feel uncomfortable asking anyone. I'll go to her and say this happened, can you explain it to me, what should I do, did I do the wrong thing?

Like Nicki, Sara spoke of the relationships she had developed among colleagues. Feeling safe was a condition of these relationships. Sara said,

> We have a magnificent Pouwhirinaki (Māori support staff member) who is always warm in her response. So, I feel safe to ask questions.

Danielle talked about her role as Kawa Whakaruruhau leader as extending beyond the curriculum and students, to supporting staff in their development. She gave the example of initiating a staff development retreat day, focused on te ao Māori and Kawa Whakaruruhau. She saw this as critical in ensuring students were supported by everyone in the school. She said,

> Yes, so that's (Kawa Whakaruruhau) another part of my role, to support that internally within my own nursing colleagues.

However, Danielle tended to go outside of the school of nursing to seek personal support related to things Māori. Although she provided support to her non-Māori nursing colleagues, she found other Māori academics across the institute were important for her to connect with and to seek support from. She explains,

> We have a really good supportive team, but when it comes to Māori issues, I can't tend to talk to them. We meet every month, just the Māori staff, to be peer support for each other.

Kate, as a relatively new nurse academic, found her colleagues vital in providing support for her. She went to a range of colleagues for different reasons, but as she explains here, it was her Māori nurse educator colleague that she found provided a critical element of support. She said,

> I go to some of my colleagues who I feel could give me good direction through their experiences of being more experienced in terms of being an educator. I think that another person that I have accessed so much lately is (name of Māori nurse lecturer) and she has been my saving grace this semester with her clinical and cultural expertise.

I asked for clarity around her response, and queried whether having a Māori nurse educator with clinical currency was important, and she responded,

> I think it's massively important because, this might sound silly but, she has the ability to work and walk in both worlds.

Kate's explanation illustrates that receiving manaaki from colleagues is important for her confidence and ability to do her job as an educator. However, she emphasised that specifically, Māori nurse educators had specific knowledge and skills that were vital in navigating what she described as the two worlds of nursing and nursing as Māori.

Manaaki was also evident in organisational structures. Awhina spoke of the effects of having good support from iwi and institutional leadership. She said,

> Having the support of local iwi, the institute and a great leader within the school behind me and any student that needs support- I mean they really get it. I just think it's the nature of how they do business here, I mean it is really progressive education.

Awhina went on to describe how leadership helped to create an environment, over time, where manaaki, supporting each other was valued. She said,

> Responsibility is shared by this whole school and while some people vary in their confidence, most people would come to ask for support or just say, how do you think I should deal with it? Would you come with me to help?

While all the interview participants spoke of collegial manaaki, Maria felt somewhat isolated. She explains she did have one colleague who was not from the school of nursing, but whose office was near hers, that she often went to. She explains,

> I go to (name) because he's really been, I mean he's just assumed the role. I've not actually had anybody else to go to and I've been quite isolated in the school of nursing, it has been very Anglo here. I don't know anyone who's stood up and said this is my role, there's been very little voice.

Awhina described how the overall culture, leadership and a collective sense of responsibility where she worked, was critical manaaki for her. She describes,

> I think being able to be Māori and exist as a Māori academic in a school that's predominantly not, certainly speaks volumes, feeling supported, having acknowledgment of things that are important to me. It's taken time and effort. But I think it's happened, I have to say with a lot of goodwill from colleagues and that's the clincher for me. It only works if the majority also are supporting. It's very hard to do this stuff in isolation. You can do it, but I think in that instance it comes at quite a big personal cost from what I have seen for others who haven't had the support like I have.

In this theme, manaakitanga was recognised as important for both students and staff. Staff providing manaaki enabled students to feel valued and supported in the nursing programme. Likewise, staff recognised that manaaki, which was expressed as the sharing of knowledge and supporting each other, was essential for job satisfaction, the ability to practice safely, and in creating a culture that was responsive to Māori. Leadership was an important aspect in role modelling and creating an inclusive culture of manaaki. Leadership, or rangatiratanga however, played a larger role that extends beyond manaaki. This is described in more detail in the following theme.

Rangatiratanga – Leadership

Rangatiratanga can be translated in English as guardianship or leadership. Interview participants recognised that leadership was an important influence on the emphasis that was placed on Māori as priority learners in their organisations. Leadership was identified in the data as being both enabling, and a barrier. Rangatiratanga was also demonstrated by Māori participants in this study where they described areas in which they advocated for Māori and where they lead staff development. Māori nursing academics rangatiratanga was also recognised in their ability to act as conduits to Māori stakeholders and they were recognised as critical in leading staff and students in practising Kawa Whakaruruhau.

Leadership within institutions and schools was identified as important. Erena and Awhina recognised their institutions had long-standing and ongoing relationships with local iwi (tribe). Erena said her institute worked with a local Kaumatua (elder) and had solid relationships with iwi in the area. Awhina said that the leadership team had formalised a relationship between her organisation and local iwi. She said,

> A memorandum of understanding was signed…when that was signed off they became an absolute key partner. Now, that is the overarching Treaty iwi governance partner…and it informs Council, it informs the CEO.

Prior to this formal arrangement between her organisation and the local iwi, Awhina said the school of nursing had their own relationships that were built by the head of school at that time. She explains,

> Even before the degree, when the diploma was occurring here, I know that there was a relationship between the head of nursing and the local iwi. Here they had people that were leading the school that were very aware of this local presence. So that was formalised at our school very early and by the time I got here there was this thing called a committee Kawa Whakaruruhau.

School leadership, particularly the head of school was critical to advocate and enable resourcing related to Māori. Danielle described how the implementation of her additional role as Kawa Whakaruruhau leader wouldn't have been possible without the support of her head of school. She said,

> So, the Kawa Whakaruruhau role came in about a year and a half into my starting (as a lecturer), and then I spent a lot of time consolidating it for six months to roll into the next year. Yeah, so how it started, it was with a really supportive head of nursing, she was very supportive of us getting it somewhere.

Awhina described that leadership was the driver of the culture of the school, in motivating staff, and in ensuring Māori learners were the responsibility of everyone. She said,

> I actually think that comes back down to the people who have walked the talk, that are doing the performance appraisals, the heads of school, the program leaders, the middle management and probably iwi governance. Maybe we've got a particular strong sense of social justice- I don't know. I know that above me in middle to top management those decisions were followed through and people held accountable, if you didn't meet or why didn't you go and attend that, and how come you don't know what's happened to that learner? There's been an absolute awareness that people have made a choice and followed through with it.

Erena reflected on her previous school leader, and the way in which he provided manaaki (support; care) as well as role modelled the importance of te ao Māori in nursing education. She said,

> Previously I went to my Dean who I could have a normal conversation because he was totally committed (to Māori) and he put his money where his mouth was and understood. He just seemed to, as someone who's not a New Zealander, he just had a deeper understanding or comprehension of what we needed to do to improve things. Plus, he was also someone who was responsive. He was able to give a mihi (welcome) in Māori and he had started to learn the language. That was in terms of job satisfaction, that was very encouraging.

Māori nurse educators within the school were also recognised as leaders through their understanding of te ao Māori and their abilities to apply it in nursing education. Sara recognised the need for Māori staff but was concerned that Māori nurse educators were hard to recruit. Here, she reflects on why that may be and the role that the organisational culture may play. She said,

> I think the students really respond to having a Māori lecturer to support them. There's a real need to have Māori lecturers. Why do Māori nurses not apply for the jobs? Does word get out that you're not inclusive or you're on your own, you can try but there's resistance? I don't know, I just think we haven't made it a really safe place perhaps.

As described by Kate previously, having a Māori nurse colleague was important to her because she said they had the ability to walk in both worlds, nursing /education and te ao Māori. This also was raised in relation to stakeholders, and the unique leadership skills Māori nurse educators had in this area. They used their leadership to connect nursing education with Māori and vice-versa. In effect, they act as a conduit. Danielle and Erena illustrate this. Danielle said,

> I engaged with hapu and iwi (tribe, subtribe) in regard to what they wanted from Kawa Whakaruruhau. That relationship was already established through the head of school, but I came on board and I knew most of them, so it made it easier, a relationship. I was able to say to them, what do you want?

Erena was able to make professional connections for the school, where she knew Māori colleagues. She said,

> I have started to engage with more Māori colleagues from the DHB, they've appointed Māori nurse leaders and they're people I know already through our Māori networks, so I personally connect with them.

Sara similarly recognised this in her colleagues. She saw value in her colleague's abilities in establishing relationships. She said,

> The Māori lecturers we have had have been very much engaged with getting out there and really going to all the hui and conferences and things like that. By having those good relationships, we can kind of enhance our stakeholder relationships, because it's all about relationships.

This theme has described the importance of culturally safe leadership, or rangatiratanga. This was described by participants as being the factor that could drive a positive or create a negative organisational culture in relation to Māori. The importance of the leadership role of Māori educators was also described as being important both in guiding staff and in supporting students. The next and final theme in this chapter brings together the benefits or the goal of ensuring a culturally safe learning environment for Māori.

Tino Rangatiratanga – Self-determination, autonomy

The previous themes, whanaungatanga, tikanga, manaakitanga, and rangatiratanga were identified from the data as values that underpinned teaching practices and educational environments in nursing that participants described as important to Māori and important to culturally safe practice. The goal of these practices has been interpreted as a desire to promote student tino rangatiratanga.

Tino rangatiratanga is often translated in English as the right to be self- determining or autonomous (Smith, 2017). In the context of the research findings, tino rangatiratanga refers to the ability of Māori students to be Māori in the learning environment, to have appropriate spaces, culturally specific and appropriate support to develop, achieve and safely navigate through the programme into the nursing profession.

Smith (2017) describes tino rangatiratanga in relation to education as a learner-centred teaching environment that promotes the development of independent learners who are able to make their own decisions about their education and lives. In a nursing education context, the practices participants described promote tino rangatiratanga by affirming Māori world views have a legitimate place in tertiary education and in nursing.

Māori identity and associated responsibilities could be difficult for some students to manage while studying. Rob refers to the tino rangatiratanga (self-determination; autonomy) of students where he talked about helping them balance their responsibilities as a learner and as Māori with responsibilities to whānau, hapu, iwi (family, tribe, sub-tribe). He said,

> A challenge for our students is they get torn between the importance of their relationships and connections with their community and their hapu and the responsibility and demands in the programme, so it is important part for us to manage really. So, it's a balance of harmony to ensure their growth is fairly represented and protected, and that one isn't disadvantaged over the other you know.

Danielle also referred to the importance of helping students to recognise and manage responsibilities. She described the tensions students sometimes encounter between whānau and study. She explains,

> Sometimes they might get challenged if there's an assessment due or clinical practice they've got to be at and there's a tangihanga (funeral) process going on…So walking them through that…

Danielle also talked about herself as a lecturer and the importance of her Māori values guiding her practice and being aligned with the institutional approach. Danielle used the analogy of

being on the marae (Māori meeting place) and working in the kitchen to describe this. She said,

> It's probably working in the back in the kitchen. You know you could have your masters, your degrees, be it your doctorates or whatever, but you're still always going to keep yourself grounded and be humble and always go back to the kitchen. That's me, I'm always in the back of the kitchen. Yeah, and it's all those philosophies that we believe in, it's that manaakitanga which is the same values here, te aroha, rangatiratanga, so all of those values that we practice at the marae are the same values also within this organisation.

Tino rangatiratanga (self-determination; autonomy) as making space for Māori was described in several ways by participants. For Maria, it was a matter of adjusting the rules to allow Māori students to flourish in a non-Māori environment. She said it was just about, "*making space*".

Erena stressed that having a dedicated space for Māori to be Māori in the learning environment was a legal right according to the Treaty of Waitangi. She discussed their whānau (family) room on campus, and she said,

> The Tertiary Education Commission says tertiary providers need to create environments where Māori can be Māori. Well, that's what our whānau room always has been.

Awhina noted that it was a philosophy of education where she worked of dual development. That is, to teach students nursing but also to develop their Māori identity. She said,

> Māori learners come, and they're given the opportunity to connect and identify and have support in regards to not only academic matters but if they want to get on a pathway of understanding more things about te ao Māori, te Reo that has always been the premise we have worked from in this school.

Tina recognised that her approach was not always right when working with students. Tino rangatiratanga (self-determination; autonomy) was constructed within her practice in recognising the individuality of students, understanding, and acknowledging who they were outside of the student role that was important in her teaching practice. She explains,

> I can think of a couple of times, a few years ago now I was teaching skills in the skills lab and there was this group of Māori women and they were older women, mature women. I had quite a direct approach to kind of like, right you're doing a blood pressure, let me see how you're doing that blood pressure and they found that quite threatening, so I had to adjust according to – like the individual person as well but also realise that within a teaching session sometimes it's a bit threatening for them. I mean it's hard to explain – these women had other roles; acknowledging that other role in their family, their mana, because they have quite strong big roles in their family.

Nicki described tino rangatiratanga as valuing students for who they are, what they bring to their communities and to learning. She said,

> We view the programme as a taonga (treasure) and we view the tauira (student) as taonga also. Then the taonga belongs to the community.

Valuing Māori, and the expression of Māori values in the educational environment were key themes constructed from the findings of the interviews that described culturally safe practises. Participants described whanaungatanga (making connections), tikanga (custom and ritual), manaakitanga (support; care), rangatiratanga (leadership) and tino rangatiratanga (self-determination; autonomy) as being important to Māori student wellbeing and success, and in creating teaching environments and practices that contributed to this. Relationships and values-based teaching that occurred in the context of biculturalism, where Māori were enabled and acknowledged for their uniqueness were described by participants as ideal and culturally safe practice in nursing education.

Chapter Summary

This chapter has introduced the interview participants and presented the first part of the interview findings. The characteristics of the interview participants were described, including their experience in nursing education and their current roles. Their motivations for participating in this study became clear early in the interview process as have a genuine desire to be responsive to Māori and a commitment to practising biculturally.

The first part of the interview findings have been presented in this chapter in two sections, educators' understandings of Cultural Safety and educators practises of Cultural Safety. Within the themes, descriptions of what culturally safe practice in the classroom have been identified as values and practices that align with te ao Māori. The next chapter presents the second half of the interview findings, where the challenges to teaching Cultural Safety and the environments, attitudes and barriers that hinder this are explained.

Chapter Six

Part 2 of the Interview Findings

Challenges to Teaching Cultural Safety – Resistance to Māori as Priority Learners

Pai tū, pai hinga, nā wai, nā oti

Good at standing, good at falling, the work is eventually finished

Introduction

This chapter presents part two of the interview findings. The previous chapter introduced and described the interview participants and presented the first half of the interview findings. The themes in the previous chapter centred around educators' understandings and practices of Cultural Safety in nursing education. The findings demonstrated that environments encompassing te ao Māori (the Māori world) and staff practises that aligned with this were enabling for Māori nursing students. Despite this, the findings presented in this chapter illustrate there are many barriers to this becoming fully realised in nursing education practice.

This chapter describes the challenges that participants faced in teaching and practising Cultural Safety which are illustrated in the themes *challenging ground,* and, *making uncomfortable places safe(r).* A deconstruction of the sense of resistance to Māori as priority learners became evident in the findings of the questionnaire and is more fully articulated in the final section of interview findings. This resistance is represented in the themes, *colonised thinking and structures,* and *racism and unconscious bias.* (see table 8).

Table 8

Overview of Part Two Interview Themes

Part	Themes
Part 2	
Challenges to teaching Cultural Safety	Challenging ground
	Making uncomfortable places safe(r)
Resistance to Māori as priority learners	Colonised thinking and structures
	Racism and unconscious bias

Challenges to Teaching Cultural Safety

This section describes the challenges participants faced in teaching and assessing Cultural Safety. The first theme in this section, *challenging ground* describes some of the challenges and the methods educators used to overcome them. A key approach reported by participants to managing challenges was in ensuring safe spaces for students and staff to the have difficult discussions and challenge assumptions inherent in understanding Cultural Safety. This is illustrated in the theme, *making uncomfortable places safe(r)*.

Challenging ground

This theme is about the challenges to teaching Cultural Safety. It encompasses the range of issues educators said that they navigate related to Cultural Safety. These include working with varied curricular and pedagogical approaches to Cultural Safety, varied understandings of Cultural Safety from nurse colleagues in education and in practice, managing classroom dynamics and challenging student attitudes and beliefs.

Initially, participants described their practice. There were a range of teaching methods described which reflected the varied experience and subject areas participants were involved with. Dannielle spoke about how she had worked with her school to integrate Cultural Safety into every course and every assessment. She said,

> It is in every assessment, cultural safety and Te Tiriti o Waitangi. It's taken a while to get in every assessment, and again it's come down to the curriculum.

The comprehensive integration of Cultural Safety within nursing curricula was not common among the participants who represented a range of different nursing programmes. However, experiential learning opportunities were more common and were described an important method in assisting students to develop understanding regarding te ao Māori (the Māori world). Carl spoke of the importance of marae (Māori meeting place) visits and was frustrated that his school didn't offer them for nursing students.

> I think the most useful thing is if they talk to somebody from the community have some kind of interactive experience, so yeah, I could talk about Māori health and Pacific health or whatever, but I am not Māori or Pacific, so it doesn't ring as true. Somebody talking about it from their experience is truer. I would have liked to arrange a marae experience for all the students.

Danielle's students did go to the marae. She described how students had the opportunity to experience their own culture through learning their whakapapa (genealogy) and then presenting it on the marae. She explains,

> They have to do their pepeha (speech about genealogy). Each of the students have to know where they are from. I want them to connect to where they come from.

She talked about participation on the marae as being important learning. She said,

> They have to participate in the pōwhiri (formal welcome) process at the marae and they have to participate in the whole day. They've got to be there, they've got to be present. Then they write an essay on Te Tiriti o Waitangi and on colonisation. So, it kind of brings what I'm teaching, what they're participating in, and then what they're going to demonstrate in their essay all together.

A key aspect of students learning about the concept of Cultural Safety begins with developing an awareness of self and the assumptions everyone has. Awhina described some of her teaching methods related to this, and how she helped students examine their assumptions and values. She said,

> We do debates in our groups and they have to hold position on the value of it and what's good about it and what's not so good about it. We give them free license, not abusing people, but to be able to say openly what they think and to talk about what the value is of it. I think that's been a useful technique that's brought forward some polarising views that then allow us to talk around what those views are. Then we get them to deconstruct them, but they require quite careful facilitation.

She went on to describe the importance of students being able to explore their ideas and attitudes and the skill required to help students gain insight into them. She said,

> If you do it right, you should be able to bring it forward because ultimately if they can't explore those ideas here and deconstruct them then they go away holding on to those attitudes.

Rob discussed the importance of ensuring students had the opportunity to demonstrate their understanding in a range of ways and in a range of settings. He explains,

> It's easy to give a student an exam- here tick the right answers and thank you very much but it is something else when you have them demonstrate it. We evaluate it through clinical practice as well- can they demonstrate the principles of emotional intelligence coupled with cultural safety and in a range of different clinical settings? Being able to do something in one setting doesn't necessarily make you master of another, but it gives you the foundational skills of what you are doing and why you are doing it.

Reflection on scenarios in clinical practice and developing a deeper understanding of Cultural Safety over time were also features of how student learning occurred. Tina described how she assesses students differently over the three years of the degree. She said,

> I assess by getting them to explain their understanding and giving examples in clinical. I accept more basic understanding in year 1 and I get them to expand a bit more in year 2 and I think by year 3 they should really understand what that means and if they don't I get them to work on it a bit more.

Carl also talked about assessing student's understanding in clinical practice. He said,

> They have to write a Cultural Safety reflection in placement (clinical practice). Some kind of situation that challenged them on an interpersonal level or that made them stop and think.

Participants agreed that clinical practice was the ideal setting to assess for students understanding and application of Cultural Safety, however, they were not confident that this occurred well. Nicki, Kate and Sara had concerns that assessment practice varied or was in some instances too subjective. Nicki said,

> Well I must admit preceptors aren't all that great at assessing for Cultural Safety.

Kate talked about the importance of helping students to apply Cultural Safety in a clinical setting. She said this was a critical part of being able to assess students understanding but that it was challenging if she was not there an able to coach students. She explains,

> I may come in when they are doing assessments and I get to see what they are doing. So that when you are writing examples down, I can guide that – well I saw you do this, and you did that. If I am not there and able to kind of give them that support, then I don't know how on earth people are assessing it to be honest with you.

Sara also said assessing Cultural Safety should be happening in clinical practice, though she wondered how effective that practice was. She said,

> I guess when you're out on practicum you're supposedly as a competency assessing it, so you know, it's such a hard thing I guess because you don't go and talk to the patient and say have you felt safe? You don't do that (you probably should) but you don't do that. It's something that's ticked off because they haven't sat on a pillow or sat on a table, so I think it's a hard one to assess – it's a bit amorphous really.

Assessment of Cultural Safety was described as a challenge, due to differing interpretations and varied emphasis that individuals placed on the importance of Cultural Safety. Educators describe having to advocate and champion Cultural Safety in nursing. They also describe having to negotiate attitudes, lack of knowledge and in some cases a lack of value placed on Cultural Safety by other nurse colleagues.

Rob described a challenge in relation to stereotypes. He said media stereotyping worked to reinforce racist attitudes and it was difficult to try and counteract this. He said,

> It doesn't help that we have a media that will report news in very culturally orientated lines. You know, a young Māori gentleman was found in possession of such and such and they were arrested. They don't turn around and say a young white fella or a young Pākehā - they only seem to use the label Māori in news media or when there is a negative aspect to it.

Carl also described having to try and counteract attitudes that students brought with them into the programme. He said the lack of New Zealand history and Māori perspectives taught in schools was a factor in this. He said,

> I think there are a lot of students here who come into the programme and they have an attitude around Māori and have got their attitude from their upbringing. I think it comes from school-they are not taught properly about the Treaty and Māori and Pacific health. Why New Zealand is where is it at and I think a lot of students think that they come in and they don't understand that the Treaty is important. We have to focus on it more, where did all that come from, getting them to understand that it really came from colonisation. So, they don't get that at school.

Awhina also identified the lack of preparation students had in schools related to New Zealand history as a challenge and that many concepts were being taught to students for the first time in nursing programmes. She said,

> It just blows me away how little they know. It's not taught in many schools. New Zealand history it's not spoken or talked about in schools.

Participant's colleagues lack of understanding of Cultural Safety also presented challenges. Maria worked in a model of teaching where she had oversight of clinical assessment forms after they were completed by clinical facilitators and the students. She was disappointed in the lack of understanding evident in the assessments. She said,

> Some of the things I see coming back lead me to believe that nobody really knows what they're doing. That it's just been given sort of this kind of superficial 'yeah you did it' and signed off. When I see they talk about cultural safety, 'I took care of a Māori patient', well that doesn't mean you understand. It's like no, that's not what this means- but we don't actually have the support to make sure that this doesn't happen.

Maria felt frustrated that the model of teaching did not allow her to interact with students in clinical practicum, or with preceptors and clinical staff to help students connect the theory in practice and develop a sound understanding of Cultural Safety. Her example also implies nurses working with students in practice either did not understand Cultural Safety themselves or did not help students to accurately articulate it in their assessments.

Kate had similar frustrations to Maria, where she felt other nurses did not understand the application of Cultural Safety in practice, although she did work with students in practice. Kate said she felt nurses did not understand the Nursing Council competencies related to Cultural Safety and Treaty of Waitangi. She said,

> Being out on clinical and trying to explain that particular domain to people and their interpretation of that domain is incorrect. So, they are using incorrect examples for that particular competency and students are doing it because they have been miseducated or misguided so you look back to the educator and you think who is teaching that and where has their understanding come from in terms of that context?

She reflected, and wondered if perhaps the misunderstanding stemmed from education, and staff not being prepared to teach Cultural Safety. She wondered why nurses had different understanding of the same concept. She said,

> Maybe the educator has just been told to take over a particular class because they can't find someone to confidently get up there and teach that, it might be that someone was not prepared for the lecture and did not do it properly, or they have just been misinformed themselves. Yeah, it's just interesting, and how my understanding of that domain does differ from my colleagues. But should it not be the same?

Sara also reflected on wanting to teach students how to apply Cultural Safety better, but that she felt it was a challenging concept at times for educators to do so. She said she had met some resistance in getting the concepts better integrated into the curriculum and in assessment. She explains,

> I think lecturers should have more understanding about how to assess it and I also think that students should know how to practice cultural safety. But I don't think we're given examples of that, we don't get practical we get very – I think we're frightened to do that because it kind of gets personal and it's about two people – the nurse and the patient and we don't do that really well. Because we can talk about the Treaty and what it means but we don't actually talk to the real stuff (or practice it). I have tried, gently but it's never happened, to get it included.

She went on to say that is was a challenge to give priority to Cultural Safety in the curriculum because of a perceived hierarchy of knowledge. Other types of nursing knowledge, such as biomedical content was prioritised. Sara said,

> So that's a really good example of it not being seriously and all we want to do is look at the physiological health assessment, and whether they can take a blood pressure instead of looking at communication and those sorts of things. It's not recognised as being important because it's a bit ethereal. It's all about how we see physiological practices being the most important in nursing really.

Because teaching Cultural Safety was seen by participants as challenging, educators were required to have a degree of mana (power, prestige) to teach it and to advocate for it amongst colleagues. Educators described the skills and what I have interpreted as courage and conviction, to manage attitudes and beliefs that were challenging. Carl described going in to teach as class, he said,

> It's a bit of an art as well isn't it- you're sort of dancing around in the moment and you just pray your dance works.

Tina reflects on teaching Cultural Safety and the skills needed to do it well. She said,

> I think you need to be good at teaching it. I think you need to be able to give them real world examples of it so that they do kind of understand it. I feel exhausted coming out of those classrooms sometimes. You know you kind of feel like you've done group counselling sessions.

I asked her how she developed her skills in the classroom. She replied,

> I mean once again it's trial, error, reflection, what could I do better, constant reflection on practice. Because you know when something hasn't gone so well and actually acknowledging that with the students as well which is very important.

Kate described teaching and working through attitudes and beliefs in practice with students as a privilege. She explains,

> Well I have the privilege of being an educator and being out in the clinical environment, so for me that is about not just showing up to just to be with the student for the one hour that we are allocated, but it is actually for me to be a part of their learning journey.

She describes that it is not always easy. She said,

> It is hard when students have got very aggressive understandings about things and preconceived ideas which they come to the classroom. I am also trying to unblock this fixated idea of what they have and try to almost pull it apart in order for them to open up their perspective about things. I think we achieve that in some contexts.

Teaching Cultural Safety was often described as challenging ground for nurse educators in this study. This theme has described the varied teaching approaches and skills that educators use to navigate these challenges. At the heart of managing the challenges was the core principle of ensuring a safe environment for everyone. The next theme explores how the participants describe they do this.

Making uncomfortable places safe(r)

Cultural Safety is an essential competence that students need to learn to practice as a nurse, however, the process of learning about Cultural Safety involves challenging assumptions, attitudes and beliefs. In doing so, conflict may occur. In some instances, the classroom may become unsafe for both educators and students, the literature describes this as a paradox (Ariel, Friedman & Hirschfeld, 2012). This theme describes the ways in which educators mitigate this risk by creating safe spaces for students to learn. Here, educators describe the ways in which they manage classroom dynamics, and work with students while ensuring they create and maintain safe spaces.

Kate described how she creates safety in class through establishing a set of rules with the class about how they would interact together. She said,

> I have really strict discussions at the start of classes. I acknowledge by saying we are going to talk about particular things which for some of us may be upsetting. We have created a contract amongst ourselves about how we ae going to talk to one another, how we are going to be respectful of other people's ideas, how we are going to let people openly discuss their feelings in a safe environment.

Despite this, she said there was still potential for things to get heated. She described how she manages that,

> It's about me calling a time out and saying okay so we are just going to leave that there for today, if you want to discuss it further with myself then you make an opportunity to come and do so. So that person still has an opportunity to share what their ideas is but it not in the context of 85 students or so.

Carl was also careful in managing group dynamics and ensuring the class was safe. He said it was important to be able to read the room and make a judgement about it. He said,

> If I felt like the temperature is going up and one student is going 'nee nee nee' to another student I make sure I intervene and moderate and bring the temperature down. That is the teacher's role not to let people spiral into a situation where they tear each other apart.

Awhina said student discussions could also become heated, but said the way knowledge and learning were structured, planned, and scaffolded helped to create awareness for students, which stopped some of the negative dynamics. She said,

> Certainly, there have been times where students have raged against, but this course that I teach is a 600 level course, at 500 level there's a specific prerequisite to the course which requires them to unpack their own cultural values and context. So,

> they've done quite a bit at 500 level of exploring not only their own culture values but the values in their group, looking at difference and how to appreciate each.

Danielle said working in smaller groups was a way in which she created safety for students to talk, rather than in a large lecture group. She said,

> I do a lot of group work to take off the tension of the big work. So, then they can have discussions in their personal group and it's safe. So, it's not just one big group and three or four get their say and you're just hearing their voice all the time.

She offered students time to speak with her alone if they needed to. She said,

> I'm happy to do one-on-ones. You know sometime students will come to me, talk with me, non-Māori and Māori, I always provide a safe space.

Danielle also used the Nursing Council competencies as a reference and rationale for the content. She thought this created safety because they are regulated guidelines and competencies rather than personal opinions and beliefs. She said,

> I direct it back to Nursing Council, and that's something that kind of keeps it grounded and keeps it safe. It keeps it safe for our Māori students, our non-Māori students, and for me as a Māori tutor.

Tina said sometimes students disagree, and it is important to acknowledge that. She explains,

> Sometimes you just have to say that is your belief, and that is your belief, and the two don't match and they're not going to match, and that's okay.

Tina also talked about what could happen when the class was not managed well. She said,

> I've heard from the students when something hasn't gone so well with another lecturer- it was because the lecturer didn't keep control to a point where nobody got insulted. You've got to make sure it doesn't get personal and I think that's what happens – that it gets personal. So, you've just got to be on your toes, you've got to be really guiding that, so that nobody gets traumatised by the conversation because that's not good.

Sara also referred to the importance of having skill and managing emotions when teaching Cultural Safety topics. Sara said that she struggles in situations where there is conflict, though she acknowledged the importance of open dialogue. She said,

> I'm probably the worst person because I get really cross-I find it really distasteful, which isn't right, and I know it's really important that the discussion happens – really important. Sometimes I think you just need to have that discussion and be really honest – in a balanced frame when the students aren't frightened to say what they're thinking.

This section has presented two themes related to teaching Cultural Safety and some of the challenges it can present. The first theme, challenging ground described how teaching Cultural safety required a certain courage of conviction, as challenging student attitudes could cause conflict. In addition to this, the emphasis and support for Cultural Safety within the curricula was not always perceived as adequate and staff attitudes and lack of understanding in some instances created further challenge. Maintaining the learning environment as a safe space for everyone was an important aspect to participant's practice, which was described in the ways in which educators made uncomfortable spaces safe(r).

A key component of the challenges described relate to Cultural Safety being associated with Māori and the focus on 'difference' to Western, educational, and nursing cultures. In addition to this, interview participants specifically described a range of cultural, structural, and attitudinal barriers that impact Māori in nursing education and practice. Collectively these barriers form a sense of resistance to Māori being strategically positioned as priority learner, which was evident across the data. This is explored in more detail in the final section of interview findings.

Resistance to Māori as Priority Learners

Chapter four reported the findings of part one of this research, the survey of nurse educators around Aotearoa- New Zealand. Questions in the survey exploring Māori nursing student success strategies, revealed some negativity amongst participants, and a sense of resistance to Maori as priority learners. This was an area of interest which was explored in greater detail with the interview participants.

The interview narratives provided a range of examples which explained and elaborated on the sense of resistance towards Maori that was evident from the survey data. Two themes have been identified that are illustrative of this resistance: *colonised thinking and structures,* and, *racism and unconscious bias*.

Colonised thinking and structures

Colonised thinking and colonised structures describe how some ways of thinking, and organisational processes have negatively influenced Māori, and staff efforts to support Māori. Organisational structures and thinking, in this theme, are described as colonised because they appeared to dominate or influence educators' practice. They were perceived as serving to maintain Pākehā hegemony in nursing education.

Colonised thinking was characteristic of the resistance described towards Māori as priority learners. Kate, Erena and Danielle gave examples of how they experienced this resistance to Māori in their workplaces. Kate described it as an undercurrent related to fear or a lack of understanding. She said,

> I think there is an undercurrent of misunderstanding within educators. Maybe that is also related to a bit of fear and lack of educational awareness of what is required for Māori students in order to support them.

Kate linked the undercurrent of resistance to misunderstanding colonisation. She went on to say,

> I don't know why it is such a sensitive topic for many. Maybe it's their own interpretation going back to colonisation and misunderstanding about that whole experience and where we are now and what we are doing to address it.

Danielle said the resistance came from staff at her school of nursing who were not from New Zealand, and they just didn't understand. She explains,

> Certainly, when I came into the organisation half our staff in nursing were from overseas. They're not going to have a connection or understanding of the Treaty- so if they didn't have that connection, they weren't able to understand about Māori deprivation- Māori anything really.

Although Danielle felt that staff that were new to New Zealand did not understand the place of the Treaty of Waitangi or Tiriti o Waitangi in nursing education, or Maori student needs, it is important to note that two of the interview participants who were New Zealand immigrants, did. Both Maria and Carl are internationally qualified nurses who demonstrated clear understanding of the importance of supporting Maori students and described their educational practice in relation to it, throughout their interviews.

Erena felt frustrated at barriers Māori learners faced even before they were enrolled. She used the example of standard entry criteria for applicants into nursing degree programmes, and how these can exclude some Māori applicants. She said,

> Why aren't we looking at the value Māori applicants bring? I'm not ever advocating that you don't need science or literacy and numeracy, but what they bring is valuable to the workforce. So why aren't we recognising applicants that don't quite make entry criteria- let them in and then support them? We're not changing the criteria they need to meet in order to progress through the programme- we're just opening the door wider for them to come in and intensifying the support.

Erena's example shows a system that does not recognise inequities or demonstrate educational responsiveness to Māori. She went on to say, that those with the power to be responsive, in leadership positions were not. Erena said leadership did not understand and consequently progress for Māori was stalled. She seemed to accept that coming up against this resistance was part of working in a Pākehā dominant system. She said,

> It's the new leadership position unfortunately, where the lack of understanding exists. If I have to describe it, it's just really deflating. I feel we made some really good progress, but right now I've got a sense that it's all gone backwards a little. And that's what it's like for Māori. We know that.

Erena spoke passionately about the struggles she encountered in trying to get a whānau (family) room space for Māori students at her organisation. Her organisation said that the whānau room had to be inclusive for everyone. She was given a space that had been previously designed as a Muslim prayer room with specific plumbing and layout. She was frustrated that organisational restructuring resulted in a loss of dedicated space for Māori and loss of Māori staff. She said,

> It's just a symbol of the frustrating ideas that prevail when our core and key people are made redundant and that progress which occurred under their support has gone. So, we're sort of back to the drawing board.

Nicki also recognised that colonisation had an impact in education environments. However, Nicki remained hopeful that New Zealand could improve. She said,

> It's the same with any colonised people isn't it. If you look globally it's the same stuff everywhere, and I think that New Zealand can do better than that. I think we have to change things and maybe lead the way.

Colonised thinking was one aspect participants described as contributing to the notion of Māori as priority learners, however, this also extended to organisational structures. Carl and Maria spoke of a lack of formalised structure and resource available to them. Regarding Māori staff or support for things Māori, Carl said,

> There wasn't anyone official to go to.

Maria said she felt isolated and in her school environment. She said,

> It's been very Anglo here.

Maria described wanting to assist with introducing tikanga (custom; ritual) into her school and explains that she as an internationally qualified nurse and fairly recent immigrant to New

Zealand, was tasked with organising a mihi whakatau (welcome) for the new year of students. She explains,

> No one else stood up for that, and you'd think they would have picked up on the mismatch there!

The absence of Māori nursing staff and formalised processes for an official Māori welcome in the school provides a clear example of colonised structures and Pākehā dominance of the organisation. In addition to this, the absence of Māori staff and adequate resourcing for things Māori were also identified as barriers.

Awhina reflected on why her organisation perhaps did not provide adequate resource for Māori learners. She rationalised that this may be down to the education business model. She said,

> I can see why they prioritise the way they do- their business model. They take the learners that they know they're going to get the best return from- and that's brutal, but you know, that's business.

She went on to say, some Māori learners need more input that other learners, and that she recognised why organisations might now prioritise that in a competitive education business environment. She explains,

> Our people require a hell of a lot of input and sadly that input should have come well before tertiary- and I can see why they're not prioritised in a lot of our institutions.

She then reflected, that individuals could still make a difference within organisational constraints and that it was expected of all teachers. She said,

> It's easy to say organisations don't get it right, but for me I believe it's up to each of us. If we're taking a role in leadership, in education, then we take on the full range of what goes with that, of living and learning and teaching in Aotearoa.

Sara talked about why Māori staff were perhaps not engaging with the school of nursing and the tertiary education sector. She suggests that colonised thinking and structures may be recognised by Māori and that was a barrier for them in wanting to engage. She said,

> I think we haven't made it a safe place perhaps…I think perhaps they have met with resistance and that's not forgiven or forgotten for a long time, and I think that's just a part.

Awhina also recognised that a colonised environment was fatiguing for Māori to work in. She said,

> I understand that we've got some really frustrated and angry colleagues out there, and they may eventually leave. They get tired and they think they're not supported- that's really sad.

Sara said there had been welcome changes in organisational structures to be more inclusive of Māori recently and that she felt it had been a long time in coming. She explains,

> We didn't have a director Māori for many years, so it wasn't taken seriously. I know that for Māori over there who were in Māori studies they were pretty much going for it by themselves and were not really well included.

She said she felt that a bicultural instructional approach and positioning Māori as priority learners, was not taken seriously until it became something that impacted on Pākehā. By this, she meant the requirements of the organisation to demonstrate accountability to Māori, such as reporting to the Tertiary Education Commission as a condition of funding. Sara wondered whether some institutional practices were effective and if Māori were empowered within systems to work to their full potential. She said,

> Even now I think it might look a wee bit surface-y having a Director Māori. I wonder if they really given him any governance power.

Some participants, (Rob, Tina, Awhina) described formal institutional strategies that they thought worked well in promoting responsive environments for Māori. While most participants described barriers within educational structures and practices related to colonisation, overall, they were positive that progress was possible, albeit slowly, with collective efforts.

While organisational structures and ways of thinking may not be obvious or explicit barriers to everyone in nursing education, racism is. The final theme presents numerous examples of racism and unconscious bias in nursing, that were described by all of the interview participants.

Racism and unconscious bias

As previously outlined, a range of studies recognise that racism and unconscious bias are part of the lived experiences of Indigenous students. Understanding nurse educator's awareness, experiences and responses to racism and unconscious bias was important to establish. A specific question was posed to participants related to this. All of the participants had experiences to share of racism. This was described as institutional racism and racism amongst their nursing colleagues. Many gave examples of how they supported students through racist

encounters in clinical practice and how they pre-empted racism by preparing Māori students for what they described as an inevitable part of the nursing culture.

Nikki, Erena and Maria talked about institutional racism and gave examples from their experiences. Nikki talked about the disadvantage many Māori students bring to tertiary study and described it as institutional racism. Nicki explains,

> I think that's why Māori don't do as well in our education system, it's not because of them, it's because of the education system. It's been this way for decades. There doesn't seem to be a lot happening to change that, it's changing very, very slowly. That's why we're used to a lot of tauira (students) who have those educational needs. That's why we run a bridging programme, not just to upskill them, but also to instil confidence, because I think for a lot of our tauira, they might be the first person who has gone to university in their whānau.

However, institutional racism was also evident in tertiary setting and affecting nurse educators' abilities to effectively support Māori students. Maria described programme regulations that disadvantaged students wanting to use te Reo in assessments and how she broke rules in order to support them. She said,

> Students had to submit their papers 2 weeks in advance in order to have it translated to English. I decided that this was quite punitive. I basically have reached my point where it's like, I'm sorry that's not okay, they can actually turn it in at the end of the term. Why exactly am I creating this punitive arrangement?

Erena was frustrated and tired of having to fight for what she saw as student's right to culturally- appropriate spaces and the inaction of institutional strategies to support Māori. She illustrates this in her struggle to establish a whānau (family) room for students. She said,

> So we were told there was no money for a whānau room and yet previously the organisation had deemed it important to resource a space that was dedicated for Muslim students. That sort of left a hard battle to fight because the irony of you can have this space but that's all we can offer and then we've now occupied that space, but we were told that it has to be an inclusive space, so it can't be a dedicated space for Māori – it has to be inclusive because that's what we're about.
>
> The organisation's blanket rule that any whānau room has to be inclusive of all students just tells me that there's still terrible ignorance around what Māori need and what the Treaty says we have by right but even if we never had a Treaty for me it's a no-brainer. If our indigenous people are lagging behind everyone else, then we've got to do everything we can – that's what we say with our flash publications on strategies to do this. We say it. But when we actually try to implement initiatives or do things that are going to achieve those goals we're told, oh you can't do that because that's not fair to other people.

Leadership that advocated for Māori was described in an earlier theme as an enabler, however, participants also gave examples where leadership was a barrier to Māori and contributed to a culture of institutional racism. Referring to leadership, Erena said,

> Well sadly I see a lot of hypocrisy. If you say those things, then you need to take action and you need to put your money where your mouth is and recognise that you need to do things differently. It has to be argued and the minute I'm told by a leader we can't do that for Māori – that's not fair we've got to do it for everyone. I actually get quite frustrated and angry because the real difficulty is that people don't understand inequity.

She went on to describe that often what organisations espoused in their strategies for Māori student success did not translate into what she observed happened in practice. She explains,

> Organisations can say what they like in their strategic plans and what they publish and what they say to the media. Well the minute that you say, okay this is what we need to do, the response is no we can't do that because that's not inclusive or that's exclusive. Well that's exactly what it has to be. It has to be exclusive.

Kate felt a lack of Māori nurse educators and leaders that advocated for Māori was a problem. She said,

> It's about leadership and I don't see enough of it, not good leadership promoting Māori. And a lack of Māori staff, more Māori staff will bring about the normalisation.

Within the schools of nursing, interview participants talked about racism and unconscious bias amongst their nursing colleagues. Sara, Rob and Awhina described this as a subtle undercurrent. Sara said,

> I think it's underlying, it's like racism, it might not be said but it's there. There is a resistance.

Rob described hearing conversations of his colleagues with this undertone. He said,

> I think it is going to take another generation or two before we start seeing an absence of this sub-current that exists within our profession around attitudes by a number of our colleagues towards Māori. You know, I have heard some conversations and have been quite concerned about the tone of what has been said. I am quite certain that if my complexion was different that those conversations and comments would not have occurred.

Awhina described how she felt the racism amongst colleagues had become more covert over time. She gave an example of hearing her colleagues referring to workshops and the Nursing Council competency related to the Treaty of Waitangi, as a waste of time. She said,

> Now I'm not hearing, you know, all 'Māoris' do this and that'. It's more of a feeling, or a more of an undertone. I think it's just how it's delivered now it's a little bit more guarded and it's done in a more PC (politically correct) way. Like not referring specifically to, but oh you know we can't say that, it's not very PC to say that, but we're actually sick of having to go to all these Treaty workshop updates and you've done it once you've done it twice, it's so PC and I wish they'd tell us what they mean by 1.2[14] because it's just such a whole lot of PC twaddle.

Kate felt the resistance to things Māori and supporting Māori students was less subtle. She could not understand how some of her colleagues had such differing views to hers and she describes outright resistance from her colleagues to te Reo (Māori language) and participation in Māori specific celebrations. She said,

> We're doing a curriculum review and there is SO much resistance from staff to incorporate te Reo in things, I mean WHY? I don't get it- the arguing over the use of te Reo in titles etc. The resistance from staff is astounding, I mean I went to the [name of specific Māori scholarship] presentation and it was a really big event, such a special occasion and I was the ONLY lecturer there other than the management staff and Māori lecturers.

She went on to explain her frustration at her perception of her colleagues' lack of understanding of inequity. She explains,

> If a Māori student for example comes for additional support or fails, the question is, why are we doing that for her? Would we do that for a Pākehā student? You know, like, why are we putting more time and effort into this? I mean is it happening all the time.

Sara reflects on what she sees in practice and wonders whether staff are aware of their unconscious bias and stereotypes around some Māori students and their circumstances. She said,

> I think that attitude about students with big families, it's like benefit-bashing, where they've come from, what their experiences are. There's still that little element of blaming that we do and we do it well for women anyway, but we do it for Māori women as well because their lives are often really complicated. Sometimes we say it's amazing and then when things turn to custard we say, oh they couldn't get through so things like that. I think that those are the attitudes that are things to work on.

Some of the more distressing examples of racism that interview participants described related to students and encounters that occurred within clinical practice. These encounters were often

[14] This refers to the Nursing Council of New Zealand competencies for Registered Nurses (2016). Competency 1.2 is, "demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice" (p.10).

with registered nurses with whom students were in dependant relationships with. Nicki, Danielle, and Carl recounted experiences that were overtly racist and distressing to students and staff. Nicki described several situations including this example that a Pākehā wānanga (non-Maori student at a Maori university) student encountered. She said,

> Then there was another incident, oh my God this was terrible, where a Pākehā student was on placement and her preceptor and another nurse was saying, oh why do you go to a Wānanga you're not Māori blah, blah, blah, this kind of thing, and then the preceptor started using that American gangster language and using the N word.

The effects of racism extended beyond this student's experience. A Health Care Assistant (HCA) was also affected by the nurse's racism. Nicki explains,

> This woman, the preceptor who made all those comments is a Pākehā and she made them in front of an Indian HCA who took my student aside later and said, I really hate it when she talks like that, but obviously it's not the first time that that woman talked like that.

Carl described a similar situation where a student witnessed a nurse manager making jokes about Māori. Carl said,

> She was the manager of this clinical practice in the community. She was making some sort of racist joke, something about Māori people, but the student was Indian by background. The student felt that the manager thought it was okay to make that joke because they were Indian rather than Māori.

Danielle talked about her student's eyes being opened to how racism occurs in health care. She described a Māori student's experience where staff treated a Māori whānau (family) differently. She said,

> So, there was a Māori whānau, it was in an older people ward. One of their parents had just had a stroke. Whānau came in and as soon as whānau came in, the cleaner automatically stood up and went to move the milo container and brought it into the office. The student was sitting there and said, oh I notice you've got the milo container here and she said oh yes well you know those people they'll probably eat all the milo, and she goes, who are you talking about? She goes that Māori whānau, there's about twenty of them, and she said, so we've got to take the milo away all the time. She was shocked, the student. She noticed as she was there over a three-week period, that that happened often, not just once.

In two cases, students either did not report events at the time or did not want academic staff to address the events with the clinical staff. The vulnerability students felt being dependant on staff in the clinical environment often lead to their silence. Nikki describes,

> I suspect the reason for not taking it further is she made lots of excuses this woman, this preceptor who was talking like that, she said the woman was just trying to be cool and stuff like that. Also, it illustrates the imbalance of power.

Carl's students felt similarly. He explains,

> She felt she had to be quiet about it because she was the student and did not want to get herself off-side, and you know, students always feel vulnerable. They feel like they are not going to get a positive assessment from a preceptor if they create waves in a clinical environment.

Danielle's student, with Danielle's guidance, decided to turn her experience into learning. She reflected on her feelings and what could have been done differently, as well as shared her learning with others. Danielle said,

> We spoke about it, I said so what do you think was going on? We used the Nielson's reflection cycle, and that's a nice reflection tool for our students to kind of observe and then they can articulate, respond and they can reflect.

Danielle's student then chose to write an essay about the experience and unconscious bias. She then presented it to her peer group during a clinical debrief.

Danielle herself experienced racism in the clinical environment as a nursing lecturer. She said being Māori she was looked at differently and was shocked at some nurses' reactions to her. She said,

> I've seen it myself as a nursing lecturer. One of the things I always do is introduce myself with kia ora (hello). I use te Reo Māori when I'm out there clinically. So sometimes I get real biased opinions back just by saying kia ora, in a hospital setting and they'll go, oh no we don't use kia ora here, you've just got to say hello. So, I said that's how you can connect with Māori just in an instant, just by saying kia ora. But she walked off, she wasn't interested really, and I'm not even sure if she had her cultural safety orientation through the hospital, she was only just new.

Danielle said it was not always that overt. Mostly it was subtle, but it was still very noticeable to her. She describes the reception she receives at times from nurses in clinical practice. She said,

> Sometimes you can have it literally in your face and other times it can be so subtle just the raising of an eyebrow or by a tone of a voice-not even that- you'll get the look up and down. I've had that many times when I've walked in, just looking at you up and down and not even engaging with you.

Māori interview participants seemed to have accepted racism as a part of life and nursing practice. It was something they said they regularly encountered and something they strived to help Māori students to come to terms with. Danielle said,

> It's a real topic that comes up every year for us, every year and how to navigate our students through it. How they keep their mana (integrity) intact is a really big thing. So, we talk about mana we talk about integrity, manaaki (care), whakawhanaungatanga (connection with others).

Erena talked about her own struggle being Māori in a system geared towards Pākehā. Though she laughed when she said this, there was also raw emotion evident. She said,

> Other Māori listening to me would say oh shut up Erena this is our reality, and I can understand that. It is a reality being Māori and our experience working in mainstream organisations is the experience is that we require extra energy and effort just to be able to navigate our way through and respond to these concrete walls and stuff that's thrown our way.

She also talked about strategies she had for Māori students to resist racism. She knew students would encounter racism and comments from peers, particularly where historical content related to colonisation and inequities were concerned. She explains,

> The way that we help our Māori students is to prepare them and try to coach them when they first come that you know, you must avoid, be a bigger person, you walk away when you're challenged by other students when students make comments. The students say to us during the third year when they have the Māori paper the flack they get from classmates. We have to prepare them to be strategic and quite deliberate in a way. We say don't respond – we say walk away; don't argue; don't get into conflict.

It has been almost 30 years since the original Kawa Whakaruruhau/ Cultural Safety in nursing education model was released (Ramsden, 1990). One of the original objectives of the model was, "to educate registered nurses so that they become open minded and non-judgmental" (p.4), yet, encountering racism appeared to be a reality in nursing education for all of the participants in this study. This final theme has evidenced this.

Chapter Summary

This chapter has presented the second and final part of the interview findings which have presented a counter-narrative to the positive practices of cultural safety and te ao Māori described in the previous chapter. The challenges and resistance to teaching Cultural Safety have been described, and some of the methods educators used to overcome these were explored. A core theme that was evident across the findings, resistance to Māori as priority

learners has been presented from the perspectives of the interview participants. Racism was a common occurrence which suggests that Cultural Safety is not well understood or practised by all nurses in Aotearoa New Zealand.

The next chapter, the discussion, brings both phases of the research together. Data from chapters four, the findings of the questionnaire, and both chapters of the interview findings are analysed as a complete, integrated data set in the following chapter. Responses to the research questions will be established and supported by contemporary literature. Critical discussion regarding the implications of the research will then be explored.

Chapter Seven

Discussion

He kakano koe I ruia mai I rangiatea, e kore koe engaro

You are a seed born of greatness and you will never be lost

Introduction

The aim of this research was to determine how New Zealand tertiary education institutes, schools of nursing and nurse educators respond to Māori nursing students' learning needs. Data were gathered from nurse educators' working in undergraduate nursing programmes in two phases consisting of a questionnaire and interviews.

This chapter considers the results of the research findings from both phases of the study. As an explanatory sequential mixed method study, data were analysed sequentially and then considered as a whole, where data integration occurred. In this chapter, the findings are explored in terms of what they may mean and how they may be valuable for nursing education in Aotearoa New Zealand. They are further discussed considering the research questions and in the context of current literature, in doing so, this chapter brings together and critically analyses the findings of the research.

Considering the data as an integrated whole has provided responses to the research questions and generated points of discussion which are presented in this chapter. This chapter begins with a summary of the findings in relation to the research questions. Following this, in depth discussion around key themes arising from the study are presented which centre around, colonisation in nursing education, the concept of Ngakau mō ngā Māori (a heart for Māori), critical consciousness, and how Cultural Safety and Kawa Whakaruruhau may be the original model of decolonisation for nursing education.

Responding to the Research Questions – A Summary of Findings

The purpose of this research was to explore how New Zealand tertiary education institutes, prepare for and work with Māori nursing students. The research was guided by four research questions. Examining the findings, it is possible to address each of the research questions, however in some instances evidence used to answer one question contributes to answering the next. In that sense the questions and the findings are inter-related and collectively contribute to the wider research discussion.

The following section presents a summary of how the findings have addressed each of the research questions. Following this, key discussion points are identified and discussed in greater detail in the context of the literature. Data to address the first two research questions was gathered in phase one, the questionnaire. Whereas the second two questions were explored in the phase two interviews.

Question 1: What are institutional and school strategies that seek to support Māori nursing students?

The questionnaire asked direct questions related to both institutional and school strategies. Most participants said their institutions had specific strategies related to Māori student success, (87 per cent), and 13 per cent were unsure. This is not a surprising finding given the Tertiary Education Strategy (2014-2019) provides clear directives to education provides related to the prioritisation of Māori learners (Ministry of Education, 2014). Participants described a range of institutional strategies and it appeared each institute had differing approaches to both their strategy and how this was enacted. Overall, those nurse educators that were aware of their institutional strategy were able to describe the ways in which the institution implemented it. Despite the variations, they appeared similar in their understandings of how their institutional strategies for Māori learner success influence practice. Creating conducive environments for Māori, focusing on Māori student achievement, ensuring formal support for Māori learners and staff development opportunities were common. Most institutes employed specific Māori learner support staff (83.3 per cent) and most participants had the perception that there was overall good institutional support for Māori students (72.2 per cent). Despite these favourable responses, participants also identified issues with the strategies, particularly related to ineffective implementation, inadequate resourcing and variable buy-in from teaching staff.

At the school of nursing level there was less clarity and positivity regarding strategies related to Māori nursing student success. Just over 60 per cent of participants said their school had a strategy, 17 per cent said their school did not have one and 19 percent were unsure. Of those that had strategies, respondents described these as helping to raise awareness and set expectations for staff. One participant wrote, "*The framework encourages Māori success to be an expectation not an exception"*. Conversely, another respondent replied, "*It's something to report on but doesn't necessarily influence teaching practice or understanding of student needs*".

Likewise, support strategies employed by schools appeared to be variable in their effectiveness. Some schools described strong leadership and support for Māori students and staff, whereas others felt the responsibility was delegated to Māori staff and was not a collective school responsibility.

Perceptions about the support for Māori nursing students, and Māori nursing staff were less favourable than the overall institutional ratings. Less than half of the respondents reported that their schools employ a specific staff member to support Māori nursing students (over 44 per cent), over half felt school engagement with Māori stakeholders was average or below average and half rated support for Māori nursing students as average or below average. Furthermore, school support for staff to provide for Māori learners was rated poorly with over 60 per cent rating this as below average (61.5).

Overall, the findings provide evidence that institutes and schools do have strategies in place to support Māori students, however, these appear variable in their approach and varied in how staff understand them. The implementation of the strategies also appears inconsistent, with some staff knowledgeable and reporting ways in which they positively influence their practice and others, finding approaches wanting due to ineffective resourcing or lack of staff buy-in. These inconsistencies become more pronounced when the findings related to barriers and enables to Māori student success are explored.

Question 2: What are nurse leaders' and educators' perceptions of barriers and enablers in providing nursing education to Māori nursing students?

A greater sense of division in opinion and approaches was evident when analysing the barriers and enablers in providing nursing education to Māori. In answering this question, data from both the questionnaire and interviews is drawn on.

Barriers

Barriers relating to organisational culture, staff resistance, attitudes, understandings, and racism were identified. A lack of Māori faculty was also raised by participants in both the questionnaire and interviews. Organisational culture was identified as a barrier in two ways. First, in the questionnaire a culture lacking responsibility for Māori was identified by some respondents, and secondly in the interviews many participants described a Eurocentric culture as a barrier to Māori in education.

The approach of the team as either collective or individualistic was raised by participants in the questionnaire. An educational culture that was enabling was depicted where there was good understanding and implementation of strategies to support Māori and where a collective

sense of responsibility existed. Examples of this include, "*We consider our Māori students to be taonga*", and "*The strategy keeps me conscious of influencing Māori outcomes*". Conversely, where this collective culture of responsibility did not exist there was a sense of dissatisfaction from participants. In one example, from the questionnaire, responsibility was devolved to Māori staff, "*There is an expectation that the problems will be resolved by Māori teaching staff".*

In chapter five, the theme *colonised thinking and structures*, describes in detail some of the barriers that exist for Māori students and staff efforts to support Māori in educational environments. Examples were provided describing decision making that had negative consequences for Māori, related to resourcing, and academic rules and regulations. Attitudes and understandings of staff were also highlighted as barriers. Within the questionnaire there were comments that revealed a sense resistance to Māori being positioned as priority learners. This was a key area that I followed up in the interviews, where this resistance was more fully articulated in the themes '*colonised thinking and structures'* and '*racism and unconscious bias'.*

Racism was a common barrier that all educators in the interviews said negatively affected Māori students. Their examples mainly occurred in clinical practice settings with students, but also examples of institutional racism and racism amongst student peers and between nurse colleagues were provided.

A lack of Māori faculty and nursing workforce was also identified as a barrier. The questionnaire participant demographics were not entirely representative of the nursing workforce, nor the nurse educator workforce. The number of Māori respondents was higher than the overall Māori nursing workforce, which was not unexpected given the topic of the study. However, participants said more Māori faculty would be beneficial. This was echoed in the interviews, where Māori nursing faculty were highly valued by their peers. Those that had few Māori colleagues found this was a barrier. Although there are high profile strategies aimed to increase the Māori nursing workforce, the number of Māori nurses has remained relatively static for the past decade (Nursing Council of New Zealand, 2017, 2020). The lack of Māori in general, in academic positions in tertiary education has also been raised as a concern in recent literature (McAllister, Kidman, Rowley & Theodore, 2019).

Enablers

Enablers included organisation strategies, culture, leadership, staff champions, and teaching environments, staff and practices that reflect te ao Māori values. An organisational culture

that was collective in approach towards Māori was described as an enabler. Often it was identified as the leadership that drove this culture. Further to the sense of collective responsibility, organisational culture was described in greater detail by participants when they talked about their practices to support Māori nursing students. Section three of the interview findings (chapter 5) describes educators' practises of Cultural Safety- which are also enabling practices for Māori. While participants did not all use Māori concepts to describe their practices, during the analysis of interview data, it was clear that these practices align within te ao Māori concepts, hence the themes of *whanaungatanga, tikanga, manaakitanga, rangatiratanga* and *tino rangatiratanga* were constructed.

Educators described how they used whanaungatanga, the practice of making connections as an enabler, such as, knowing students, knowing their names, making genuine connections with them and seeing them holistically in their learning. Incorporating tikanga, custom and ritual, such as the use of karakia (prayer), using Te Reo (Māori language) in everyday teaching and learning practice and showing manaaki, care, through developing supportive relationships were all descriptors of how educators enabled Māori students. It was the practice of te ao Māori and incorporation of Māori world view and values into everyday teaching and learning that contributed to relationships based on mutual trust and respect and promoted environments conducive to Māori learners.

Question 3: How do nurse educators understand and interpret Cultural Safety in nursing education?

Research questions three and four were addressed by interview participants. Specific questions were asked about what Cultural Safety meant to educators in their practice, how they understood Cultural Safety and I asked for examples of how they practised it.

Participants had varied definitions of what Cultural Safety was for them. For some, these definitions were not clearly articulated beyond a broad sense of respecting others. Some participants defaulted to the Nursing Council definition of Cultural Safety, which defines cultural in a broad sense encompassing "age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief, disability" (Nursing Council of New Zealand, 2011, p.8). However, there was a sense of dissatisfaction with both the Nursing Council definition of Cultural Safety and the Council competency related to Cultural Safety for registered nurses which states nurses, "Practises nursing in a manner that the health consumer determines as being culturally safe" (Nursing Council of New Zealand, 2016b, p.13).

Section two of the interview findings detailed the tensions and differences in understanding of Cultural Safety. Whilst educators described their understandings of Cultural Safety, they also said there was a clear difference between Cultural Safety, and the concept of Kawa Whakaruruhau. The theme *Kawa Whakaruruhau-specificity and richness* describes how participants acknowledge and respect the origins of Kawa Whakaruruhau as being distinctly Māori, specifically developed for the care and protection of Māori. Although everyone that was interviewed acknowledged there were differences in the concepts, Kawa Whakaruruhau was clearly by and for Māori, whereas Cultural Safety was considered a concept that applied to everyone

Question 4: How do nurse educators' practice and apply the concepts of Cultural Safety in nursing education?

The final research question, how nurse educators' practice and apply the concepts of Cultural Safety, has been partially explored when describing the enablers to providing nursing education for Māori (research question two). Examples of the ways in which educators incorporated practices of whanaungatanga, tikanga, manaakitanga, rangatiratanga and tino rangatiratanga were provided, and became key themes from the interview data. Ensuring the learning environment was safe was also important to practice. The theme, *making uncomfortable places safe(r)* describes the ways in which educators managed the learning environment and navigated with skill the task of challenging students' assumptions, while ensuring a safe space for everyone was maintained.

Knowing what resources were available and taking responsibility for Māori students' needs also served to create Cultural Safety for students. Examples provided by participants included seeking support from appropriate people such as kuia (elder), a Māori nursing lecturer, or in advocating for a student whānau (family) room in the organisation were described. Educators also described how it was important for them to continue learning and take time to reflect on situations because they said Cultural Safety was a 'journey' that didn't end, that is, there wasn't an end point to say you achieved Cultural Safety because each situation was different.

The overarching way in which educators practised and applied the concepts of Cultural Safety in nursing education was through their conscious efforts and actions of embracing te ao Māori in their practice. For Pākehā (non-Māori) participants, this required a worldview that was bicultural and that was based on an understanding the impacts of colonisation and of their own power and privilege.

This section had provided a summary of the research findings and how they have provided evidence to respond to the research questions. In doing so, data from both phases of the study were integrated and analysed as a cohesive whole. From this summary, a critical analysis of the findings in the context of the literature, the New Zealand socio-political environment, and theoretical lens guiding this study is provided as discussion. This next section is organised using headings that have been generated from the analysis of the findings.

Discussion of the Research Findings

Nursing education is colonial, maintains Pākehā hegemony and perpetuates inequities

Colonisation was a key element that was identified by participants in both the questionnaire and through the interview narrative. It was explicit in some of the themes constructed from the data, particularly the second part of the interview findings where challenges to teaching Cultural Safety and resistance to Māori as priority learners were explored. Aotearoa New Zealand is a colonised land and because of this history, there are ongoing processes that serve to maintain colonial power and perpetuate inequities for Māori.

Colonisation can be defined as, “an ongoing philosophy of domination that involves dehumanizing of Indigenous peoples, underpinned by an ethnocentric worldview” (Curtis, Jones, Tipene-Leach, Walker, Loring, Paine & Reid, 2019, p. 514). The overarching consequence of colonisation is described by Ranginui Walker as, “a structural relationship of Pākehā domination and Māori subordination” (Walker, 2016, p. 20). The Crown, parliament, government structures and Crown Entities are all examples of subsequent colonial social structures and are sites of continued control. Walker elaborates that these structures, which include the education sector, serve to maintain the structural relationship of Pākehā dominance. “Apirana Ngata, the most influential Maori leader of the 20th century, was the first to recognise the economic and educational gap between Maori and Pākehā” (Walker, 2016, p. 28). Walker described how in education, Ngata recognised the “relationship between power and knowledge and the role of the state in generating knowledge” (2016, p.28).

Ongoing intergenerational effects of colonisation present wicked problems in education and in nursing practice. The term wicked problem was first used in a social policy setting to describe complex social problems that are interconnected, not easily solved, and often values based (Head, 2018; Rittel & Webber, 1973). They describe complex problems such as inequities in education and health which to some extent inform the purpose of this research. Wicked problems cannot be definitively described, nor can objective definitive answers be provided

for them. They are values based, meaning the right course of action related to the problem is informed by individual's beliefs. As described in the literature, in a pluristic society, agreement on problems dependant on values is unlikely. Furthermore, wicked problems are inherently entangled with political agendas, both health and education are inevitably political (Head, 2018; Rittel & Webber, 1973).

Responses to inequities perpetuated by colonisation may also be viewed through needs or rights-based lenses (Curtis, Jones, Tipene-Leach, Walker, Loring, Paine & Reid, 2019). In response to needs, Māori may receive targeted health funding, and in education are strategically positioned as priority learners (Ministry of Education, 2014). A rights-based approach draws on the legal framework of Te Tiriti o Waitangi or Treaty of Waitangi and on the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) which states Indigenous peoples should have the same access and outcomes in health and education as all other people (United Nations, 2008). Despite these two approaches, the enactment of both needs and rights-based principles fall short on their delivery of equity for Māori, largely because those in power continue to perpetuate colonial structures, colonial thinking and hold values that reinforce Pākehā power and privilege.

The ongoing impacts of colonisation are evident in the study data, and the themes *colonised thinking and structures*, and *racism and unconscious bias* are illustrative of this. Participants identified colonisation as producing educational inequities for Māori learners, and as they described, Pākehā educational structures, practices and beliefs perpetuate these. Eurocentric organisational structures and resourcing in some instances contributed to the maintenance of colonised educational practices. The absence of Māori nursing staff and formalised processes for an official Māori welcome in the school and the removal of Māori student's whānau room can be interpreted as examples of colonised structures and Pākehā dominance in organisations. The features of colonised thinking and structures are the ways in which they serve to maintain the dominant culture's power.

There is a range of literature exploring racism in health and racism in education. Research in Aotearoa New Zealand demonstrates that Māori, Pacific and Asian people experience racism in health care systems and from health practitioners which negatively impacts access and health outcomes (Harris, Cormack & Stanley, 2018; Harris et al., 2006a; Harris et al., 2006b; Huria, Cuddy, Lacy & Pitama, 2014). Racism is also considered a key determinant of health that perpetuates Indigenous health inequities (Harris et al., 2018; Jones, 2016; Jones, Crowshoe, Reid, et al., 2019). Likewise, in education, Indigenous students experience racism from teachers and peers (New Zealand School Trustees Association and Office of the Children's

Commissioner, 2018a; 2018b). Māori nurses and nursing students experience racism in education and in practice from nursing colleagues (Chittick, 2018; Chittick, Manhire & Roberts, 2019; Foxall, Forrest, & Meyer, 2017; Wilson et al., 2011). The connections between racism in health and education demonstrate that colonised thinking, Pākehā hegemony and a lack of collective critical consciousness is a dominant force in Aotearoa New Zealand. This study demonstrates racism clearly is an issue in nursing education.

The study findings detailed in chapter six indicate that nursing education and nursing practice are affected by deep seated attitudes, racism and unconscious bias that stem from colonised thinking and lead to a lack of understanding of and resistance to Māori as priority learners. Evidence across the data and a strong consensus amongst participants suggest that racism and unconscious bias are a common occurrence in nursing education and practice. Despite these negative findings, all the interview participants could be described as being champions for Māori in nursing education. Or, as having Ngakau mō ngā Māori (a heart for Māori).

Nurse educators with Ngakau mō ngā Māori– A heart for Maori

Nurse educators' practices of Cultural Safety in nursing education were explored in this study and explained by interview participants. While nurse educators' interpretations of Cultural Safety varied and were not always clearly articulated, when they spoke of how they practised in ways to support and enable Māori learners, it was clear to me that they were describing culturally safe teaching practice. They ways in which they did this were through embracing te ao Māori (Māori world) and genuinely making efforts to incorporate Māori ways of knowing and doing into their work and relationships. They did this either because they were Māori or, for non-Māori participants, by consciously making the effort to learn, understand and embrace te ao Māori and practice in a bicultural manner.

Despite the barriers posed from the Eurocentric model of tertiary education and persistent colonisation most participants worked within, it was evident that all the interview participants understood these barriers and were champions for Māori students. These educators had what I consider Ngakau mō ngā Māori, a heart for Māori, and they used their positions to guide, support and advocate for Māori in nursing education and practice. They were champions for Cultural Safety and beyond that, they understood that for Māori, Kawa Whakaruruhau encompassed more than this.

While there is not explicit literature around the concept of Ngakau mō ngā Māori in nursing education, the philosophical approach and way these participants practiced can be compared to the principles of culturally responsive teaching practice. Common in literature related to

Indigenous student success are pedagogical approaches and teachers who are culturally aware, culturally responsive, and who value students' culture (Bishop, 2008; Bishop, Berryman & Wearmouth, 2014).

It is unclear why some nurses in this study demonstrated Ngakau mō ngā Māori and others did not. There were clear examples of racism expressed throughout nursing education and practice. This suggests that although Cultural Safety, Kawa Whakaruruhau and Treaty of Waitangi or Tiriti o Waitangi have been regulated requirements of nursing education and practice for over twenty-five years, not all nurses accept and/or practice according to these regulated standards, and, that this practice goes unchallenged by leaders, managers and colleagues.

To unpack what the elements of Ngakau mō ngā Māori consist of, and indeed what it meant for participants when they described Cultural Safety and Kawa Whakaruruhau, an exploration of critical consciousness is required. Interview participants had Ngakau mō ngā Māori and were able to describe how they applied Cultural Safety to their education practice, but in order for them to practice in this way they had developed critical consciousness related to their own position and worldviews.

Critical consciousness is a pre-requisite for Cultural Safety

Despite tertiary strategies positioning Māori as priority learners, the ongoing 'problem' of Māori inequities in nursing education is perpetuated by Pākehā (non-Māori). What I mean by this statement, is that the 'problem' is one of Pākehā hegemony. This study has illustrated that Pākehā hegemony is evident in nursing education in Aotearoa New Zealand. The examples evident in the theme *colonised thinking and structures*, and the racism described by the study participants in chapter six, clearly demonstrate that nursing can be a site of continued colonisation. It is the dominant culture hegemony, systems, and attitudes that need to be identified and challenged if nursing education and practice is to be equitable for Māori.

Having power, or hegemony, is critical to continuing colonisation. The study findings illustrate Pākehā hegemony is embedded in some structures and practices in nursing education in New Zealand, however, this is invisible to Pākehā without a critical lens. Nursing education is influenced not only by the dominant Western educational paradigm, nursing and nursing education have a number of 'cultures' impacting those who work within such settings. These 'cultures' stem from a legacy of Eurocentric cultural contexts, stemming from Nightingale, religion, sexism, classism and domination by Western science. Within this tradition, nursing education historically has valued assimilation, that is, through education the nursing student

assimilates to the cultural of nursing, effectively erasing their own (De Souza, 2018). I like to refer to this as education that produces the 'cookie cutter' nurse.

Additionally, nursing knowledge is immersed in a tradition of treating everyone equally which is a, "universalist assumption that dominant culture, experience and ways of knowing are true for all cultures" (McGibbon, Mulaudzi, Bidhan, Barton & Sochan, 2014, p.183). This nursing legacy, I suggest, is maintained by a hidden aspect of nursing education, white privilege. White privilege is defined as, "the benefit that white New Zealanders have access to, simply through belonging to the dominate ethnic culture…it is a privilege…where to white is to be normal" (Amundsen, 2018, p.146). While study data clearly demonstrated racism in nursing, more subtle aspects demonstrated through the resistance to Māori as priority learners, resistance to incorporation of Māori content and language, and lack of Māori specific resourcing which are complicit with racism. However, this is mostly I suggest through a lack of awareness and a lack of critical consciousness that renders this privilege invisible.

Nurse educator's ability to recognise these influences is key to understanding this deep-seated power imbalance in nursing. An educator with this ability to recognise these influences, acknowledge how they may impact their practice and respond in ways that are learner centric demonstrates culturally safe practice. McNamara and Naepi describe this as an act of resistance to colonial agendas in education environments, where teachers must, "foster critical reflection on how knowledge is produced and legitimised" (2018, p. 348). The ability to do this requires critical consciousness.

Critical consciousness has its roots in Critical Theory, specifically from philosophers of the Frankfurt School and from Freire (Kumagi & Lypson, 2009). Freire describes critical consciousness as conscientization, where the thinking individual does not do so in isolation, but does so in the context of the world, place, history, and other people. Freire describes the concept of conscientizacao as a consciousness or awareness of the dominant cultures social, political and economic dominant forces that impact those that are not of the dominant culture, and that conscientizacao requires action, "against the oppressive elements of reality" (Translators note, in Freire, 2017/ 1970, p.9). "The development of critical consciousness involves a reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships" (Kumagai & Lypson, 2009, p.783). As Freire describes, once individuals develop conscientization reciprocal relationships where, for example, communication, learning, and problem solving are equal, collaborative and mutually respectful, and a 'rehumanising' of relationships (Darder, 2018; Freire, 2017/1970; Kumagai & Lypson, 2009).

To describe what I understand critical consciousness means to nursing education and for nurses, it means that nurses are able to recognise inequities in health and education understanding their historical roots in colonisation and have the ability to recognise the socio-political and cultural contexts that perpetuate them. They can understand this because they have developed awareness and insight into their own positions and worldviews and recognise other worldviews as legitimate. They are willing to listen to and value discourses other than their own. They recognise the power dynamics that serve to reinforce dominant worldview, structures and systems in health and education and recognise the impacts theses have on those not of the dominate culture. This understanding that stems from critical consciousness provides the foundations for nurses to challenge the status quo in nursing education and in practice.

Kumagai and Lypson (2009) connect critical consciousness with social justice. They posit that health professionals need to develop a critical consciousness which is a skill beyond the traditional notion of competence (knowledge, skills, and attributes). They describe critical consciousness as the ability to place health care, or the person/whānau within the context of social, cultural, and historical influences and the ability to recognise (non-judgementally) these influences and seek appropriate care. They state that the outcomes of critical consciousness and subsequent professional actions is social justice.

In 2019 the Medical Council of New Zealand in collaboration with Te Ora, Māori Medical Practitioners changed their standards for doctors from cultural competence to Cultural Safety. Key to their definition of Cultural Safety is critical consciousness. They state that Cultural Safety requires, “a critical consciousness where health professional and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care” (Medical Council of New Zealand, 2019, no page).

The Medical Council’s shift from competence to safety is significant, and although it is based on Ramsden’s original theory and early nursing regulation, the work of New Zealand and international Indigenous medical educators describe in detail how definitions and guidelines only go so far. (Curtis et al., 2019; Jones et al., 2019). The values of a profession must be informed by a collective critical consciousness, and understandings of colonisation and racism as social determinants that contribute to inequities. The findings of this study suggest that nursing has some way to go to achieve this despite its early intentions and focus.

A lack of critical consciousness among non-Māori students and staff could be linked to society and the education sector, being Eurocentric. Education in the compulsory sector has traditionally perpetuated Eurocentric models and Ramsden identified this in her 1990 report. The change to national standards15 in education by the National government in 2010 demonstrates political control and a narrow view of education, that is, national standards that define what knowledge and ways of measurement are valued. While the current Labour led government has ended the national standards movement and is moving towards greater te Reo and te ao Maori in schools, this has not been the case for decades.

Developing critical consciousness requires a foundation of insight or awareness of worldviews other than your own. Understanding the New Zealand history and the colonisation of the nation is one way of developing this insight. The lack of Aotearoa New Zealand history in schools is an example of the dominant culture control of education or continued colonisation of education. In 1990, included in the Kawa Whakaruruhau model was ensuring nursing students were taught about New Zealand's colonial history, because they were overall, not taught this prior to nursing school. This remains a relevant point today, and came through in this study, where participants described the flow on effects of students not knowing New Zealand history, about colonisation or the purpose of the Treaty/Tiriti. Several participants linked attitudes to the lack of early exposure to New Zealand history in primary and secondary schools. In chapter six, both Carl and Awhina said they thought that some of the attitude's students brought with them to the programme stemmed from not having learned New Zealand history.

After quite some time of lobbying, and previous parliamentary opposition, it was announced in 2019 that New Zealand history will be taught to all children as part of the compulsory national curriculum from 2022 (Belgrave, 2019). This will include the colonial past, Māori history and the New Zealand wars. Belgrave suggests that in ensuring all young people are exposed to national history, questions relating to inequities, racism and the effects of colonisation are confronted (2019).

While a national curriculum framework for teaching Māori history to years 1-8 has existed for some time, it appears that the uptake and implementation of this has varied by teacher and school preference (Ministry of Education, 2015). Similarities can be drawn here between the teaching of Māori history in primary schools and the teaching of Cultural Safety, Treaty of

[15] National standards refer to core requirements in English and mathematics that students should be able to do at certain levels.

Waitangi/Tiriti o Waitangi and Māori heath in nursing education. While there are guidelines for teaching this in nursing education, there is no direct regulatory requirement regarding how, where, and how much of this is taught in undergraduate nursing education. The fact that the Nursing Council of New Zealand guidelines for Cultural Safety, Treaty of Waitangi and Māori Health (2011) sit outside of direct nursing education regulatory requirements and are called 'guidelines' suggests that they may be optional to follow.

For many nursing students, their first exposure to NZ history, The Treaty of Waitangi or Tiriti o Waitangi and the effects of colonialism occurs in their undergraduate degree. To cover essential history and provide students with genuine transformational learning opportunities related to biculturalism and how it is applied in nursing is a significant undertaking in the context of a broad three year applied practice degree. Students may struggle to grasp these concepts without a highly skilled nurse educator and a programme culture and curriculum that supports this development.

This study demonstrates that not all nurse educators are culturally safe or are cognisant of the reasons why Māori are priority learners, that is, they lack critical consciousness. The data from this study suggests there are a few contributing factors to this, including a lack of leadership, a lack of a culture of shared responsibility for Māori student success and varied curricular approaches. Another factor in the under preparedness of educators to apply Cultural Safety to their teaching practice, particularly as it relates to Māori, may be the variation in nurse educators' teaching preparation and the lack of formal regulation and guidance in the tertiary education sector.

Nurse educators in Aotearoa New Zealand are required to have one degree higher than those they are teaching, typically a masters degree is required to teach in an undergraduate degree programme. The Nursing Council also requires nurse educators to have a current annual practising certificate and to "have completed a programme in adult teaching and learning within two years of appointment" (Nursing Council of New Zealand, 2015, p.10). As reported in chapter four, 75 per cent of respondents had a formal teaching qualification. Over a quarter of respondents did not. Participants held range of teaching qualifications from a level 5 certificate through to masters in education. It is unclear what, if any emphasis, was given to working with Indigenous students in the qualifications that educators held. The data does suggest preparation for the teaching role in nursing education is varied. This may be attributed to the applied nature of the profession which has traditionally relied on knowledge and experience in nursing practice, or it may be that the skills required to teach are underemphasised in nursing education in New Zealand.

For teachers in early childhood, primary and secondary schools there is much greater emphasis and formal guidance for working with Māori learners. The Ministry of Education's Education Council have designed Tātaiako, cultural competencies for teachers of Māori learners (2011). The purpose of the competencies is to set expectations and guide teachers in their practice related to Māori learners. As they describe, the competencies are about, "knowing respecting and working with Māori learners and their whānau and iwi…so their worldview, aspirations and knowledge are an integral part of teaching and learning, and of the culture of the school" (Education Council New Zealand, 2011, p.3). Whanaungatanga (connectedness) and manaakitanga (support, care) are core competencies in Tātaiako, which were similarly identified by participants in this study as culturally safe practices, however, the data overall suggests confusion and varied practices, attitudes and approaches to Māori learners in nursing. Additionally, institutions had varied strategies related to Māori learner success, and how these translated into practice was not clear or consistent in this study and, no link to teacher competence was made.

Within nursing education there is a duality where knowledge sits within a hierarchy. Facts, concrete science, or empirical evidence verses aspects that are less concrete, such as socio-cultural concepts, differences between people, individual responses, culture, and diversity. With the former, Freire's banking concept of education is acceptable, for example, teaching an aseptic dressing technique is based on evidence, the teacher is employed as an experienced expert to assist students to gain the appropriate knowledge and skills. However, when exploring culture, differing world views and values and how these are interrelated with health, wellness and illness, Freire's problem centred approach is required.

Nurse educators may feel comfortable with what they 'know' from clinical practice and from how they themselves have been educated. To step into curricula areas that are unfamiliar, challenging, uncomfortable and at times confrontational, requires skill, ongoing support, perseverance, and courage to work in a manner where power is not the teachers alone. A specific question was asked of interview participants about how they developed their confidence and competence for working with Māori students. For Māori participants, it was an inherent part of their identity and connection with te ao Māori (the Māori world). For non-Māori it appeared to be from their own intrinsic understanding and motivation (Ngakau mō ngā Māori) and from manaaki (support) from Māori staff within their workplaces.

However, not all educators had this motivation or understanding, they lacked a critical consciousness related to their position of power and in their understanding of how this impacts Māori. The resistance evident throughout this study occurred where Western

dominance prevailed, coupled with a lack of critical consciousness in education. Conversely, where leaders and staff were critically conscious, an enabling environment was evident. The expectations of educators and the success of strategies related to Māori learners was driven by leaders that created a collective culture of responsibility and expected bicultural practice. Without strategic direction, leadership driving strategy and a culture of shared responsibility and accountability, practices that support Māori nursing students was largely driven by individuals, those with Ngakau mō ngā Māori.

An approach to addressing the inequities Māori face in relation to nursing education, I suggest is through nursing leadership understanding the rights, the needs of Māori and clarifying the values expected of the nursing education sector in Aotearoa New Zealand. This will require leaders developing their critical consciousness and assisting educators to the same.

Cultural Safety is a pedagogy of discomfort

In order to be critical and explore the new ways of thinking that are required to develop critical consciousness, a degree of discomfort is required. The themes *challenging ground* and *making uncomfortable places safe(r)*, describe the discomfort interview participants experienced as educators. Participants described this in the ways they approached teaching Cultural Safety, the ways in which they dealt with colleague's negative attitudes, and how they made the 'journey' safe for students. There is a theoretical explanation for this which is described as pedagogy of discomfort (Boler & Zembylas, 2003). Boler and Zembylas explore the processes of emotional and intellectual challenges that occur for both educators and students in moving thinking beyond own cultural norms (2003).

Pedagogy of discomfort is based on overarching notions of pedagogies of difference, which for example, include feminist, critical and postcolonial pedagogy. In pedagogies of discomfort, educational theorists with diverse perspectives work towards, "actualizing equitable curricular contexts for teaching and learning", for all people (Trifonas, 2003, p. 1). Freire's pedagogy of the oppressed challenges notions of otherness and power imbalance and can be considered in this grouping. Freire's concept of conscientizaçc̃o requires critical consciousness and challenging the status quo which may be perceived as a threat to the power balance held by the dominant culture (Freire, 2017/ 1970). In the context of the findings of this study, Cultural Safety can be considered a pedagogy of discomfort. Cultural Safety is both a method and practice in education (pedagogy) and an educational outcome for students.

It appears however, that the process of both student and teacher discomfort is not explicitly acknowledged or supported by formal frameworks in nursing education in Aotearoa. Educators

in this study described teaching Cultural Safety as '*a dance'*, a challenge, difficult to assess and as Maria said, "*some of the things I see…lead me to believe that nobody knows what they're doing*". This may be due to the varied and in some cases, poor understandings of Cultural Safety that participants described amongst their colleagues and of nurse colleagues in practice who worked with students. It is also reasonable to conclude that two other aspects have led to the current place of Cultural Safety in nursing and nursing education. First, a sense of complacency amongst the profession, and second a lack of ownership of the concept, its definitions, and applications in education and in practice.

Problems with Cultural Safety

While several aspects of Cultural Safety and Kawa Whakaruruhau were explored in this study, there was an overarching sense of dissatisfaction amongst participants with the definition and practices of Cultural Safety. Disengagement of Māori nurses with the concept of Cultural Safety was described by participants as being directly related to the current regulatory definition and associated competencies for Cultural Safety, historical events and what is described in this study as ongoing colonial structures and practices in nursing and nursing education. There was dissatisfaction with the Nursing Council of New Zealand definition of Cultural Safety, which has all but removed the Māori concept of Kawa Whakaruruhau in its current broad, generic definition. The original intent of Kawa Whakaruruhau has been lost, and because there is no contemporary, Māori defined guidelines or explicit Kawa Whakaruruhau regulatory requirements for nursing education, understanding, curricula and pedagogies related to this are fragmented, in some instances, resisted or absent. Some Māori nurse educators who participated in this study did not feel safe or supported to provide culturally safe learning environments for Māori students. This was due to leadership and organisational decisions that were financially driven or decisions that did not value or seek Māori input.

Literature has documented the historical events, public backlash, and political interference over Cultural Safety in nursing education (Papps & Ramsden, 1996; Ramsden & Spoonley, 1994). The nursing profession in Aotearoa- New Zealand has been relatively silent on Cultural Safety in recent years. However, this study highlights that ongoing impacts from the past may be negatively impacting nursing education today. The ways in which the concept and practises related to it have changed over time continue to be a source of dissatisfaction, tension, and hurt for some participants, particularly Māori. Participants talked about how the changes to Cultural Safety meant the protections for Māori nursing students and the education of nursing students specifically related to Tangata Whenua (Indigenous people of Aotearoa) had been

lost. Indeed, a lack of understanding and recognition of the origin and intent of Kawa Whakaruruhau was evident in the questionnaire where respondents showed resistance to Māori as priority learners, and in the interview data describing the common place of racism that students face in nursing.

Cultural Safety should be an explicit philosophical principle that guides both education and practice. It has been a regulated requirement of both nursing education and of nurses who practice for several decades. The values required to be culturally safe should be shared amongst the nursing profession. Understandings of Cultural Safety, how it informs nursing culture, nursing leadership, the resourcing of nursing programmes, curriculum and pedagogy should after many years be clear. This study demonstrates that it is not.

Looking back to earlier iterations of Cultural Safety guidelines was important to understand why definitions and standards have changed, why Māori may be dissatisfied with current regulatory standards, and in understanding the shortcomings of Cultural Safety education that were identified by participants in this research. The original Kawa Whakaruruhau/ Cultural Safety document released in 1990 was clearly about Māori, Māori guarantees and rights according to the Tiriti o Waitangi or Treaty of Waitangi and about teaching nurses to understand the effects of colonisation (Ramsden, 1990). It is explicit that Cultural Safety refers to "interaction between the Treaty partners" (Ramsden, 1990, p. 20). The document is clear that racism must be addressed through nursing education, and Ramsden stresses, "that the key to Cultural Safety lies in attitude change" (Ramsden, 1990, p.11). It is also clear in this document that Kawa Whakaruruhau/ Cultural Safety standards should only be defined by Māori as is it about their realities and experiences. Kawa Whakaruruhau presented a challenge for non-Māori nurses to acknowledge Māori realities, and to understand how their attitudes, if unchallenged, could perpetuate health inequities.

The public and political backlash that occurred only a few years after these standards were introduced in nursing in the early-mid 1990's, made it clear that Non-Māori New Zealand society was not 'ready' to acknowledge their racism or consider alternative views to the Eurocentric traditional view and control of nursing. In short, those that held the power at that time were unwilling to make room for anything that challenged the status quo. The Nursing Council of New Zealand guidelines released following the external review of Cultural Safety in nursing education resulted in a 'watering down' of the original guidelines (Murchie & Spoonely, 1995; Nursing Council of New Zealand, 1996). However, this was considered a necessary compromise in order to retain the Cultural Safety concept within nursing education and regulation.

However, the current Nursing Council of New Zealand guidelines remain broad, defining culture as, “beliefs or practices of those who differ” to the nurse, and includes age, gender, sexual orientation or disability (Nursing council of New Zealand, 2011, p. 8). Cultural Safety in the current guidelines is a concept that applies in practice as understanding difference between people. Māori health and Tiriti/Treaty are described as separate concepts to Cultural Safety. While this change, separating Māori from the definition of Cultural Safety was following a recommendation from the KPMG review of nursing education in 2001, the consequence of this was, that Cultural Safety as it was originally intended as a concept by and for Māori became lost from regulatory requirements for nursing education and practice (KPMG Consulting, 2001). It can be seen, that since inception, Cultural Safety has slowly moved away from what Tangata Whenua defined as Kawa Whakaruruhau, the consequences of which are evident in the practices described and in the experiences of nurses who participated in this study.

Decolonising education and nursing practice

Given that colonisation was a recurring theme that was raised in leadership, organisational structures, curricular content, teacher and school practices and in the nursing practice experiences of students and in some cases, Māori teaching staff, it can be argued that a potential solution is to undertake a process of decolonisation in nursing. Decolonisation of education is not a new concept and in Aotearoa New Zealand Māori educationalists such as Ranginui Walker, Graeme Smith, Moana Jackson, and Linda Tuhiwai-Smith have contributed significantly to the body of knowledge. More recently the concept of decolonisation of education has been raised in social work, psychology and in medical education in Aotearoa New Zealand (Huygens, 2006; 2011; Jones et al., 2019; Ruwhiu, 2019).

There is little literature exploring decolonising nursing. Ironically, when searching the terms decolonisation and nursing, large volumes of scientific articles were identified relating to bacterial colonisation and scientific research where best nursing practice was concerned. There is some emerging discourse from Canadian nurse scholars calling for decolonisation in nursing education, however, this does not offer any examples in practice. (McGibbon et al., 2014). To explore the concepts of decolonisation and potential application in nursing education is beyond the scope of this study. However, the findings of this study offer critical evidence for the profession to consider pursuing decolonisation of nursing education and practice as an urgent and critical response to health inequities and to address the socio-cultural determinants of health.

There are several ways in which decolonisation is described. Decolonisation can refer to material processes, such as return of land, or it can refer to processes relating to decolonisation of the consciousness, such as developing critical consciousness (Amundsen, 2018). Regardless of definition, fundamentally, decolonisation is about a shift in the imbalance of power and control held by the coloniser.

Decolonisation must be a shared process between Māori and non-Māori. A process of decolonisation can also be explained by Freire, as conscientizing dialogue between the oppressed and the oppressor (Freire, 2017/1970). Huygens describes this dialogue as essential in challenging status quo, where new meanings, knowledge and action can occur in moving forward in decolonising practices (2006). Amundsen (2018) describes decolonisation as a process of reconciliation, and suggests that for Pākehā this involves, "listening to our discomforts" (p. 146). Cultural Safety, I suggest is a pedagogy of discomfort, and examining the original intent of Kawa Whakaruruhau I believe it was intended as a decolonising model for nursing education.

Jones et al. (2019) developed a consensus statement regarding Indigenous medical education. The issues identified by these medical colleagues are mirrored in this study. They recognise that the medical education model has been complicit in perpetuating colonisation and Indigenous inequities. They state decolonisation of the medical curriculum and the entire educational institute needs to occur, where Indigenous concepts are integrated in all educational practices. Coupled with this consensus statement, regulatory standards for the medical profession in Aotearoa New Zealand have also evolved to encompass Cultural Safety, with a definition that focuses on equity of outcomes for Māori (Medical Council of New Zealand, 2019). Nursing is lagging in our professional responsibility for and responsiveness to Māori in nursing education, practice and in professional and regulatory standards. Addressing this critical gap will require a degree of discomfort in order to develop a collective critical consciousness. The beginning point for this shift may be in returning to the original intent of Kawa Whakaruruhau.

Kawa Whakaruruhau – The original decolonising model for nursing education in Aotearoa New Zealand

When examining the original Cultural Safety document, it can be interpreted as a unique Aotearoa New Zealand model that was developed with intent to decolonise nursing education. Reflections from an early teacher of Cultural Safety, Takawai Murphy describe this. He said

Cultural Safety was radical to non-Māori at the time, and he describes his determination to teach Cultural Safety to all student nurses and decolonisation to the Māori students,

> Other Māori department staff had reluctantly taught these subjects prior to my arrival-reluctantly because of the hostile reception they received from students. The country was in a state of denial regarding the history of Aotearoa, and so having the Treaty as a core component of many tertiary courses was very new and challenging concepts to many. I was pretty naïve when I won that job teaching 'cultural safety' to all student nurses and 'decolonisation' to the Māori students. (Murphy, 2016, p.82)

Kawa Whakaruruhau, Cultural Safety came from the pain of Māori experience in Pākehā systems of education and health (Ramsden, 1990; 2002). Kawa Whakaruruhau was unquestionably a bicultural model about the relationship between Māori and Pākehā. It was about acknowledging colonial impact and challenging attitudes that disempower Māori right to tino rangatiratanga (self-determination) under the Tiriti or Treaty. The original model provided a framework, guiding nurse educators to teach students, and was clear about the provision of support that needed to be in place for Māori staff and student's safety. It gave clear guidance on curricula content, confronting racism and understanding the Tiriti or Treaty. It was also clear about the necessary leadership and organisational approaches required to ensure Māori were protected, and to use Ramsden's words, that there was an equal and negotiated partnership (1990). Kawa Whakaruruhau in its original form, was a bicultural model aimed at decolonising attitudes, structures, and practices in nursing education. If successfully implemented, Kawa Whakaruruhau could have been the original model of decolonisation in nursing education, despite Ramsden never referring to it as such.

The findings of this study and evidence within the literature suggest that a hierarchy of knowledge persists in nursing, which still favours biomedical domains of knowledge and practice. Nursing has been at the forefront of adopting and advocating evidenced based practice, yet this has not been the case for Cultural Safety in Aotearoa in recent years.

The reasons for this lack of focus are not entirely clear. A lack of regulatory focus, or contemporary guidelines could be one issue contributing to this. The latest Nursing Council of New Zealand (NCNZ) Cultural Safety guidelines were first published in 2005 and reviewed last in 2011. The standards of registered nurse practice, or competencies, similarly, were written some time ago, and the standards relating to Cultural Safety do not refer to Māori (NCNZ, 2016b). The only reference to working with Māori in nursing practice are contained a competence related to understanding of Tiriti/Treaty (competency 1.2, NCNZ, 2016b), which is brief. It is unclear who contributed to these guidelines, or what role Māori played in developing them. Professional rhetoric indicates that the competencies related to both

Cultural Safety and Tiriti/Treaty are not assessed appropriately and are viewed as a tick box exercise.

The nursing educational landscape has changed over time, particularly from the time when Kawa Whakaruruhau was first introduced. New Zealand nursing education has been delivered within the tertiary education sector since the closure of the last hospital-based school in 1992. Nursing education was entirely within Institutes of Technology and Polytechnics (ITPs) until the accreditation of the first University undergraduate nursing programmes in 2000 (Jacobs, 2005). In 1989, the Education Act was enacted, creating a legal framework for education, which allowed educational institutes to control their own resources and funding. Changes in funding, competitive performance-based research funding and other financial drivers in education has created a competitive rather than collaborative education environment. At the same time, the number of nursing programmes with different curricula have grown, some schools are under financial strain, and nationally the small number of, (particularly Māori) and the aging nurse educator workforce is a real concern (NCNZ, 2020). The competitive environment may have seen curricula changes that have not been in the best interest for Māori, and without a strong regulatory framework ensuring Māori and Tiriti responsiveness or Cultural Safety is rigorous in nursing education, it could, and likely has been lost in many instances.

Professional division may also have inhibited the development of Cultural Safety. There are multiple professional groups in nursing, for example, the New Zealand Nurses Organisation (NZNO) operates a bicultural organisation and Te Runanga represents NZNO Māori members at all levels within the organisation. Additionally, there are a range of 'colleges' or 'sections' such as mental health nursing organisations and emergency nurses, both within the NZNO and external to NZNO, such as Te Ao Māramatanga, the New Zealand College of Mental health nurses. While the NCNZ is the regulatory body for all nurses, the numerous professional organisations publish their own speciality nursing standards, many of which include Cultural Safety, Māori responsiveness and Tiriti responsiveness expectations that expand on, or differ somewhat to the NCNZ requirements (College of Emergency Nurses, 2016; Te Ao Māramatanga, 2012). This presents a fractionated picture of what the public can expect from nurses and may present confusion for nurses as to what is accepted practice. Heke, Wilson and Came (2018) identified this as an issue not just for nursing, but across the regulated health professions. They examined regulatory bodies definitions and competencies related to cultural competence and found them varied, lacking in measurability, and suggest universal definitions and standards could support both Māori and health practitioners in achieving equity of outcomes (Heke et al., 2018).

Ownership and leadership of Cultural Safety and things Māori may be a further barrier to progress. It is unclear how leadership across the nursing sector collectively communicate, advocate and action issues in nursing nationally. To ensure Cultural Safety/ Kawa Whakaruruhau is on the leader's agenda, will require a collective approach, with clear understandings, expectations, and accountabilities.

Chapter Summary

This chapter has brought together the findings of the research and presented a critical discussion of what the findings may mean for nursing education and practice. The findings of this study provide evidence that the impacts of colonisation are negatively affecting Māori in nursing education and practice. It is evident that within contemporary New Zealand society, racism and unconscious bias compounded by mass media stereotyping influence education and health. However, in education practice and particularly in New Zealand nursing practice, specific understanding and application of the Treaty of Waitangi, cultural competence and Cultural Safety are heavily emphasised and in nursing are core competencies for professional practice. The findings of this study indicate that entrenched attitudes, blindness to the effects of the dominant culture; colonised thinking and practices are evident in nursing education and practice.

The next and final chapter of this thesis reflects on the study and presents recommendations from this research for education, policy, practice, and future research. The limitations of the study will be identified and the contribution this research makes to the body of knowledge is outlined.

Chapter Eight

Conclusion

Ko tō hoe, ko taku hoe, ka tere te waka e

With your paddle and my paddle, the waka will travel quickly

Introduction

This final chapter provides a summary of the research. Here, conclusions and recommendations are presented, and the limitations of the research are identified. The whakataukī (proverb) used in opening this chapter speaks to aspirations of this study, in that, while this is my individual doctoral study, the findings, the implications and recommendations from this work mean little without collective engagement with the findings from the nursing profession.

This chapter begins with an overview and the conclusions that are drawn from the study. The contribution this work makes to the wider body of knowledge is then outlined. The limitations of the study are then presented. The chapter concludes with the recommendations from the study and a final word.

Conclusions from the Study

This research sought to investigate how New Zealand tertiary education institutions, schools of nursing and nurse educators respond to Māori nursing students' learning needs. The purpose of this study was to explore how New Zealand tertiary educational institutes prepare for and work with Māori nursing students.

Using an explanatory sequential mixed method, data were gathered in two phases. The first phase, a questionnaire was distributed to schools of nursing throughout Aotearoa New Zealand. 58 nurse educators responded. The results of the questionnaire created a picture of the strategies in place to support Māori learners and a picture of how nurse educators felt in terms of their preparedness, their support and confidence in working with Māori learners. While there were a range of strategies in place, and overall nurse educators described feeling mostly prepared, there was a sense that they would like further support and knowledge related to this area of teaching practice. In addition to this, there was a sense of resistance from other responses to Māori as priority learners.

In keeping with the research design, the results of the questionnaire helped to inform the line of questioning that occurred in the second phase of the research, the participant interviews.

Ten one to one interviews took place with nurse educators who volunteered to participate. The interviews were in depth and in chapters 5 and 6 the themes from the interviews were presented. The first group of themes related to how participants described their practice in relation to working with Māori nursing students. Their descriptions created a picture of culturally safe practice as being framed in te ao Māori values.

The findings of this research exposes practices and attitudes in nursing education that are both positive and negative, suggesting the profession needs significant self-examination in order to more effectively meet need the needs of Māori in education and by extension, nursing practice. This research describes nurse educators' understandings and practices of Cultural Safety and their understandings of Kawa Whakaruruhau, and in doing so revealed there are issues in understandings and applications of both concepts and suggests revised definitions are needed. While this research does not have the answers to how these concepts should be redefined, it contributes to the discussion and offers evidence on how concepts and practices related to these concepts have changed over time.

Research Contribution

The following points are offered to describe the contribution of this research to the wider body of knowledge. This research:

- Provides a unique contribution as a contemporary study of nursing education, Cultural Safety, and of working bi-culturally in the tertiary education environment. While there are studies exploring similar phenomenon in disciplines outside of nursing, to the best of my knowledge there has been no study like this of nursing education in Aotearoa New Zealand.
- Provides evidence about what may be ideal practices in working with Māori nursing students.
- Provides evidence to support a counter-narrative that nursing education is culturally safe, and evidence that Cultural Safety is not collectively understood or practiced competently amongst all New Zealand nurses.
- Provides evidence for the profession and specifically for the regulator that demonstrates how the current guidelines and definitions related to Cultural Safety are poorly understood and practiced.
- Uncovers racism and bias as common occurrences in nursing practice in Aotearoa New Zealand.

- Provides evidence of key aspects of nursing education that could be improved and areas in which nurse educators need to increase competence through professional development.
- Has implications for migrant/ethnic nurses in Aotearoa who may similarly experience racism and a sense of othering among the nursing profession.

Limitations of the Research

In any research process it is important to be clear about the limitations of the study. Reflecting on the research process the following limitations have been identified:

The interview participants were self-selected, and as it was identified in chapter five, participants shared common motivation for participation. Characteristics of the interview participants skewed the findings as they were all strong supporters of te ao Māori (Māori world) in nursing education. The interview data, therefore, is not fully representative of the overall nursing education workforce and may have presented a falsely favourable impression.

As a Pākehā (non-Māori) the interpretation of the research is limited to my experiences and my world view. I have been unable to interpret findings as they relate to te ao Māori. Therefore, the research provides evidence, comment, and recommendations that relate to non-Māori in nursing in Aotearoa New Zealand.

A final limitation is the size of the research. The breadth and depth of the research is limited by the word limit of the degree which resulted in decisions around the exclusion of some elements, such as midwifery literature. A further limitation is the relatively small sample sizes of both phases of the research. This limits the generalisability of the findings.

Recommendations

Recommendations for the nursing profession in Aotearoa New Zealand

Recommendations for the nursing profession are aimed at leaders in nursing to enact change particularly in the culture of nursing. Recommendations include:

- Nurses need to acknowledge the dominant culture hegemony that is present in education and health environments and prioritise the development and enactment of counter-responses to promote equity for Māori.
- Nurses need to develop a shared critical consciousness related to inequities and the importance of prioritising Māori learners. Nurse leaders need to urgently place

Cultural Safety/ Kawa Whakaruruhau on the agenda as a priority response to health inequities.

- Cultural Safety is not the same as Kawa Whakaruruhau. Nursing must redefine Cultural Safety and Kawa Whakaruruhau as distinct and separate models for practice, the latter to be defined by Māori and endorsed by the regulator. Clarity of contemporary meanings of both concepts will ensure their relevance for the safety of all people in nursing education environments and for those who seek health care in Aotearoa New Zealand.
- Nursing leaders across sectors, from government, policy, regulation, practice, professional organisations, and education need to collectively invest in the redevelopment of Cultural Safety and Kawa Whakaruruhau.
- Nursing should consider leading the regulated health professionals in Aotearoa New Zealand in adopting national consensus and standards for Cultural Safety/ Kawa Whakaruruhau.
- Nursing should ensure appropriate resourcing, governance structures and support for Māori sovereignty over all issues related to Kawa Whakaruruhau.
- Nursing should develop and promote a culture in the profession that values critical consciousness, critical professional examination and challenging of the status quo to address issues of power, inequities, racism, and bias in nursing.

Recommendations for the professional regulation of nursing in Aotearoa New Zealand

The Nursing Council of New Zealand as the professional regulator sets the standards for nurse's practice and for education leading to registered scopes of practice. They also address issues of conduct and competence. Therefore, I recommend:

- That the professional regulator explicitly demonstrates Tiriti o Waitangi or Treaty of Waitangi responsiveness and incorporates te ao Māori in regulatory frameworks, governance structures and operational functions.
- That the regulator works with the profession to develop contemporary definitions and standards for nursing practice related to Cultural Safety and Kawa Whakaruruhau, ensuring that the definition of any practice standard or guidelines relating to Māori are defined by Māori. Collaboration with other regulated health professions to develop and implement guidelines could strengthen cultural safety practices across the health sector.

- That the standards for nursing education programmes are more rigorous and explicit relating to bicultural governance, content and pedagogy related to Māori, Cultural Safety, Kawa Whakaruruhau and Tiriti o Waitangi/ Treaty of Waitangi.
- That education programme standards require all nursing education programmes to demonstrate responsiveness to Māori and include Māori nurse educators who are supported and valued for specialist te ao Māori nursing knowledge.
- That all regulatory assessment and/or decision-making processes related to educational programme standards, programme accreditation, Māori nurse conduct or competence issues include Māori nurses as part of the assessment processes.
- That the regulator considers the development of expanded nursing competencies that articulate the value and application of te ao Māori knowledge in nursing practice.

Recommendations for nursing education providers and nurse educators in Aotearoa New Zealand

While the nursing regulator may set overarching standards related to educational programmes, education providers can further their responsiveness to Māori within their own unique educational contexts and cultures. This study focused specifically on these education environments and nurse educators' experiences. The findings of this study lead me to make the following recommendations for nursing education:

- Nurse educators need to acknowledge and actively address the persistent 'colonisation' of Māori through the dominant culture hegemony that is evident in educational structures, practices, and racism.
- Realising Māori student success requires nursing education to develop a culture of collective and shared responsibility. Nurse educators need to develop a shared critical consciousness related to educational inequities and understand the importance of prioritising Māori learners.
- Nurse educators need to work collectively to design a contemporary curriculum that addresses the needs of the increasingly diverse population and places greater emphasis on Cultural Safety, being more responsive to Māori and Tiriti or Treaty in nursing.
- That nursing education should collectively commence a process of decolonisation which could encompass the following actions:

- Develop authentic partnerships with Māori to determine key actions and principles to be enacted.
- Developing people, environments and practices that are embracing of te ao Māori.
- Return to and the enactment of the original intent of Kawa Whakaruruhau or however Māori so determine it should be defined for the current context.
- Reassert the place of the Tiriti o Waitangi or Treaty of Waitangi in education from governance and leadership through to the classroom and nursing practice.
- Acknowledge and address the hierarchy of knowledge related to Māori world view, knowledge, and skills.
- Ensure the protection, development and support of Māori staff and students through dedicated resource and investment.
- Ensure the profession continues to invest and support Kaupapa Māori nursing programmes.
- Develop programmes of ongoing professional development for non-Māori to be able to practice in a bicultural, safe, and effective manner that is responsive to Māori and the Tiriti o Waitangi/Treaty of Waitangi.

Future Research Directions

This research has provided evidence that is useful for the nursing profession and has responded to the research questions as was intended from the outset of the study. However, further questions have arisen during the research and gaps in the knowledge have been identified. Further research could be beneficial in the following areas:

- Explore leadership in Aotearoa and how decisions and policy are formed in relation to nursing education.
- Undertake research from kaupapa Māori perspectives to identify a contemporary Kawa Whakaruruhau definition and standards for nursing practice and identify appropriate pedagogy that is defined by Māori.
- Action research could be undertaken, to explore the implementation of new educational frameworks related to Cultural Safety/ Kawa Whakaruruhau.
- Case studies could be undertaken to identify best practice in working in a bicultural model of nursing education.

- Research could be undertaken to inform the development of a bicultural framework for nursing education.

Final Thoughts

I am not certain who said during my doctoral study that research is 'me'- search. It was early into my study and I did not fully understand what they meant. However, as I have progressed through this study, come to better understand theory, and as data were collected, I began to see a new picture of privilege, my profession and the dominant culture in Aotearoa. It was not a comfortable picture to confront. It has challenged my assumptions and made me critically aware of the many entrenched systems, privileging of knowledge and othering that occurs every day in so many ways. I know this will stay with me as my way of looking at the world has changed through this study and the experiences of my participants continue to resonate with me. In that regard, this research has made a lasting impact on me.

In the forward of the first Cultural Safety book, the importance of Cultural Safety/ Kawa Whakaruruhau was described by Distinguished Professor Paul Spoonley as, "one of the most significant developments in modern nursing practice, made ever more important by the growing ethnic diversity of New Zealand communities and the centrality of Māori as tangata whenua" (Spoonley, in Wepa, 2015, p.vi).

If Spoonley is correct in the assertion that Cultural Safety is a critical domain of nursing knowledge and practice, it should *not* be marginalised within education or practice. If Cultural Safety was fit for current purpose in Aotearoa New Zealand, the nursing profession would *not* report racism amongst colleagues, students or the 'othering' of patients and nurse colleagues that are not of the dominant culture. Demonstrating the nursing impact of decreasing health and educational inequities would be explicit performance indicators of nursing practice and be reflected in the regulatory competence and professional standards for nurses. Nursing values would reflect te ao Māori and nurses in Aotearoa New Zealand would demonstrate bicultural ways of working. Cultural Safety/ Kawa Whakaruruhau is a *significant* taonga (treasure). However, it is my opinion that if it is to remain so, urgent action is required.

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Appendices

Appendix A: Letter of Ethics Notification, Massey University

Date: 12 June 2017

Dear Jennifer Roberts

Re: Ethics Notification - **SOB 17/05 - An investigation of New Zealand tertiary education institutes', schools' and nurse educators' preparedness and experiences in working with Maori nursing students.**

Thank you for the above application that was considered by the Massey University Human Ethics

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Appendix B: Transcriber's Confidentiality Agreement

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MĀTAURANGA

An investigation into the preparedness for and experiences in working with Maori nursing students among New Zealand tertiary institutes, schools and nurse educators.

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I ..... (Full Name - printed) agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: ..... **Date:** .....

Te Kunenga ki Pūrehuroa
Institute of Education
Cnr Albany Drive & Collinson Road, Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 www.massey.ac.nz

Appendix C: Questionnaire

Demographic information

1. What is your age?

- ◯ 20 to 24
- ◯ 25 to 34
- ◯ 35 to 44
- ◯ 45 to 54
- ◯ 55 to 64
- ◯ 65 to 74
- ◯ 75 or older

2. What gender do you identify with?

- ◯ Female
- ◯ Male
- ◯ Other (please specify)

3. What is your ethnicity? (Please select all that apply.)

- ☐ New Zealand European/ Pākeha
- ☐ Māori
- ☐ Pacific Islander
- ☐ Asian
- ☐ European
- ☐ African
- ☐ Middle Eastern
- ☐ Other (please specify)

4. How many years have you been a Registered Nurse?

- ◯ Less than 5 years
- ◯ 6-10 years
- ◯ 11-15 years
- ◯ 16-20 years
- ◯ 21-25 years
- ◯ 26-30 years
- ◯ 31-35 years
- ◯ 36-40 years
- ◯ More than 40 years

5. What year did you first register as a nurse in **New Zealand**?

6. If you **first** registered in another country please list

Education

7. What best describes your **initial** nursing education for registration

- ◯ Hospital nursing education
- ◯ Diploma
- ◯ Degree
- ◯ Other (please specify)

8. What **year** did you obtain your initial nursing qualification? Please write answer (YYYY)

9. Which **country** did you obtain your initial nursing qualification from?

10. What is the **highest** educational qualification you have obtained?

- ☐ Degree
- ☐ Graduate Certificate
- ☐ Postgraduate Certificate
- ☐ Postgraduate Diploma
- ☐ Masters degree
- ☐ Doctoral degree

Other (please specify)

11. What year did you obtain this?

12. Do you have a formal qualification related to being a **tertiary educator**? E.g. A formal teaching qualification

- ◯ Yes
- ◯ No

If yes, please describe

Current Employment

13. What best describes the **Māori student population where you are employed**?

- ◯ Very low Māori student population (0-10%)
- ◯ Low Māori student population (11-20%)
- ◯ Medium Māori student population (21-30%)
- ◯ High Māori student population (greater 30%)

14. What **best** describes your current role/job title in the school of nursing?

- ◯ Clinical
- ◯ Academic
- ◯ Management
- ◯ Other (please specify)

15. How long have you worked in **nursing education**?

- ◯ 0-4 years
- ◯ 5-9 years
- ◯ 10-14 years
- ◯ 15-20 years
- ◯ 21-25 years
- ◯ 26-30 years
- ◯ 31-35 years
- ◯ 36- 40 years
- ◯ More than 40 years

Institutional approaches to Māori student success

This section relates to your *overall institutional* approaches to Māori student success. Please note approaches specific to your school of nursing and practice will be asked in another section.

16. Does your educational institution have a specific strategy related to Māori student success?

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered yes, can you please describe?

17. If your institution **does** have a strategy related to Māori student success, in your opinion how does this influence practice within your organisation?

18. Does your institution employ a specific Māori student support role?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments

19. Please indicate your level of agreement with the following statement:
Within the **institute** there is plenty of support for Māori nursing students

0- Totally disagree 5- Totally agree

20. Please indicate your level of agreement with the following statement:
Within the **institution**, there is plenty of support **for staff** to enable Māori student success.

0- Totally disagree 5- Totally agree

School of Nursing approaches to Māori student success

21. Does your school of nursing have a specific strategy related to Māori student success?

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered yes, can you please comment/describe:

22. If your school **does** have a strategy related to Māori student success, in your opinion how does this influence practice within your school and your own practice?

23. Does your school employ a specific Māori nursing student support role?

- ◯ Yes
- ◯ No
- ◯ Not sure
- ◯ Please comment/describe

24. How actively do you feel your school engages with Māori stakeholders?

0-not at all — 5- very engaged

25. Please indicate your level of agreement with the following statement:
Within the **school** there is plenty of support for Māori nursing students

0- Totally disagree — 5- Totally agree

26. Please indicate your level of agreement with the following statement:
Within the **school**, there is plenty of support for **staff** to enable Māori student success.

0- Totally disagree 5- Totally agree

Preparedness for working with Māori nursing students

27. Overall, how prepared do you feel to meet the specific learning needs of Māori nursing students?

0- not prepared 5- extremely prepared

28. Working in the classroom, how prepared do you feel to meet the specific learning needs of Māori students?

0- not prepared 5- extremely prepared

29. Working in clinical practice, how prepared do you feel to meet the specific learning needs of Māori nursing students?

0- not at all 5- very prepared

30. In my opinion, the emphasis put on Māori nursing student success is

- too much emphasis
- not enough emphasis
- at the right level

Comment

31. I face **barriers** in ensuring Māori nursing student success

- Yes
- No
- Not sure

If you answered yes, can you please describe:

32. What is your level of **confidence** working with and meeting the needs of Māori nursing students?

0- not confident 5- extremely confident

33. How would you rate the School of Nursing's **leadership** around Māori nursing student success?

0- poor 5- excellent

34. How would you rate the School of Nursing's **teaching practice** related to Māori nursing student success?

0- not very effective 5- extremely effective

Professional development and other education

35. Have you completed any formal or informal education relevant to **cultural safety**?

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered yes, how relevant is this to your education practice?

36. Have you completed any formal or informal education relevant to Māori student success?

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered yes, how relevant is this to your education practice?

37. Have you completed any formal or informal Te Reo education?

- ◯ Yes
- ◯ No

If you answered yes, how applicable is this to your education practice?

38. How would you rate your confidence in saying your own pepeha/ mihi in Te Reo Māori

0- not confident 5- extremely confident

39. Please chose from the list further educational opportunities you think you could benefit from (you may chose more than one)

- [ ] Māori learning styles
- [ ] Māori student success strategies
- [ ] Māori world view
- [ ] Te Reo
- [ ] Tikanga
- [ ] Cultural safety related to teaching/educational practice
- [ ] None

Other (please specify)

Appendix D: Letter to National Chair of Nurse Education in the Tertiary Sector (NETS)

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MĀTAURANGA

17 May 2017

To Sally Dobbs- National Chair Nurse Education in the Tertiary Sector (Aotearoa NZ) (NETS)
netschair@gmail.com

Re: Permission to distribute research invitation via NETS members

Dear Sally,

As you are aware, I am completing an Educational Doctorate at the Institute of Education at Massey University. I am undertaking a project that aims determine how New Zealand tertiary education institutes, schools of nursing and nurse educators respond to Māori nursing students' learning needs. The title of my project is: *An investigation into the preparedness for and experiences in working with Maori nursing students among New Zealand tertiary institutes, schools and nurse educators.* My supervisors for this project are:

- Associate Professor Alison Kearney: A.C.Kearney@massey.ac.nz
- Professor Jenny Carryer: J.B.Carryer@massey.ac.nz
- Dr Bevan Erueti: B.Erueti@massey.ac.nz

I am seeking participants who are currently working in schools of nursing in New Zealand employed in either leadership roles within schools of nursing or nurse lecturers.

Following discussion at the March 2017 NETS meeting, I am writing to formally request permission to distribute my research invitation via NETS members. If you could kindly reply in writing that would be greatly appreciated.

If you wish to contact me, please don't hesitate to,

Roberts

Jennifer Roberts
jroberts@eit.ac.nz
Phone [redacted]
Massey University student number [redacted]

Please note,

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 17/05. If you have any concerns about the conduct of the research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicssouthb@massey.ac.nz

Appendix E: Response from National Chair of Nurse Education in the Tertiary Sector (NETS)

NETS Providing a proactive voice in nursing education

26 May 2017

To: Jennifer Roberts – jroberts@eit.ac.nz
Massey University student number [redacted]

Dear Jennifer,

Re: Permission to distribute research invitation via NETS members

As discussed at NETS during the period 23 / 24 March 2017, you have the support and permission from NETS to enable you to approach nursing schools for data collection in regards to your doctoral research. I am more than happy to circulate invitations to NETS members using the NETS distribution list.

Wishing you luck with your studies and research. If there is anything further that I can do to assist, please do not hesitate to contact me.

Kind regards,

S Dobbs

Dr Sally Dobbs
National Chair Nurse Education in the Tertiary Sector (Aotearoa NZ) (NETS)
netschair@gmail.com

Appendix F: Participant Information Sheet – Questionnaire

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MĀTAURANGA

An Investigation into the preparedness for and experiences in working with Māori nursing students among New Zealand tertiary institutes, schools and nurse educators.

INFORMATION SHEET- Questionnaire

Researcher(s) Introduction
Tēnā koutou katoa. This research project is being undertaken by Jennifer Roberts as part of a Doctor of Education degree at the Institute of Education at Massey University. Jennifer is a Registered Nurse currently working in nursing education. This research is being supervised by Associate Professor Alison Kearney (Institute of Education), Professor Jenny Carryer (School of Nursing), and Dr Bevan Erueti (Institute of Education) at Massey University.

Project Description and Invitation
This project aims to determine how New Zealand tertiary education institutes, schools of nursing and nurse educators respond to Māori nursing students' learning needs.
You are invited to participate in this research project.

Participant Identification and Recruitment
Participants who are currently working in schools of nursing in New Zealand employed in either leadership roles within schools of nursing or nurse lecturers are invited. Selection criteria include: current employee within a school of nursing in New Zealand, Registered Nurse or Nurse Practitioner, current employment as a Nursing Lecturer or in a position of leadership (i.e. Head of School, Programme Leader). There are no anticipated risks to participants as a result of participation in this project.

Project Procedures
This project will be conducted through the use of a survey, or questionnaire. The questionnaire (link included with this invitation) is electronic and uses SurveyMonkey software. Participant responses will be anonymous and will take 15-20 minutes to complete.

Data Management
Data obtained will be used to answer the research question for the purpose of the postgraduate study. Participant details that are potentially identifiable will be deleted or obscured. To maintain the confidentiality of the information gathered and any identifiable features of the participants will be removed from data while maintaining the overall context. Pseudonyms where appropriate will be used, and institutions will not be named. No information that may identify an institution will be used.

Findings of the study will be used as the basis for articles in New Zealand and international educational journals and publications.

Storage of data will be secure with only the researcher and academic supervisors having access to raw data. Data will be destroyed at the conclusion of this study

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
- *Completion and return of the questionnaire implies consent;*
- *decline to answer any particular question;*
- *ask any questions about the study at any time during participation;*
- *be given access to a summary of the project findings when it is concluded.*

Project Contacts
Participants are invited to contact the researcher(s) and/or supervisor(s) if they have any questions about the project.

Researcher: Jennifer Roberts email: jroberts@eit.ac.nz phone: [redacted]
Supervisors: Associate Professor Alison Kearney: A.C.Kearney@massey.ac.nz
Professor Jenny Carryer: J.B.Carryer@massey.ac.nz
Dr Bevan Erueti: B.Erueti@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 17/05. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz

Appendix G: Participant Information Sheet – Interview

An investigation into the preparedness for and experiences in working with Māori nursing students among New Zealand tertiary institutes, schools and nurse educators.

INFORMATION SHEET- Interview

Researcher(s) Introduction
Tēnā koutou katoa. This research project is being undertaken by Jennifer Roberts as part of a Doctor or Education degree at the Institute of Education at Massey University. Jennifer is a Registered Nurse currently working in nursing education. This research is being supervised by Associate Professor Alison Kearney (Institute of Education), Professor Jenny Carryer (School of Nursing), and Dr Bevan Erueti (Institute of Education) at Massey University. ***Thank you for considering continuing in the interview stage of this study.***

Project Description and Invitation
This project aims to determine how New Zealand tertiary education institutes, schools of nursing and nurse educators respond to Māori nursing students' learning needs.
You are invited to participate in this research project.

Participant Identification and Recruitment
Participants who are currently working in schools of nursing in New Zealand employed in either leadership roles within schools of nursing or nurse lecturers are invited. Selection criteria include: current employee within a school of nursing in New Zealand, Registered Nurse or Nurse Practitioner, current employment as a Nursing Lecturer or in a position of leadership (i.e. Head of School, Programme Leader). There are no anticipated risks to participants as a result of participation in this project.

Project Procedures
You are invited to participate in this project through interview. **If you choose to be interviewed, you are invited to contact the researcher directly by email** jennifer@nursingcouncil.org.nz Interviews will take place at a mutually agreed time and will take place either face to face or via Skype. The interview will take between 30-60 minutes. Your informed consent will be required before the interview, where the researcher will fully explain the project and provide you with a chance to have any questions answered prior to you making a decision about participating in the project. If you wish to review your interview transcript and provide any corrections you will be provided the opportunity to do so once this has been transcribed.

Data Management
Data obtained will be used to answer the research question for the purpose of the postgraduate study. Participant details that are potentially identifiable will be deleted or obscured. To maintain the confidentiality of the information gathered and any identifiable features of the participants will be removed from data while maintaining the overall context. Pseudonyms where appropriate will be used, and institutions will not be named. No information that may identify an institution will be used.

Findings of the study will be used as the basis for articles in New Zealand and international educational journals and publications.

Storage of data will be secure with only the researcher and academic supervisors having access to raw data. Data will be destroyed at the conclusion of this study

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study (within the first 2 weeks);*
- *ask any questions about the study at any time during participation;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

Participants are invited to contact the researcher(s) and/or supervisor(s) if they have any questions about the project.

Researcher: Jennifer Roberts email: jennifer@nursingcouncil.org.nz phone: [redacted]
Supervisors: Associate Professor Alison Kearney: A.C.Kearney@massey.ac.nz
Professor Jenny Carryer: J.B.Carryer@massey.ac.nz
Dr Bevan Erueti: B.Erueti@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 17/05. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz

Appendix H: Indicative Interview Schedule

Indicative interview schedule for study by J Roberts Massey University Institute of Education Ethics approval number SOB 17/05

Can you tell me a bit about yourself, your current role, how long you have been in nursing education?

What do you think works well to support Māori nursing students?

How do you support Māori?

How did you get the confidence/ skills to do that?

Māori stakeholder engagement was reported as low in the questionnaire, is that your experience? Why do you think that is?

How do you engage with local Māori stakeholders?

How does that inform practice?

There seemed to be a tension or resistance in the findings of the questionnaire around Māori being positioned as priority learners.

What are your thoughts around this?

What barriers/challenges do you see for Māori in nursing?

Who do you talk to about dilemmas or problems related to things Māori?

Racism and unconscious bias are prominant themes in the literature- is this something you are aware of?

Can you think of any examples where you or students have had to address issues of racism or unconscious bias?

How do you address this in practice?

What does Cultural Safety mean for you in your educational practice?

How/ Do you differentiate between Cultural Safety and Kawa Whakaruruhau?

How do you manage when there are values/attitude conflicts between students/colleagues?

How do you assess for Cultural Safety and Kawa Whakaruruhau?

What do you think hinders understanding and application of Cultural Safety / Kawa Whakaruruhau ?

Appendix I: Participant Consent Form

MASSEY UNIVERSITY
INSTITUTE OF EDUCATION
TE KURA O TE MĀTAURANGA

An investigation into the preparedness for and experiences in working with Maori nursing students among New Zealand tertiary institutes, schools and nurse educators.

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

Te Kunenga ki Pūrehuroa
Institute of Education
Cnr Albany Drive & Collinson Road, Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 www.massey.ac.nz