Desirable Attributes for Medical Graduates:

The health aspirations and needs of Maaori living in Te Rohe Pootae

A thesis

Submitted in partial fulfilment

of the requirements for the degree

of

Master of Health, Sport, and Human Performance

at

The University of Waikato

by

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THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2022

I acknowledge all my dear friends and family who passed

while I have been completing this work.

At times I wondered if I had the strength to continue,

but then I knew that you would have been encouraging me to keep going… I did.

Abstract

Health disparities for Maaori, the tangata whenua of Aotearoa New Zealand, are prevalent when compared to the health of European New Zealanders, and even more so in remote and rural communities where access to health-care services is limited. Moreover, Maaori are underrepresented in the medical workforce in which there is a serious and escalating shortage of doctors and nurses.

In the context of the University of Waikato's proposal to establish a Graduate Entry Medical School, Te Huataki Waiora School of Health has identified the need for a collaborative approach to 'growing' a fit-for-purpose health workforce with the skills and commitment to care for and work with Maaori (and Pacific peoples) living in remote and rural communities. This study thus explores the health perspectives, needs, and aspirations of Maaori living in and around the King Country rural service towns of Te Kuiti and OOtorohanga. Conducted by a Ngaati Maniapoto tribal member, the location for the study is known by Maaori as Te Rohe Pootae - the lands of Rereahu/Maniapoto, to which the Waikato people sort refuge after the invasion and confiscation of their lands in the 1860s. The perspectives, needs, and aspirations of Pacific peoples living in these communities have been explored in a 'sister' Masters study conducted by Janina Galewski.

The present exploratory study incorporates a co-design research process underpinned by an Indigenous health framework with Kaupapa Maaori values. Kanohi ki te kanohi (face to face) semi-structured interviews were conducted with 30 community members, 11 males and 19 females aged 18 years and over. The data analysis included a combination of values, verses and holistic, and provisional coding methods (focused, thematic, descriptive) (Saldana, 2021).

The findings reveal that these community members view themselves as either rural or remote based on distance, access to services, and geographic isolation, but not population numbers. In terms of services, they want a mobile health workforce including clinics, carers, doctors, nurses; mental health workers who are equipped with the resources and time needed to reach and serve their patients; and better access to dialysis and related services. The research also identifies three healthcare strategies. When ill or injured, one-third of the group go directly to their GP; one-third try other things before seeking medical assistance, including going home to their parents and/or to their marae for comfort and advice, 'going bush' to (re)connect with nature, and forms of pure (cleansing rituals); and although the remaining third are registered with medical centres they do everything they can to avoid seeing a doctor at all. Instead, they rely on rongoaa and other 'complementary and alternative' treatments such as physiotherapists, chiropractors, osteopaths, and other healers. Adopting and adapting a table created by Woolley et al. (2013), the findings also revealed three sets of desirable attributes for

medical graduates (and other healthcare professionals): Skill-based attributes include quality care and communication skills, knowledge-based attributes include medical knowledge and culturally appropriate knowledge, while attitude-based attributes include personality and community engagement. This framework can be used to inform a medical education curriculum, with a specific emphasis on the health needs and aspirations of Maaori living in rural and remote communities.

Mihimihi

Tenei te mihi ki a kooutou katoa. He mihi aroha, he mihi maahaki, he mihi oranga.

Te pou, te pou

Te tokotoko i wheenuku

Te tokotoko i wheerangi

Tokia, tukia

Ko te muumuu, ko te aawha

Ko te manihi kai ota

Takiri panapana

Ka rau i runga

Ka rau i raro

Ka whai taamore i runga

Ka whai taamore i raro

Tena ko to pou

Tena ko te pou

Te pou o Rongo

Noo Rongo Mauri Ora

Ka ora eeei

Tooku Pepeha

Ki te taha o tooku whaea

Ko Tainui te waka

Ko Rangitoto raatou ko Pirongia, ko Kakepuku ngaa Maunga

Ko Waipa te Awa

Ko Ngaati Apakura raaua ko Ngaati Maniapoto ngaa iwi

Ko Ngaati Urunumia te hapu

Ko Whakataamanawa Tanirau-Taratu-Tanirau raaua ko Kohatu Hemara-Wahanui ona maatua

Ko Kahotea raaua Ko Te Kotahitanga ngaa Marae

Noo Ngahape i tupu ake ai ia.

Ko Matuakore Wikitoria Hemara-Wahanui toona ingoa.

Ki te taha o tooku matua

Ko Tainui te waka

Ko Taupiri raaua ko Orangiwhou ngaa maunga

Ko Waikato raaua ko Mitiwai ngaa awa

Ko Tahaaroa te moana

Ko Ngaati Te Ata raaua ko Waikato ngaa iwi

Ko Ngaati Mahuta ki te Hauauru te hapuu

Ko Te Werawera Teruki-Waaraki raaua ko Katipa Maikuku ona maatua

Ko Rere-te-whioi raatau, ko Te Kooraha, Maketu me Aruka ngaa marae

Noo Tahaaroa i tupu ake ai ia.

Ko Pairama Robert Katipa-Maikuku toona ingoa.

Ko wai au?

Ko Victoria Louisa Wikitoria Maikuku tooku ingoa

Ko Ngaati Te Ata raatou ko Waikato, ko Ngaati Apakura, ko Ngaati Maniapoto ngaa iwi

He maha ngaa hapu me ngaa marae

Engari, i tupu ake ai i Tahaaroa me OOtorohanga

Noo OOtorohanga ahau e noho ana inaianei.

Nooreira teena kooutu, teena kooutou, teena oranga kooutou katoa

Acknowledgements

He mihi aroha me te oranga ki a kooutou

I would like to express my heartfelt gratitude to all the whanaunga who took part in my study from the Waitomo and OOtorohanga districts. I admire your bravery for trying new things and appreciate you having to take time out of your busy schedules to connect with me and share your personal experiences, ideas, and goals for your health aspirations and needs.

I would especially like to acknowledge those of you who had to learn new software in order to talk to me over Zoom.

I express my sincere appreciation to those of you who contracted COVID-19 but insisted on being interviewed after your recovery.

To my friends and family, I'd like to express my gratitude to you all for your assistance with images, information, and most importantly moral support.

Thankyou uncle Tom, I appreciate you taking the time to help me with information and thankyou for everything you do for all of us.

Ngaa mihi aroha ki a kooutou katoa mo too kooutou, tautoko - support, me too whakapono - trust, too aroha - love, me too manaaki - kindness, ki ahau. I am forever grateful.

To my husband Clayton, ka nui taaku aroha maau. You are my biggest supporter and fan in everything I do, my hun, ko koe taaku tooka, you can relax now.

My awesome moko girl Luna who always brought me timely reminders to take time to play, laugh, and meditate - love you Manawa.

My mother Wikitoria, thank you maamaa for your love, support, and encouragement, especially when I was doubting myself about getting this work done, you can breathe a sigh of relief.

To my children, mokopuna, family and friends, thank you for your patience and support.

Amanda and Tracy my sisters from another mother. I am forever grateful for the both of you, and the amazing support and friendship you both gave me through this process, I will never forget.

I want to also thank Alan, Deane and Anne for assisting me at the last minute with proofreading and tidying up and finishing my thesis. You three came to my aid when I felt like giving up.

The University of Waikato

My project team for ‘Creating Culturally Responsive Doctors’, I learned so much from all of you; thanks for your patience, support, and encouragement.

Emeritus Professor Roger Strasser - Project team leader

Roger, much appreciation for all your help and especially for allowing me to experience and be a part of this project team. Thank you for the scholarship opportunity.

Dr. Nikki Barrett - Project team manager

Thankyou Nikki for the encouragement along the way when I was doubting myself. You have a wonderful positive and motivating nature about you. Mauri ora e hoa.

Dr. Apo Aporosa - Supervisor

Apo thank you for always making me laugh or smile with your infectious energy and happy way of being. Your support and encouragement throughout this study has been really appreciated. Nui te aroha ki a koe.

Dr. Gloria Clarke - My Supervisor

I appreciate being chosen as your very first master's student. This mature student's mental, physical, and spiritual development have all undergone significant growth over the process. With everything that has transpired, it has truly been a voyage of adapting. Thankyou for your support, advice and help throughout this research journey. I appreciate the advice you gave me when things did not go as I had hoped or as our team had hoped due to COVID19 and other factors. I am forever grateful even though the entire process was challenging for us both. Ngaa mihi mahana

Janina - Masters teammate

Nina, words cannot express my appreciation for you during this master's journey, you helped and supported me through some real tough times. I don't think you even realised you were helping me. Intuitively knowing what to say and do at the right times meant so much. He mihi aroha ki a koe, e te tuahine.

The awards that enabled me to conduct this research study:

University of Waikato Taught Postgraduate Scholarship (Round1)

The University of Waikato. You gave me an opportunity to fulfil something that I could only have dreamed about when I was a young Maaori girl growing up in the remote village of Tahaaroa. The scholarship enabled me to open my mind and see the potential for myself and my people. Ngaa mihi nunui.

Research & Enterprise Study Award - UMVC44

Emeritus Professor Roger Strasser, thank you for the award; it enabled me to expand my research skills and to learn about my people. The study has been a real experience of learning, adapting and growing.

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Chapter 1 - Introduction

The health disparities for Maaori, the tangata whenua of Aotearoa, New Zealand, are prevalent when compared to the health of European New Zealanders (Henry, 2001; Lawrenson et al, 2017; Ministry of Health, 2020), and even more so in rural and remote communities where access to health services is limited (Eberhardt, & Pamuk, 2004; Henry, 2001; Simpson, 2020; Strasser, 2021); Wilson et al. (2021) refer to the continuing disparities as an "issue plaguing" the New Zealand healthcare system, and this issue was grossly exposed during the recent COVID-19 pandemic (Van Dalen, 2021; Strasser, 2021).

Moreover, Maaori are underrepresented in the medical workforce (Medical Council of New Zealand, 2021) in which there is a serious and escalating shortage of doctors and nurses (Lawrenson et al., 2017). The shortage of health care professionals has led to a reliance on international medical graduates and General Practitioners (GPs) to help fill the gaps, which has added to a growing concern around cultural competency and the ability to relate to New Zealanders as this jeopardises patient-doctor-medical staff relationships (Lawrenson et al, 2017; Strasser, 2021).

In response to these issues, the University of Waikato proposes the establishment of a third medical school. Consequently, the University wants to partner with rural communities, Maaori, and to work with other academic institutions across New Zealand to establish a new and different graduate-entry medical school. Recruitment will focus on students from underserved rural and remote areas, as they have a better understanding of their community's needs and are, therefore, more likely to return to their communities rather than seek employment overseas after graduating (Strasser, 2021).

There is widespread support for a third medical school. Academics and Members of Parliament (MPs) feel that a new school will address the healthcare worker shortages, our country's reliance on foreign doctors, and more importantly, will help combat the continuing health disparities for Maaori and rural and remote communities (Bennett as cited in Leaman, 2020; Lawrenson, 2020; Moxon as cited in University of Waikato, 2022). At a recent event, Health Advocate Lady Moxon (as cited in University of Waikato, 2022) stated, "we are a country of people who need to work together to bring about the best our country can offer to everyone in it." She went on to say that not only do we need to train our foreign doctors in the Treaty of Waitangi, but to also "grow and train our own doctors." In short: "We need to have that medical school here [Waikato], we need it and we need it right now" (Moxon, as cited in University of Waikato, 2022). Professor in Population Health, Ross Lawrenson (as cited in Leaman, 2020) also supports the need for a third medical school in our region, stating, "It's important a third med school is located in Waikato given the region has high health needs and the biggest deficit of medical practitioners" (para, 9). While some might perceive a third medical school as a threat or a

decision that needs careful consideration, as Fraser (as cited in Goodwin, 2016) said that the plan for a new school was "ill-conceived and unwarranted" (para, 6). National's Hamilton East MP David Bennett (as cited in Leaman, 2020) says that our focus should be "...the shortage of health professionals in rural communities…." National's health spokesperson Dr Shane Reti (as cited in Bremner, 2022) argued "…even though a third medical school has been unsuccessfully floated before" it "is needed now" (para, 8).

Research Purpose and Aim

To support the proposal for a third medical school, academics in Te Huataki Waiora School of Health at the University of Waikato have commissioned a pilot study aimed at understanding the health needs and aspirations of Maaori and Pacific peoples living in a rural and remote community in the King Country region. This information will be used to inform the future curriculum of the Medical School.

This project comprises two 'sister' studies. One conducted by a Maaori master's student (me) and the other by a Pacific master's student. As a member of Ngaati Maniapoto, my aim is to gather and understand the health experiences, aspirations, opinions and needs of Maaori living in the rural and remote Te Rohe Pootae King Country region. The sister project was conducted in my community by my colleague, Janina Galewski and is reported in her thesis.

Research Questions

For this study, the three major research questions are:

1. What are the health experiences of Maaori living in Te Rohe Pootae?
2. What does 'rural and remote' mean for Maaori living in Te Rohe Pootae?
3. What are the healthcare needs and aspirations of Maaori living in Te Rohe Pootae?

Under these major themes, other topics included their thoughts about a third medical school, and what and how we should be teaching and training student doctors (see Appendix A), for the full interview schedule.

Structure

Chapter One

In this chapter, I introduce the research topic and briefly outline the purpose of the study, what I hope to achieve, the research questions, and now the structure of the thesis.

Chapter Two

In this chapter I provide the Context for the research and thesis. It consists of three parts. First, I provide the reader with an introduction to Aotearoa New Zealand; our landscapes, population figures, and tangata whenua (Indigenous people) including Te Tiriti o Waitangi, our country's founding document. I then describe Maaori health outcomes, outline the government's obligations under the Treaty of Waitangi, and briefly describe the state of our medical health workforce. In Part 2, I introduce the community of interest, Te Rohe Pootae, which includes the Waitomo and OOtorohanga districts and the rural service towns of Te Kuiti and OOtorohanga. To give the reader some idea of what it is like to live in Te Rohe Pootae, I briefly describe the healthcare and transportation services provided in these towns. In the final section, I locate myself within this rural and remote landscape, including my reasons for undertaking this research.

Chapter Three

Chapter 3 is about methodology and is comprised of two parts. Part 1 explores the concept of methodology and then introduces Kaupapa Maaori: What it is, where it comes from, what it means to and for me, and how it underpins my methodological framework. In Part 2, I then describe my *Te Pae Maunga o Kaakaamutu* framework. This framework is based on my own health and wellbeing beliefs and practices and informs my conduct as a researcher of Ngaati Maniapoto.

Chapter Four

Following methodology, this is the methods chapter and is presented in two parts. Part 1 details the research design, including ethics, story collection, and analysis methods. Part 2 describes the research process including recruitment and interviews. In this section I also introduce the research participants, 30 members of our rural and remote community.

Chapter Five

Chapter 5 is the literature review. In the first part of this chapter, I define and briefly explore the terms/concepts of health and well-being, rural and remote, and disparity and (in)equity. In Part 2, I describe my search strategy and discuss what I discovered – which includes a lack of literature about the health of Maaori who live in rural and remote areas. The key themes that emerge out of the literature are what we have in common with other countries, including health workforce shortages in general and in rural and remote communities; poorer health outcomes for Indigenous people living in rural and remote areas; and concerns about the elderly who live in rural and remote areas, while the final theme highlights a small number of studies that have focused on the qualities of a 'good' doctor.

Chapter Six

Chapter 6 is the Findings chapter. This chapter highlights the main themes that emerged from the semi-structured interviews. The chapter is organised in line with the interview schedule, which comprised three sections: Healthcare experiences, 'Rural and remote', and Healthcare needs and aspirations.

Chapter Seven

The final chapter is the Discussion and Conclusion. In this chapter I discuss a selection of key points in relation to the overarching purpose of the study, which is to gather information that will inform the curriculum for the proposed medical school. In Part 1 and Part 2, I briefly reflect on how the research participants describe 'rural and remote', and the key services they have identified as lacking in Te Rohe Pootae. In Part 3, I discuss the three health strategies that emerged in the findings, and what they might mean for a medical school curriculum. In Part 4, I present and discuss an adapted version of Woolley et al's (2013) desired attributes for the medical graduate framework. In the Conclusion (Part 5), I offer some concluding thoughts and recommendations for a rural health curriculum, outline some of the limitations of the study, make suggestions for future research, and close with a final reflection.

End Sections

Chapter 7 is followed by a list of references and appendices. A glossary for te reo Maaori, (the Maaori language) used in this document is included in the very back of the thesis for easy access.

Some Writing Conventions

The following are some key writing conventions that I wish to highlight for the reader.

Reflections

With the exception of chapters one and two, each chapter and every section in this thesis begins with a short reflection. These reflections are based on my own health and well-being, including childhood memories of growing up in remote and rural areas, the values, and beliefs I follow today for my own health and wellbeing, and how I coped with learning and writing during the research process. I share these reflections and stories because I want the reader to get a clear understanding of, and to connect with, who I am and what well-being is for me, and the mental, physical, and spiritual challenges that students face when undertaking higher tertiary education qualifications.

I, We, Our

When referring to Maaori, my people, generally, and in my personal reflections I have chosen to use personal pronouns (I, we, our and me) rather than speak in the third person.

Double vowels for Maaori words

I am of Waikato-Maniapoto descent and have decided to use double vowels rather than macrons for Maaori words. I recently learned the history of double vowels which were strongly advocated for by Bruce Biggs of Ngaati Maniapoto (T, Roa, personal communication, 31 August, 2022) of Parewaeono hapuu of Te Keeti marae, OOtorohanga (Pawley, 2021). Biggs used the vowels as an aid to pronunciation, and to differentiate and show the clear meaning of words (T, Roa, personal communication, 31 August, 2022). In contrast, and demonstrating our individuality within iwi, Pei Te Hurinui Jones also of Ngaati Maniapoto (Biggs, 1998) advocated for macrons. Te Taka Keegan of Waikato-Maniapoto adapted word documents on PCs to allow the use of the macron. Waikato Tainui official documents use the double vowel, while Maniapoto official documents use the macron (T. Roa, personal communication, 31 August, 2022). In short, the use of either double vowels or macrons is personal preference.

Kupu Maaori and Translation

Where Maaori words appear in the first instance I have added a translation/interpretation in brackets. For quick access, a glossary of words is included at the very back of the thesis.

Aotearoa New Zealand

Being a tangata whenua Maaori I have chosen to use Aotearoa New Zealand instead of just New Zealand throughout my writing.

Pseudonyms

In place of participants' real names, pseudonyms have been used. Square brackets show their age range [e.g., Rangatahi, wahine] – Rangatahi (young adult, 18 - 35), Pakeke (mature adult, 35 - 65) or Kaumatua (respected elder, 65 +), and also if they are wahine (female) or tane (male).

Chapter 2 - Context

The purpose of this chapter is to give the reader the context or background to this study and comprises three parts. Part One provides the reader with a 'picture' of Aotearoa New Zealand, including tangata whenua, Te Tiriti o Waitangi, and the consequences of colonisation concerning Maaori health outcomes. In Part Two, I describe the communities of interest in this study, including their healthcare services.

2.1 Aotearoa New Zealand

Aotearoa New Zealand is a remote mountainous group of three major islands located some 1,600 kilometres southeast of Australia (McSaveny, 2015 as cited in Te Ara, 2022). The main islands are Te Ika a Maaui - more commonly referred to as the North Island; Te Waipounamu, known as the South Island; and Rakiura, Stewart Island (McSaveny, 2015 as cited in Te Ara, 2022). Aotearoa New Zealand was created some 23 million years ago, when volcanic activity caused the land to be thrust up out of the south Pacific Ocean to form a majestic landscape featuring lofty volcanoes, snow-covered peaks, rugged coastlines, deep valleys, meandering rivers, picturesque lakes, and dense native bush/forests (Encyclopædia Britannica, n.d.)

Over time the landscape has been reshaped and developed with settlements, but exponentially more so with European colonisation beginning in the early 1800s. Much of the native bush/forest was cleared for farming, towns, and transportation infrastructure. Over time, our major industries have become agriculture, forestry, mining, hospitality/tourism, and fisheries (Statistics New Zealand, 2020).

As at the last census (Statistics New Zealand, 2018), Aotearoa New Zealand had a population of approximately 5.12 million. The major ethnic groups are Europeans (70.2%), Maaori (16.5%), Asians (15.1%), and Pacific Peoples (8.1%). Just over half our population (51.2%) live in the major cities. Almost a quarter (24.7%) of us live in small rural towns, while 834,560 (16.3%) live in rural areas (Statistics New Zealand, 2018), including 18.0% of the Maaori population.

Tangata Whenua

Maaori are tangata whenua - the people of the land. There are different stories about when our ancestors migrated to Aotearoa New Zealand from the Pacific, but it is generally accepted that they arrived in approximately AD 850 -950 (Williams, 2004; Walker, 2004) Kuramaarootini (sometimes known as Hine-te-aparangi) the wife of our Polynesian ancestor Kupe, is credited with providing the name Aotearoa. Sailing from Raiatea and approaching land cloaked in a long white cloud, she called

out, “he ao, he ao, he Aotearoa '' (a cloud, a cloud, a long white cloud) (McLintock, 1966). However, it is important to acknowledge that different tribal groups departed from different islands and arrived at different times at different locations and gave these islands different names and origin stories.

Like all indigenous peoples, Maaori view the world differently from Paakehaa, the New Zealand descendants of the European settlers. Te Ao Maaori (the Maaori worldview) is natural, cyclic, and holistic and we have an intimate familial relationship with everything in Te Taiao (the natural world) - animate and inanimate; tangible and intangible (Te Manawa Taki, 2020) - and are thus related to everything through whakapapa (genealogy). This whakapapa begins with the primordial parents, Ranginui (Sky father) and Papatuuaanuku (Earth mother), who are the parents of ngaa Atua, the various gods (Williams, 2004). Maaori believe that there is a natural order to everything, and this is woven together with three primary cultural concepts/principles of tapu, noa, and mana (Ka’ai-Oldman, 2004). These concepts intrinsically interconnect through whakapapa to form the foundation for other cultural concepts that were given to Maaori by the Atua (Ka’ai-Oldman, 2004).[1]

Europeans began arriving here in the mid-16th Century (Walker, 2004; Wilson, 2016 as cited in Te Ara – The Encyclopedia of New Zealand) when Maaori had occupied Aotearoa for at least 800 years (Walker, 2004). In time, Tangata Whenua and Europeans formed trading, working, and personal relationships. However, it was not long until the unruly behaviour of some Europeans began to raise concerns amongst Maaori, who began to petition the British Crown for law and order for their European ‘neighbours’ (Mutu, 2010). In response, the Crown appointed a British resident in the form of James Busby, who in 1835 facilitated the creation of He Whakaputanga, a Declaration of Independence, (Walker, 2004; Mutu, 2010) to ensure that Maaori had total chieftainship over their whenua (land) and their taonga (resources) and were recognised as an Independent State under the united Tribes of Aotearoa (Mutu, 2010). However, Te Whakaputanga was supplanted with the signing of Te Tiriti o Waitangi and the creation of the Treaty of Waitangi in 1840 (Walker, 2004).

Te Tiriti o Waitangi

Te Tiriti o Waitangi was an agreement signed by 500 Maaori chiefs and representatives of the British Crown (Ministry of Culture and Heritage, 2016). Te Tiriti of Waitangi is the original version of the document that was signed and written in Te Reo Maaori. This document was later translated into English and is known as The Treaty of Waitangi (Walker, 2004). In Te Tiriti of Waitangi, Maaori agreed to let the British set up a system of government for their people (Europeans) provided they respected

[1]For more information about a Maaori worldview refer to Walker, (2004)

and Maaori would retain their Tino Rangatiratanga and taonga - their independence, leadership, and tikanga (sovereignty), and their lands and treasures (Joseph, 2012). Not long after the signing, however, the British Crown used Article 1 of the English version to announce their Sovereignty and thereafter to take possession of New Zealand (Orange, 2011).

The discrepancies between Te Tiriti and The Treaty have been the cause of enduring grief for tangata whenua. The Europeans believed that they now 'owned' Aotearoa, and with that, the Treaty was used to initiate full colonisation. Waves of colonists arrived and settled at major harbours, (Orange, 2004) and from there they moved inland. Soon, the settler population was booming and needed and therefore took more land - often by manipulation, and later, by force and legislation (Walker, 2004). The settlers milled the ancient native bush and forests and cleared the land for towns, cities, and farming. They mined for minerals, introduced foreign species of flora and fauna, and cut the land for roads and railway lines. They also introduced European institutions such as schools, churches, banks, and hospitals. As a result of colonisation, Maaori were dispossessed and bereft of land and critical and cultural resources. As illustrated in Figure 1, in 1860 Maaori held 80% of the land (23.2 million acres or 9.4 million hectares) but by the year 1910, they could only access 27% (7.7 million acres or 3.1 hectares). By the year 2000, tangata whenua only held approximately 4% of their homelands (Ministry for Culture and Heritage, 2021).

Figure 1**:** Alienation of Maaori land between 1860, 1910 and 2000 respectively[1]

Note: The shading represents Maaori owned land.

Colonisation has had and continues to have a devastating impact on generations upon generations of Maaori. Through the colonial settlers and their hegemonic views, our people have lost their land, language, culture, customs, and way of being (Smith, 2012; Walker, 2004). Over time, Maaori were

pushed and pulled into the towns and cities for employment, education, and to access social services; while Maaori who continued to live in rural and remote locations received lower welfare and support from the Government. To illustrate, in 1936, 83% of Maaori lived in rural areas, but by 1986, 83% lived in urban areas (Derby, 2011).

Treated as second class-citizens in our own country (Humpage, 2008) and separated from our lands and identity, tangata whenua have suffered intergenerational poverty and trauma (Smith, 2012). To this day, we are over-represented across many negative statistics including incarceration, education, unemployment, under-employment, and health (Durie, 1998).

Maaori Health Outcomes

A key indicator of health disparities and outcomes for Maaori is life expectancy. Non-Maaori and Pacific people live 7.5 years longer than Maaori (Statistics New Zealand, 2021). Maaori are more likely to suffer from heart disease, cancer, stroke, asthma, chronic pulmonary disease, diabetes, and chronic respiratory diseases (Gurney et al., 2020; Nixon et al, 2021; Ministry of Health, 2022; Moxon, as cited in University of Waikato, 2022). There is evidence that inadequate access to services, poorer quality of care, and a failure of health services to improve outcomes for Maaori can and do lead to health inequities, and, were exposed during the WAI 2575 Health Services and Outcomes Inquiry (Hobbs et al., 2019).[2]

The life expectancy for Maaori who live in rural areas is also lower than non-Maaori living in the same areas, and statistics show that Maaori who live in rural towns have a lower life expectancy than Maaori who live in urban areas (Nixon et al, 2021; Henry, 2001; Simpson, 2020). Acknowledging these inequities, the *Te Pae Ora (Healthy Futures) Act 2022* under the Rural Health Strategy sets out priorities for services and health sector improvements relating to the health of rural communities, including 'workforce development.'

The Treaty and Health

In recent years, the Crown has acknowledged that under the Treaty it must protect Maaori health and well-being, and a responsibility to actively respond to Maaori health aspirations, and to meet and protect Maaori and their healthcare needs (Ministry of Health, 2018). More recently, the Health and Disability System Review (aka. The Simpson Report, 2020) identified a failing healthcare system and

[2] Heard by Waitangi tribunal. Breaches of Te Tiriti o Waitangi within the health sector in relation to primary care, legislation, and health policy.

recommended that the *Public Health and Disability Act 2000* be "repealed in its entirety" and be replaced with the *Pae Ora Bill (Future of Health, 2022)*. The purpose of the Bill is:

> … to protect, promote and improve the health of all New Zealanders; achieve equity by reducing health disparities among New Zealand's population groups, in particular Maaori; and build towards pae ora [Future of Health] for all New Zealanders.

The Bill identifies the need to develop and provide a new structure that encompasses Te Tiriti o Waitangi. Working in partnership, the Bill has established Health New Zealand (Te Whatu Ora) and a Maaori Health Authority, Te Aka Whaiora.

In short, Te Whatu Ora replaced the district health boards and is leading the operation of the health system. Working in partnership with Te Aka Whaiora they both design and deliver health services (Future of Health, 2021). Te Aka Whaiora (Maaori Health Authority) is an independent entity created to improve hauora Maaori (Maaori health and wellbeing). This entity ensures that 'Maaori are involved in all decision-making' (Future of Health, 2021).

The Pae Ora Bill has also identified the need to develop and train a health workforce that is better able to serve the underserved communities and groups that are struggling to cope due to the shortages of healthcare workers. These underserved communities and groups are Maaori, Pacific peoples, people living with disabilities, women, and rural communities (Future of Health, 2021).

Our Medical Health Workforce

To meet the health needs of New Zealanders, New Zealand has two medical schools, one in Auckland (North Island) and the other in Otago (South Island) (Mckimm et al, 2010). On average, these schools produce 250 graduates a year (Medical Council of New Zealand, 2021c). However, recent estimates indicate that we need approximately 16,000 more doctors across the country and that this shortage will worsen as hundreds of doctors reach retirement and our graduates leave the county to train and practise overseas (Cook, 2022). To illustrate, in 2019, while New Zealand produced 521 medical graduates, 355 doctors ceased practising (Strasser, 2021). In a recent article, Thomas-Maude and McLennan (2022) state that the shortage is also related to the transience of doctors as they head offshore to upskill, learn new medical knowledge systems, or specialise in specific areas. Our country, therefore, relies heavily on international medical personnel, including doctors, nurses, and specialists, and the current estimate is that we import 800-900 doctors annually (Strasser, 2021).

Our reliance on international medical graduates and doctors means that a good number of the doctors in our communities do not reflect and are less likely to understand the needs and nuances of New Zealanders – especially tangata whenua (Thomas-Maude & McLennan, 2022). The ideal would be to train more of our doctors, especially Maaori doctors and healthcare workers (Durie, 1998; Miller, 2021). Maaori are under-represented in the medical workforce and with a population of 16.5 percent the ideal number of Maaori doctors is estimated to be 2,807, however, the actual number of registered Maaori doctors is only 647 (Medical Council of New Zealand, 2019a).

Another issue is that doctors are more likely to live and work in urban areas. As of 2018, almost three-quarters (74.8%) of doctors in Aotearoa, New Zealand, live in the main urban towns and cities where they serve 61.2% of the population (Medical Council of New Zealand, 2019b). In contrast, while over 700,000 New Zealanders, nearly one in seven, live in rural parts of Aotearoa (Te Aka Whai Ora and Te Whatu Ora, 2022) only 11.6% of our doctors live and work in rural areas (New Zealand Medical, 2019b). Research indicates that GPs who work in rural areas also tend to be older and, therefore, closer to retiring (Medical Council of New Zealand, 2019a).

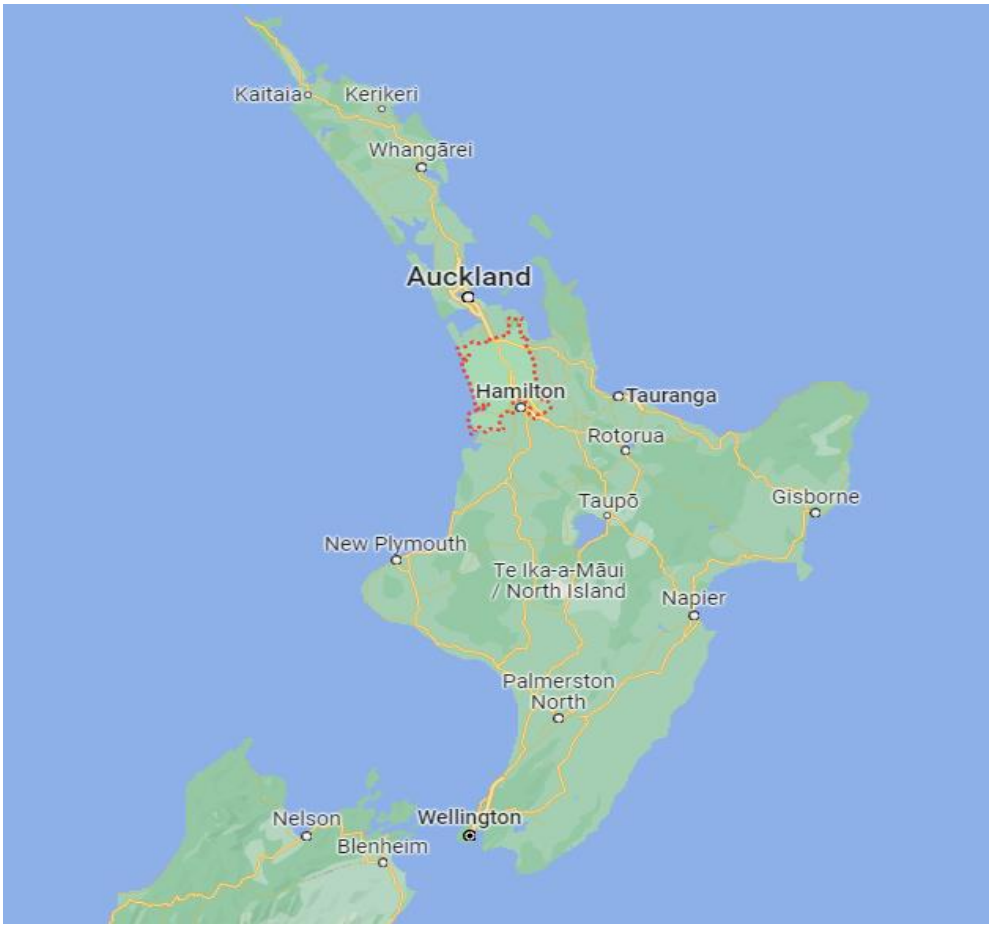
Hence, the University of Waikato's proposal to establish a third medical school, with a focus on rural communities and training Maaori and Pacific doctors. With these issues and goals in mind, staff in Te Huataki Waiora School of Health understand the importance of hearing what Maaori living in the rural and remote community want from their doctors, and as a woman of Ngaati Manaiapoto, I have set out to ascertain the health needs and aspirations of Maaori living in the rural and remote region of Te Rohe Pootae.

2.2 Te Rohe Pootae

Kia mau tonu ki teenaa; kia mau ki te kawau maaroo. Whanake ake! Whanake ake!
Stick to that, the straight-flying cormorant!

Taking a kaupapa Maaori approach to research, it was important to the research team that at least one of the student researchers lived and/or grew up in a rural and remote community in or near the Waikato region, where the proposed Medical School is to be established at the University of Waikato in the city of Hamilton. Waikato is located on the North Island, just below the Auckland region (see Figure 2), and north of the communities of interest.

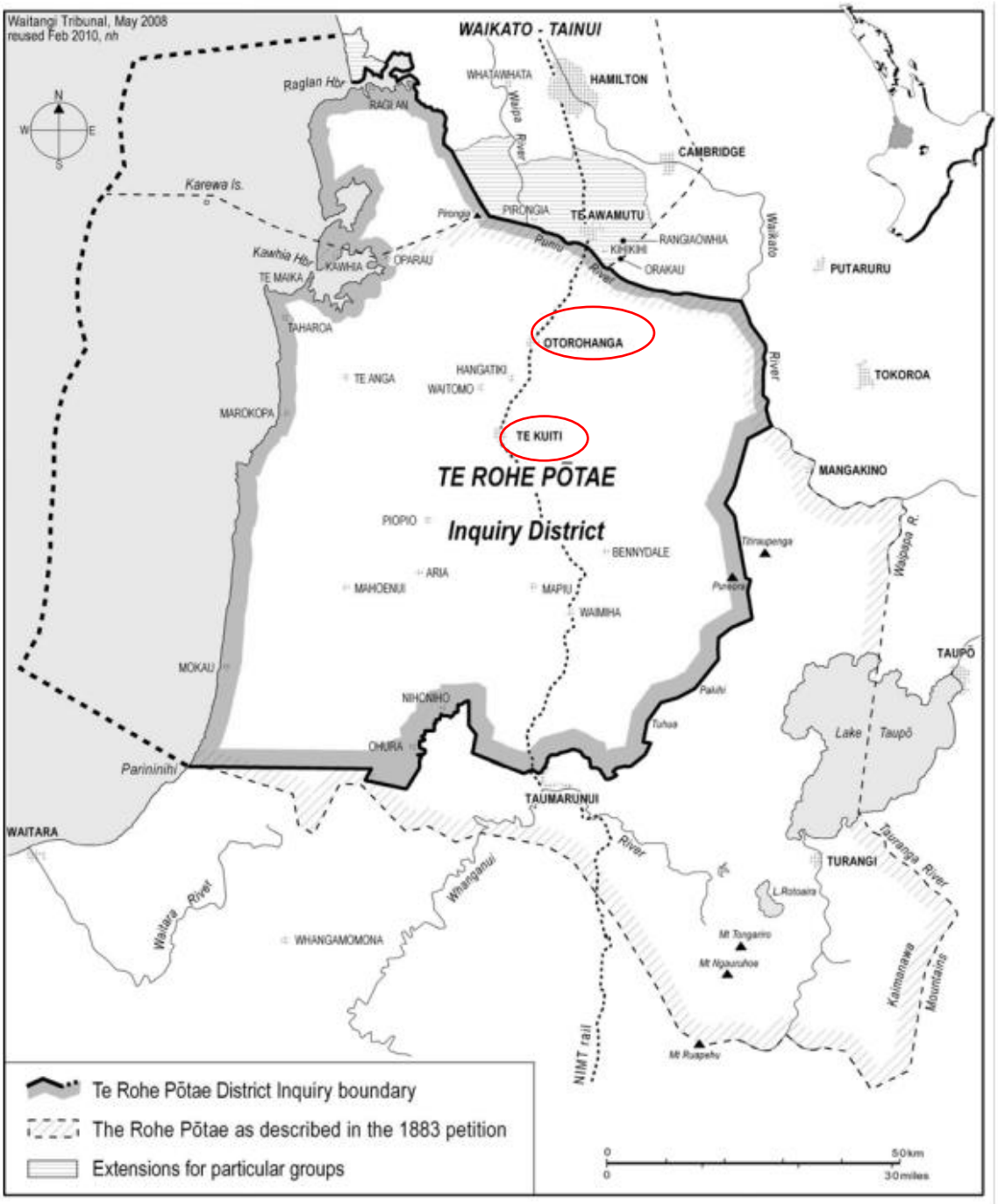
Figure 2: Location of the Waikato region[3]



The communities of interest are located within Te Rohe Pootae, which refers to the tribal lands of Rereahu Manaipoto, lying to the south of the Waikato region (Figure 2). There are two stories about the origins of the name Te Rohe Pootae. Both stories talk about the use of a hat - some say it was a top hat, others a bowler hat - during a meeting between our Tupuna chiefs and Governor Grey regarding the partitioning of our lands. The hat was eventually laid on the map of the North Island by our Tupuna and the area around the circumference of the hat became known as Te Rohe Pootae. One story states that Wahanui placed his hat on the map (Wikitoria Katipa-Maikuku, personal communication, 2022), while the other says that it was King Tawhiao that placed his hat (Tom Roa, personal communication, 2022). The circumference of that region became the Aukati line - meaning that no white man was allowed to cross its boundary.

[3] Source: Google Maps. (n.d.). [Google Map of Waikato Region, New Zealand]. Retrieved November 11, 2022. https://www.google.com/maps/place/Waikato+District,+Waikato/@-37.5157824,175.1009544

Figure 3: Te Rohe Pootae Inquiry District[4]



[4] Soure: Te Rohe Pootae inquiry district [WAI 898, 2012, p xxii)
https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_39837794/Wai%20898%2C%20A088

Figure 4: The geographical boundary of Te Rohe Pootae, the King Country[5]

The iwi and hapuu (tribes) living within the Aukati, stood strong in their mana motuhake (Autonomy) for the next 20 years. Te Rohe Pootae became a sanctuary and many sought refuge there, including the Maaori King and his followers after their lands were taken in the invasion of Waikato by government forces. The people from the massacre at Rangiaowhia also found refuge in Te Rohe Pootae. Another rangatira (leader) who sought refuge here was Te Kooti, who the Crown had labelled a rebel. In return for sanctuary, Te Kooti and his followers built as a gift for the Maniapoto people, *Te Tokanganui-a-noho*, the carved meeting house that still stands at Te Kuiti Paa located at the south end

[5] Source: Te Rohe Pootae, n.d. [Te Ara, The Encyclopaedia of New Zealand]. Retrieved November 12, 2022. https://teara.govt.nz/en/interactive/34848/boundaries-te-rohe-Pootae-1880s

of Te Kuiti's main street (Tom Roa, personal communication, 2022; Ta Pou Temara, personal communication, 2019).

However, everything changed when the five tribes within the Aukati gave the Crown permission to lay the main trunk railway line through Te Rohe Pootae. This is when the loss of land began for Ngaati Maniapoto and all our hapuu (Taa Pou Temara, personal communication, 2019). But that is a story for another day and kaupapa.

Due to the sheer size of Te Rohe Pootae, I have narrowed my focus to the Waitomo and OOtorohanga Districts, and more specifically, to the rural towns of OOtorohanga and Te Kuiti at the heart of the region. These two towns service the surrounding towns/villages including (but not limited to) Piopio, Mokau, Hangatiki, Tahaaroa, Kinohaku, Te Kuiti, Maniaiti - Benneydale, Waitomo and Oparau (see Figure 4).

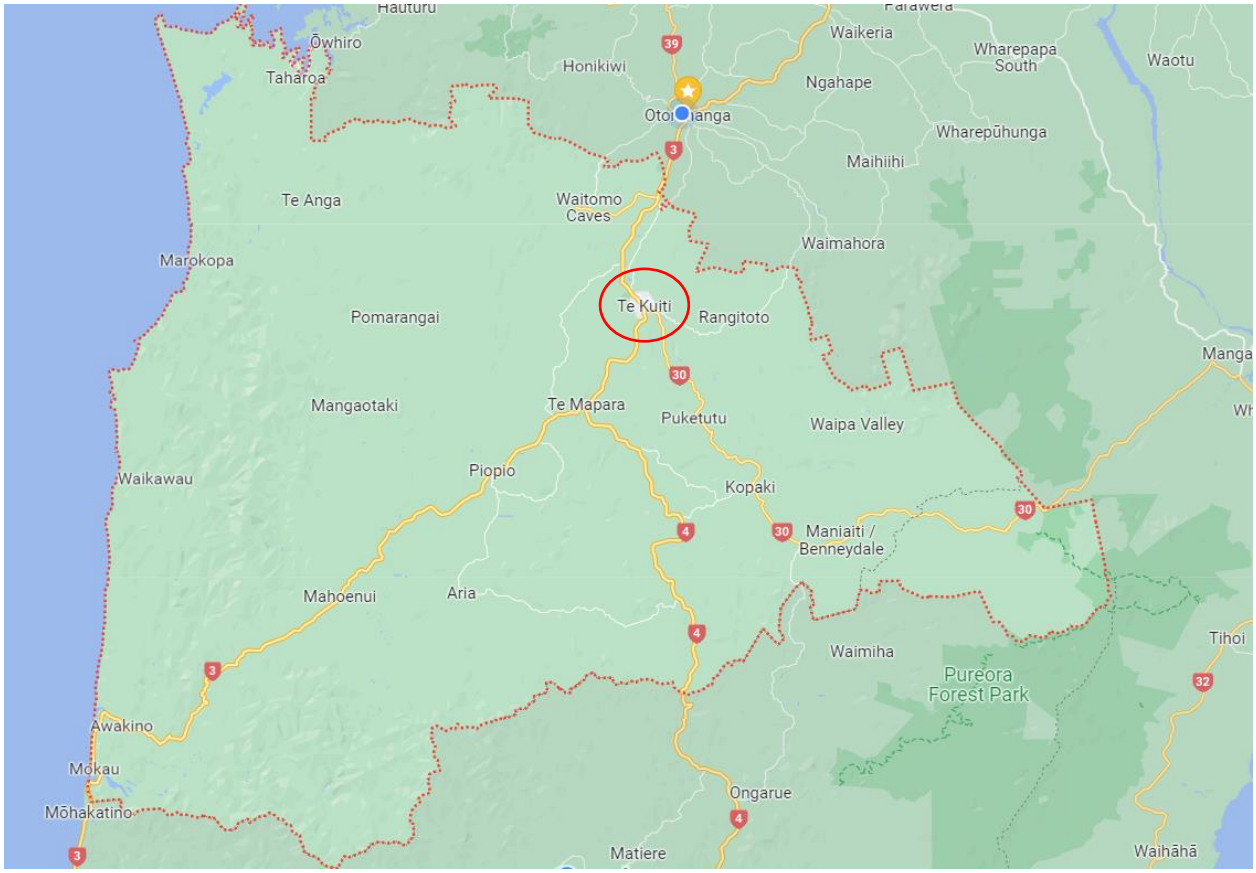
Figure 5: The geographical District boundaries of OOtorohanga, Waitomo, and Taumarunui[6]

Waitomo District - Te Kuiti Township

The Waitomo District is rich in natural beauty and features farmlands, native bush walks, lively west coast beaches, and limestone rock formations and caves that attract thousands of tourists who come to experience black water rafting and glow-worm caving activities (Waitomo District Council, 2022). At the centre of the Waitomo District is Te Kuiti, the self-proclaimed 'Shearing Capital of the World.' This town services smaller rural and remote settlements including (but not limited to) Maniaiti, Piopio, Waitomo, Tahaaroa, Marokopa, Mokau, Kiritehere, Kinohaku, and Te Waitere (see Figure 7) (New Zealand History, n.d; The Mighty Waikato Zealand, 2022; Waitomo District Council, 2022).

[6] Source: Te Rohe Pootae, n.d. [Te Ara, The Encyclopaedia of New Zealand]. Retrieved November 12, 2022. https://teara.govt.nz/en/interactive/34848/boundaries-te-rohe-Pootae-1880s

Figure 6: Towns and communities within the Waitomo District[7]



As of the last census (2018), the population of the Waitomo District was 9,303. The median age of the residents was 38.2 years, and there were roughly the same number of men (n=4,695) and women (n=4,605) living in the district. Almost half of the population (44.82%) identify as Maaori (n=4,170) and the median age for Maaori was 28.2 years (Statistics New Zealand, 2018).

The main occupations for people living in and near Te Kuiti and its service settlements include farmers, managers, professional trades, community workers, clerical workers, sales workers, machinery operators, and labourers (Statistics New Zealand, 2018) The main employers include the lamb and beef processing plants; sheep, cattle, and dairy farming; forestry and timber milling; transport/haulage; engineering; the Lines Company; Inframax, the roading company; and various trades (Waitomo District Council, 2022). Te Kuiti also has some major retail outlets (e.g., Warehouse, New World, Postie Plus, and Mitre 10) and many cafes and takeaway establishments. Accommodation within the township and the wider district includes backpacking accommodations, motels, B&Bs, camping

[7] Source: Google Maps. (n.d.). [Google Map of Te Kuiti District]. Retrieved November 11, 2022. https://www.google.com/maps/place/Waitomo+District,+Waikato/@-38.4310685,175.1222669

grounds, and caravan parks. The township also has three early childhood providers, a Kohanga Reo, one kindergarten, three primary schools, and one high school, and there is a kura kaupapa Maaori and Kohanga Reo located in Oparure 13.6 km from the town.

Healthcare provision

Te Kuiti has five health and well-being providers who tend to the needs of the community. The Te Kuiti hospital is a part of the Waikato District Health Board (now known as Te Whatu Ora, Health New Zealand). The hospital offers a range of services including a 24-hour Emergency service, a 20-bed care ward, X-rays, a day surgery unit, a laboratory, an on-site physiotherapist, and a new Plastics and Pacing unit. The hospital does not offer surgery, dialysis, or cancer treatments. Community members who need these services must travel to Waikato hospital in the city of Hamilton, 75.9km away (Healthpoint, 2022).

Te Kuiti Medical Centre is situated on the Te Kuiti hospital grounds and has a practice team of nine GPs, a practice nurse manager, ten practice nurses, and five receptionists (Te Kuiti Medical Centre, n.d.). Six of the doctors are New Zealand-born (non-Maaori). The other three doctors are English. The practice offers a range of general practice services, including minor surgery, family planning, ACC acute trauma, and diabetes and smoking cessation clinics (Te Kuiti Medical Centre, n.d.).

Maniapoto Whaanau Ora Centre is a branch of Taumarunui Community Kookiri Trust and offers a full range of general practice services that include diagnoses, minor accident care, minor surgery, immunisation, cervical screening, and disability assistance. The practice team comprises one GP (non-Maaori), and one practice nurse. Other nurses are loaned to the centre from Te Whatu Ora when needed. The centre has a receptionist and administrators (Maniapoto Whanau Ora Centre, 2022). The Maniapoto Whaanau Ora Centre is within walking distance of the town centre.

The Ngaati Maniapoto Marae Pact Trust provides comprehensive social, welfare, and health services for all whaanau within the Maniapoto rohe who choose to use them. The Trust provides free comprehensive and quality health and disability community support services for tamariki (children) through to kaumatua (the elderly) (Ministry of Health, 2018).

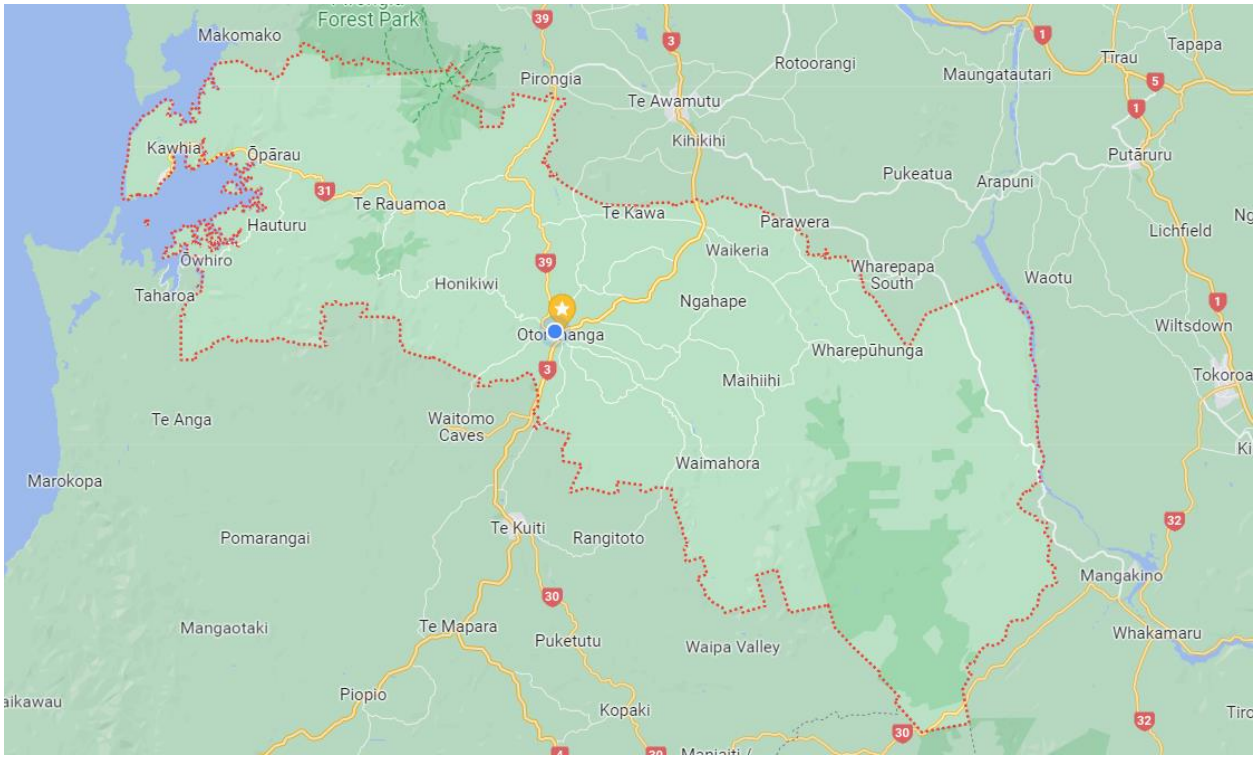
The Hillview Home and Hospital is a 52-bed residential facility that is certified by the Ministry of Health and offers a specific rest home or hospital level of care (The Hillview Trust, 2020). Other health and wellness provisions in the community include two pharmacies, two physiotherapists (one at the hospital), a public swimming pool, at least two gyms, a rugby club, and a netball centre. The community is also in the process of fundraising and building an indoor sports stadium.

OOtorohanga District - OOtorohanga Township

The Waitomo and OOtorohanga districts are neighbours. The OOtorohanga district is surrounded by captivating green landscapes and breath-taking views of the mighty Rangitoto ranges situated in the southeast, the majestic Pirongia in the northwest, and Kakepuku in the north. The beautiful Waipaa Awa (river) begins her meandering journey from the Rangitoto ranges and travels through the district to connect with the mighty Waikato (river) at Ngaaruawaahia. The district offers a range of outdoor activities including bush walks, mountain tracks for tramping and biking, riverbank walks, river floats in the summertime, coastal beaches, and a world-famous Kiwi House and Native Bird Park. OOtorohanga has branded itself as New Zealand's official Kiwiana Town of New Zealand. (OOtorohanga, n.d; Waikato New Zealand, n.d; New Zealand History, n.d).

The OOtorohanga District has two main service centres, the township of OOtorohanga and the coastal village of Kaawhia. As a rural service town, OOtorohanga services the same rural and remote communities as Te Kuiti.

Figure 7: The OOtorohanga District[8]



[8] Source: Google Maps. (n.d.). [Google Map of OOtorohanga Distric]. Retrieved November 11, 2022. https://www.google.com/maps/place/OOtorohanga/data=!4m2!3m1!1s0x6d6cc0604e3269e7

As of the last census (2018), the population of the OOtorohanga district was 10,104, roughly the same as the Waitomo District. The median age for both men (n=5,292) and women (n=4,812) is 36.3 years. 30% of the population identify as Maaori (n=3,030) and the median age for Maaori is 27.8 years (Statistics New Zealand, 2018).

The main occupations for the people living in the OOtorohanga district and the serviced settlements are managers, professional trades, community workers, clerical workers, sales workers, machinery operators, and labourers. The main employers include the timber processing plant; sheep, cattle, and dairy farming; forestry; transport/haulage; engineering; Inframax, the roading company; and various trades (Statistics New Zealand, 2018). The town also has some major retail outlets (e.g., Countdown supermarket, Mitre 10, Gold Pine, and Mcdonald's) and many cafes and takeaway establishments. Accommodation within the township includes backpacking hostels, motels, holiday parks, caravan parks, batch rentals, and B&Bs. The OOtorohanga township has three early childhood providers, one kindergarten, four primary schools, one college, and a Kura kaupapa Maaori school and Kohanga Reo located in Oparure (13.9kms from the OOtorohanga township).

Healthcare Provision

OOtorohanga has only two major health and well-being providers. There is only one owner-operated medical centre, and the team consists of five GPs, seven practice nurses, two healthcare assistants, and 10 reception and administration staff. The GPs are diverse in ethnicity and only one is New Zealand born and is not Maaori (or Pacific). The Centre offers many services including diagnostics, contraception, smoking cessation, accident and emergency care, minor surgery, an express pharmacy, and Waikato Radiology is onsite two days a week (OOtorohanga Medical, 2022).

The Beattie Community Trust operates the town's sole retirement and residential care facility (Health Community Trust, n.d.). The facility includes 19 residential units, a 36-bed residential care facility, a 20-bed dementia unit, and two respite beds, and is managed by a Registered Nurse and a team of aged-care staff. Other health and well-being providers include a physiotherapist, a chiropractor, four gyms, a public swimming facility, two rugby clubs, a soccer club, a netball centre, a squash and tennis club, and one pharmacy.

Depending on their needs, people living in Te Rohe Pootae access the services in both OOtorohanga and Te Kuiti. There are also some local Maaori practitioners that offer mirimiri, romiromi, healing, and rongoaa, as well as Maaori and non-Maaori massage therapists across Te Rohe Pootae.

Transport

One of the major issues for rural and remote communities is access to the range of services that they need (Ministry of Social Development, 2021). Both districts do not have regular town bus services, such as those provided in the larger towns and cities. People living in the outlying communities that surround Te Kuiti and OOtorohanga (see Figures 6 and 7, and Appendix B) must transport themselves, although some are being serviced by a satellite doctor or mobile nurse service, or transportation operated by volunteer community members.

If people living in the Waitomo and OOtorohanga districts need specialist services, they must travel to the Waikato Hospital in Hamilton City - which is roughly a 1 hour and 15-minute drive from Te Kuiti, and 45 to 60 minutes from OOtorohanga. If a patient does not own a car, cannot borrow a car, and/or cannot afford petrol, they have the following options. One option is a bus service provided by Te Whatu Ora Waikato. This public transport service operates once a day and departs from Taumarunui township, from the neighbouring Ruapehu District, and is free for patients with appointments. Te Whatu Ora Waikato also provides transport to and from Waikato hospital for patients living in the Waitomo and OOtorohanga districts (Busit, n.d), and the Saint John organisation in OOtorohanga provides a daily shuttle service to the hospital as well (St John, n.d). Another option is to book a seat on the main line bus service that passes through OOtorohanga and Te Kuiti.

OOtorohanga is the community where I live today. I grew up in the small village of Tahaaroa also within the boundary lines of Te Rohe Pootae.

2.3 Ko Wai Au - Who am I

My name is Victoria Louisa Wikitoria Maikuku. My people are Ngaati Rereahu/Maniapoto, Waikato, Ngaati Apakura and Ngaati Te Ata. I grew up in the small remote community of Tahaaroa on the West Coast of the North Island. In that haapori, being related to everyone through whakapapa is normal, as was spending many days at our local paa - Aruka and Te Kooraha. Dad worked at the New Zealand steel mine, which opened in 1972, and on his days off he worked on the family farm. Mum worked around the house cooking and cleaning and washing the clothes by hand, and when dad was home mum was helping him on the farm.

At one time there were seven children (four are atawhai) in our three-bedroom house. We had a smelly long drop toilet, coal range stove, rainwater tank, and no hot water. However, with the arrival of the steel mine, everything changed. We connected to electricity and got an electric stove and lighting throughout the house, which was exciting. But we did not connect a hot water cylinder as our

water tank was insufficient to fill and heat the cylinder. So, we continued to boil our water in the big pot for washing, cooking, and cleaning. Sometimes the tank ran out of water so we would have to go to the neighbours with buckets to get water. Food was sourced from the land through gardens, farm animals, and nearby whaanau.

In the 1970s as a young child, I was always sickly. My mum wondered if I had caught a disease from the soil while I was a toddler. I spent three months in Te Kuiti hospital, the nearest at the time. Having no car meant that my parents had to leave me in the hospital, and they would visit me when they were able. Having no car meant that we were dependent on whaanau for rides to the nearest store or town - Te Kuiti, OOtorohanga, or Te Awamutu. Again, this all changed with the arrival of the steel mine, which contracted the Perry buses, which ran a weekly town bus service to Te Awamutu every Thursday, and a daily service to Te Kuiti.

When I was aged seven, my father was diagnosed with pancreatic cancer. Although there was a village nurse situated in Tahaaroa at this time because of the steel mine, Dad still had to make the epic journey to Waikato. My dad passed away that same year -1979, at the age of only 52 years. Although we struggled financially after Dad's passing, Mom was able to get a new home built in 1984 for us with the money that she and dad had saved. The home was 'flash' - hot water 'on tap', a flush toilet, a washing machine etc., life changed. However, we did not get a car until 1987, when my eldest brother could drive.

As I near my 52nd birthday, I reflect and understand what it means to live remotely, although I admit times have changed from when I lived there some 30 plus years ago, and some things remain the same. The positives of living and growing up in a small village are the connection with whanau and community, the connection to the land and growing up on one's marae. The negatives would be the distance and limited access to health services, and although the conditions I grew up with as a youngster may look like a disparity by today's standards, back then that was normal for us.

When I became a teen, it was time for high school which meant leaving Tahaaroa. During my first year at Napier girls high, I lived with my mother's sister and family. Then I came back to OOtorohanga College for the next year which meant that I could go home for the weekends. Although it was nice to go home for the weekends, the 'downfall' was that I was unable to play weekend sports due to the lack of access to a car. Furthermore, Mum moved to Kihikihi in my fifth form year and then on to OOtorohanga when I was in my sixth form year.

Today, I live in OOtorohanga with my husband, and we have three adult children and two mokopuna. My husband and I have always been passionate about health, fitness, and wellbeing. I am a qualified

personal trainer, massage therapist, healer and fitness instructor, and together we run community fitness classes. When I heard about this project, I quickly took the opportunity, not fully understanding what I was getting myself into. I heard that the topic was about finding the health aspirations and needs of Maaori and Pacific people and thought, 'I want to know this', so I applied.

Summary

Maaori health and wellbeing has been a contentious topic for many years and can be directly linked to colonisation and the arrival of the settler colonialists. Maaori lost everything including their language, customs, and connection to their lands. Today Maaori health and wellbeing continues, and the Aotearoa New Zealand Government is finally honouring its Te Tiriti o Waitangi obligations and is working with Maaori to bring about a change in the negative health statistics. The role out of the Te Aka Whaiora and Te Whatu ora are a step in the right direction. However, in order to achieve health equity for Maaori, Aotearoa New Zealand needs more healthcare workers. Statistics show that the two medical schools are not producing enough doctors to counter the growing population and needs of the people. Moreover, the schools are not producing enough Maaori doctors and non-Maaori doctors from rural and remote areas.

We need more doctors; we need a new medical school, and we want and need them now.

The services provided by the two rural service towns of OOtorohanga and Te Kuiti complement one another for the nearby smaller rural and isolated settlements. The two towns' combined services keep growing and expanding for the benefit of the surrounding communities and the townships. Both of these communities are beautiful and have a strong sense of interdependence among their residents. The bus services are essential for persons without cars to get to Waikato Hospital for specialised care, such as dialysis and cancer treatment.

Chapter 3 - Methodology

As a new postgraduate student, I found writing about research methodology intimidating but exciting. It was intimidating because my understanding of research methodology was limited, and I was unsure if I could articulate my methodological approach. I also worried about what my research methodology lecturers might think about my work. Interestingly, my concerns about what my lecturers might think also excited and inspired me because I knew that they would encourage me to be brave: "Take one step at a time, be brave…" (Linda T. Smith, personal communication, 2021). I am also inspired by the words of Te Puea Herangi: "Mahia to mahi hei painga mo te iwi." This is a reminder to put aside your worries and to get on with the work.

My research methodology papers also raised my awareness about our historical experiences with research and researchers. Historically, non-Maaori researchers developed a tradition that undervalues Maaori knowledge, processes, and practices (Bishop, 2010), and viewed Maaori as objects to be studied (Linda T. Smith, 2021). These traditions were a means of control, driven by a desire for power (Bishop, 2010) and have been questioned and challenged by leading Maaori academics such as Graham Smith, Linda Tuhiwai Smith, Russel Bishop and others. Their strength and courage have paved the way for the next and future generations of Maaori and other Indigenous researchers to be heard, our culture and knowledge to be seen, and our right to rangatiratanga (self-determination). Indigenous peoples now claim the right to sit at the table of academia and to challenge the status quo.

Introduction

This chapter describes my methodological framework and is presented in two parts. In Part One, I briefly explore what methodology is and then introduce Kaupapa Maaori: What it is, and what it means to and for me. In Part Two, I describe my *Te Pae Maunga o Kaakaamutu* methodological framework. This framework is based on my own health and wellbeing beliefs and practices and informs my conduct as a researcher of Ngaati Maniapoto descent.

3.1 Research Methodology

The term methodology has proved challenging to understand. Some writers refer to methodology as an approach (Leedy and Omrod, 2001), and others as a paradigm (Lincoln, et al, 2011; Mertens, 2010) or a worldview (Capaldi, & Proctor, 2005). The terms qualitative, quantitative, and mixed methods are also referred to as approaches and methodologies (Williams, 2007); while the terms positivism, constructivism, and interpretivism are referred to as approaches, paradigms, and worldviews as well

(Lincoln, & Guba, 1990). Positivism, constructivism, and interpretivism are also referred to as research methods, which adds further to the confusion regarding the term 'methodology' in research.

Moving from terminology to explanation, Babbie (2017) describes methodology as "the science of finding out" (p. 6). Being more specific, Leedy and Omrod (2001) describe methodology as "the general approach the researcher takes in carrying out the research project" (p. 14). Hart (1998) then explains that methodology "provides the starting point for choosing an approach made up of theories, ideas, concepts…." (p. 28). Approaches also comprise "a system of methods and rules to facilitate the collection and analysis of data" (Hart, 1998, p. 28).

Providing a simpler and more concise description, Linda T. Smith (2012), refers to methodology as one's theory about how research should be conducted. Methodology informs our selection of theories, concepts, and methods and how we behave as researchers (L T. Smith, 2012), and is informed by one's worldview or paradigm. Which brings us to Kaupapa Maaori.

Understanding Kaupapa Maaori Methodology

In her keynote speech at the Kei Tua o Te Paehui conference, Linda T. Smith (2011) said, "If I think about kaupapa Maaori as it was, as it is, and as it will be, in some kind of definitional framework I think it's really simple" (p. 10). Kaupapa Maaori as a methodological approach is "our language, our terminology" our way of being" (L. T. Smith, 2011. p.10). Kaupapa Maaori is underpinned by Maaori values, beliefs, strengths, ideas, and attitudes from a Maaori paradigm or worldview (L. T. Smith, 2015). Pihama, Cram, and Walker (2002) describe Kaupapa Maaori as capturing "... Maaori desires to affirm Maaori cultural philosophies and practices…." (p. 30). And more specifically, Wilson (2008) description of a 'paradigm' can be used to describe Kaupapa Maaori "... use[ing] our beliefs to guide the way that we conduct our research, which includes, the way we view reality (ontology), how we think about or know this reality (epistemology), our ethics and morals (axiology) and how we go about gaining more knowledge about reality (methodology)" (p. 13).

In a society that privileges western knowledge and ways of conducting research, Kaupapa Maaori challenges the status quo (Royal, 2012). Kaupapa Maaori gives Maaori a platform to voice their concerns and to share and to use their knowledge and apply Te Ao Maaori (a Maaori worldview) (Royal, 2012). Kaupapa Maaori is culturally safe (Irwin, 1994) and as a research approach gives research participants the power to exercise tino rangatiratanga (self-determination) (Bishop, 1999) - meaning that their cultural aspirations, practices, and beliefs guide the research process (Bishop, 1999). Kaupapa Maaori also addresses and highlights issues that continue to cause inequality for Maaori and

seeks solutions that lead to transformation and positive change (Royal, 2012). In short, Kaupapa Maaori research is research conducted "by Maaori, with Maaori, for the benefit of Maaori" (L. T. Smith, 2015).

Kaupapa Maaori is also fluid (Jackson, 2013; L. T. Smith, 2015). This adaptability and fluidity is illustrated in the following examples of Kaupapa Maaori frameworks: *Kaupapa Maaori Theory* as coined by Graham Hingangaroa Smith; *Kaupapa Maaori Research Methodology* as described by Linda T. Smith (1997); and the *Principles of Kaupapa Maaori* and *Ethics of Kaupapa Maaori* as devised by Moana Jackson. To illustrate, a brief description of these Kaupapa Maaori frameworks is provided below.

Kaupapa Maaori Theory

Since the 1980s Linda T. Smith and Graham H. Smith have been developing Kaupapa Maaori theory and Kaupapa Maaori methodology. The following framework was developed by Graham H. Smith, in which he identified six principles of Kaupapa Maaori within the context of kaupapa Maaori education:

- Tino Rangatiratanga - The Principle of Self-determination
- Taonga Tuku Iho - The Principle of Cultural Aspiration
- Ako Maaori - The Principle of Culturally Preferred Pedagogy
- Kia piki ake i ngā raruraru o te kainga - The Principle of Socio-Economic Mediation
- Whaanau - The Principle of Extended Family Structure
- Kaupapa - The Principle of Collective Philosophy. (G. H. Smith, 1997)

Kaupapa Maaori Methodology

Applying and expanding on kaupapa Maaori theory as a research methodology, Linda T. Smith developed a set of guiding principles for kaupapa Maaori research. In the 1990s, she began with the following set of principles:

- The Principle of Whakapapa - generally defined as genealogy
- The Principle of Te Reo - as being integral to Kaupapa Maaori
- The Principle of Tikanga Maaori - customary practices, ethics, cultural behaviours, considerations, and obligations
- The Principle of Rangatiratanga - autonomy, which allows Maaori to shape their own research processes. (L. T. Smith, 1997)

Intersecting with the above principles, Linda T. Smith (1996) also developed some important questions to be considered by the researcher and the Maaori communities that they work for and with:

- What research do we want to carry out?
- Who is the research for?
- What difference will it make?
- Who will carry out the research?
- How do we want the research to be done?
- How will we know it is a worthwhile piece of research?
- Who will own the research?
- Who will benefit?

Linda T. Smith also provides the following Kaupapa Maaori practices as a guide for Maaori researchers. She said that "these sayings reflect just some of the values that are placed on the way we behave.''

- Aroha ki te tangata - a respect for people
- Kanohi kitea - the seen face, (i.e., present yourself to the people in person)
- Titiro, whakarongo … korero - look, listen … then speak
- Manaaki ki te tangata - share and host people, be generous
- Kia tupato - be cautious
- Kaua e takahia te mana o te tangata - do not trample over the mana of the people
- Kaua e mahaki - do not flaunt your knowledge. (L. T. Smith,1999)

A number of Maaori researchers have adopted and employed Linda T. Smith's kaupapa Maaori methodological principles or Graham H. Smith's kaupapa Maaori theory (e.g., Currucan, 2021; Seed-Pihama, 2017). Others have been inspired and motivated to build upon their frameworks, and Kaupapa Maaori. (e.g., Pohatu, 1996; Clarke, 2020; Cram, 2001; L. Pihama, 2001). In considering my own methodology, another framework that has caught my attention is offered by the late Moana Jackson.

Ethics of Kaupapa Maaori in Research

At the *He Manawa Whenua Indigenous Research Conference,* Moana Jackson (2013) shared three short stories. These stories drew on and referred to Te Taiao (the natural world), whakapapa (genealogy), and his whaanau (extended family). The first story was about walking along the awa (river) at night; the second was about his maunga (mountain) and his koro (grandfather) and his last story

was about his mokopuna (grandchild) weaving a raurau (basket) with her Tuupuna (ancestor)[9] He then talked about Kaupapa Maaori and how it is fluid and enables us to explore and to *whai whakaaro* (follow the thought). Reflecting on these experiences, Jackson identified a set of 10 ethics. He refers to these ethics as being similar to the raurau (food basket) his mokopuna made for him, "inter-lapping and overlapping" (p. 59).

- Ethic of prior thought - Drawing on the wisdom of our ancestors
- Ethic of Moral or Right Choice - Research requires a moral focus
- Ethic of Imagination - There is joy to be had in our flights of imagination
- Ethic of Change - Seek transformation in the lives of those researched
- Ethic of Time - 'Maaori time'; there is value in this
- Ethic of Power - If knowledge is power, then we need to be really clear about whose knowledge we are defining
- Ethic of Courage - To research well we need to be brave
- Ethic of Honesty - In our research, be honest
- Ethic of Modesty - We must carry our knowledge with modestly
- Ethic of Celebration - Celebrate our knowledge, our uniqueness, and our survival!

Summary

What I have learned from these three leaders in Kaupapa Maaori theory and practice is that Kaupapa Maaori is not easy to define because it is 'a way of being' it is fluid and expansive. Consequently, Maaori academics and researchers have spent a lot of time trying to explain something that they inherently know. Kaupapa Maaori encompasses Maaori values, principles, beliefs, attitudes, and conduct. It is adaptable and changes according to our circumstances and needs. Kaupapa Maaori is a 'by Maaori, for Maaori, with Maaori' approach to research and is transformative. As a result, Kaupapa Maaori challenges the status quo of how research is conducted and should be conducted.

Inspired by the Kaupapa Maaori approach, I felt confident about developing a Kaupapa Maaori framework for my study because I was motivated by the aforementioned Kaupapa Maaori frameworks and their founders, and I recognised that they had provided a platform for future generations to establish, expand, and produce their own frameworks. My framework reflects and relates to me as a Ngaati Maniapoto woman engaged in Maaori health research.

[9] Refers to when Maaori sit down to weave it is generally noted that our Tupuna in spirit sit down to weave with us, we are never alone.

3.2 My Methodological Framework

Maunga (mountains) are one of the places I go to when I need to heal, recharge, and cleanse my body, mind, and spirit. When I need a 'blow out' - to push myself to complete exhaustion - I climb Pirongia, the second largest pae maunga (mountain range) in our rohe (tribal region). When I'm in need of spiritual replenishment and motivation, I climb either Ruapane or Kakepuku, and when I need a 'quick-fix' - a quick dose of endorphins and connection with the elements - I climb Kaakaamutu, a small pae maunga overlooking our town of OOtorohanga. When climbing maunga, I experience anything from excitement and enthusiasm to feelings of doom and dread. Initially, fears and excuses run rife, and to be honest, they continue to surface and fade throughout the ascent. I liken the climbing of maunga to everyday life and how we change throughout our day, and I now apply this experience and relationship in the construction of a guiding research methodology.

As mentioned earlier I had not been a healthy child, which led to illnesses as a teen and then adulthood. By the time I was in my late twenties-early thirties, I was on a mix of Prednisone and Hydroxychloroquine amongst other medications. By my mid to late thirties, I had had enough of the medications, and though I was grateful for them I was also aware of the toll they were taking on my body, mind and spirit and I needed to find a balance. This balance was found in combining holistic health modalities with the general medical care I was already receiving. I believe that the combination of both general and holistic health builds resilience, which leads to maintaining balance. Holistic health for me includes (but is not limited to) Chiropractic care, Reiki (Energy healing), Lomilomi (Hawaiian massage), healthy diet, exercise, meditation, and dietary supplements. Exercise consists of both gym and nature workouts. One particular nature workout that helped me obtain balance in my health at that time, and continues to help me, is walking or running over and around the Kaakaamutu pae maunga (range).

Te Pae Maunga o Kaakaamutu

The methodological framework for this study is based on my familial and health relationship with a local mountain. This is a place where I find sustenance; where my mauritau (balance) is restored, my mana (energy) is ignited, and I am immersed in Te Taiao (the environment). However, when I chose this maunga for my framework I knew it only as Mountain View. When I asked Uncle Tom Roa what its true name was, I discovered that this particular maunga is called Kaakaamutu, and is only one part of a pae maunga (mountain range). Uncle Tom explained to me that *Te Pae Maunga o Kaakaamutu* includes Kaakaamutu (aka Mountain View) and the smaller maunga of Maatai-Ata and Maatai-Whetu (personal communication, 2022).

Te Pae Maunga o Kaakaamutu (the mountain range of Kaakaamutu) stands at the northern end of the OOtorohanga township. Te Pae Maunga o Kaakaamutu was once an important source of food, materials, and resources for our ancestors. It was a lush bush that teemed with birdlife and was well known for Kaakaa (the Native New Zealand parrot). Today, most of the pae maunga is residential, and the public has access to the two remaining pockets of bush land known as 'the Rotary' and the 'Bob Horsfall' Parks (see Figure 8). At the base of Kaakaamutu stands the well-known tourist attraction, OOtorohanga Kiwi House. It was said that when a tree was needed for building purposes, our Tuupuna (ancestors) would listen for a particular pecking sound made by the Kaakaa bird, which alerted them to the readiness of the tree.

One of the stories about how Kaakaamutu got its name can be traced back to the time of our Tupuna, Te Kawairirangi (aka Te Kawa) and his pet Kaakaa. The bird had a deformed leg and was not mobile and was used to lure other birds. Te Kawa would tie the bird to a tree and the bird would cry out. Unaware of the danger, the other Kaakaa would flock to the lame bird to see what the commotion was about, only to be caught in the waiting traps. This is just one story about how Kaakaamutu got its name (Tom Roa, personal communication, 2022).

Maataiata

When our Tuupuna first arrived in OOtorohanga via the Waipaa valley, they climbed the small hill now known as Maataiata (Tom Roa, personal communication, 2022). From this vantage point, they could see the Waipaa and Mangaorongo awa (rivers) and all the surrounding lands now known as OOuruwhero, OOrahiri, and OOtorohanga. They named this hill Maataiata, and it was from there that they would witness the arrival of the ata (morning), gauge the weather and interpret the tohu of the Taiao (signs from the environment). From this vantage point sentries also watched people leave the area, but more importantly, for the approach of both welcome and unwelcome visitors. Standing upon Maataiata, they stood ready, alert and waiting, ever observant and watchful (Tom Roa, personal communication, 2022).

Maataiwhetu

Maataiwhetuu, also known as Tirotiro-Whetuu, means watching or observing (tirotiro/maatai) the stars (whetuu). This maunga was an observatory; a place to observe the stars and constellations, including Matariki (Pleiades) and Rehua (Antares). Maataiwhetuu was the other vantage point from where sentries watched people coming and going (Roa, 2005). Protruding from Maataiwhetu are two enormous koohatu (rocks); the first is known as Te Arero (the tongue) and the second as Te Taiaha

(the weapon). It was here that the Tuupuna paid their respects to the dead who had returned home amongst the stars (Temaimoa Te Whau, personal communication, 2022).

Figure 8: Kaakaamutu mountain range from above[10]

Figure 9: Maataiata and Maataiwhetu connect to the northeast end of Te Pae Maunga o Kaakaamutu. A road runs between Maataiata and Maataiwhetu. [11]

[10] Kaakaamutu from above [photo credit Amy Corston]
[11] Maataiata and Maataiwhetu [photo credit Victoria Maikuku]

Te Pae Maunga o Kaakaamutu: He Pae maunga, He Pae Oranga

In reflecting on my relationship with Te Pae Maunga o Kaakaamutu, I think about my Tupuna and how they understood their environment, surroundings, and connections to everything. They knew that different spaces provided different types of nourishment for their well-being: Body, mind, spirit, and family. Kaakaamutu was reserved for physical sustenance or food source sustainability and was where strategic thinking, planning and movement aided a person's physical energy and well-being. Maataiata was a space for mental sustenance; observation, clarity and meditation that nourished mental energy and well-being. Maatai-whetu was a place for spiritual nourishment; gazing at the stars, respecting the dead, meditation, and prayer, which aided in a person's spiritual energy and wellbeing. While always connected to one another, each maunga served a specific purpose. I think of Te Pae Maunga o Kaakaamutu as a whaanau (family), supporting one another and their descendants.

It is important to note that my framework is specific to *Te Pae Maunga o Kaakaamutu* because the other maunga that I visit offer different challenges and experiences.

Te Pae Maunga o Kaakaamutu methodological framework

Inspired by my whaioranga (well-being) relationship with Te Pae Maunga o Kaakaamutu, my framework is based on the stages in my run/walk. In examining my experience during these stages, I have identified a set of eight principles that I have applied to my research process. Like the pae maunga (mountain range), these principles are interrelated and do not stand/exist in isolation.

1 - Getting Ready

When I prepare for my run/walk, I think about the purpose and goals that I hope to achieve. I make a rough plan in my mind. Which track will I attempt? How am I feeling physically, mentally, and spiritually? Do I want to do a hard run, a mild jog or a nature walk? As I choose my clothing, I observe and check in with my physical body. Am I hydrated? Have I fuelled right? How's my breathing? I also check my motivation, attitude, and belief in self and sometimes a quick bout of self-doubt might occur at this moment - about whether I would rather sit on the couch out of sight. Lastly, I observe my energy levels, calling on inspiration and motivation.

Whakatika

To prepare, stand up, rectify, solve, amend, straighten, correct, and set out on a journey; decision, and decisive action (Te Aka, 2003a).

Whakatika is about preparation. Ensuring that you have everything you need before you undertake a task, set off on a journey or meet with someone for example. Preparation is also key in research: The project needs to be designed, the questions developed, relationships built, the literature reviewed - and all grounded in and informed by an appropriate methodology.

As a Maaori woman taking a Kaupapa Maaori approach to this study, Whakatika means checking in with myself. Am I the right person for this task? Do I have what is required? Will I be accepted by the community? When 'checking in' with myself, I reflect on my cultural beliefs, values, and morals, and these give me a better understanding about how to build relationships with the individual research participants and the haapori (community).

Whakatika is similar to Jackson's *Ethic of Prior Thought*, in relation to which he talks about the wisdom of the ancestors when making any preparation (Jackson, 2013). Expressions of Whakatika include turning to *Te Pae Maunga o Kaakaamutu* as my methodological guide, my teacher, and having conversations with and seeking guidance from kaumatua such as Uncle Tom Roa and whaanau members (e.g., uncles, aunts, cousins). Another example of applying the principle of Whakatika is reviewing both past and present-day literature.

2 - Arriving

Arriving at the base of Kaakaamutu I check in with myself again. I observe my surroundings, listening to the different sounds of the town and maunga. I look at the sky for the weather. I offer a karakia and acknowledge the ngahere (forest). The different tracks also appear in my mind's eye. I examine the ngahere and choose my path and make a mental note about how long my walk or run should take me. I am ready!

Matatika

To be ethical, fair, honest, impartial, and unbiased (Te Aka, 2003b).

Matatika is about being moral, fair, and open in everything you do. Also, being kind, caring and impartial. Knowing that there are certain customs, ethics and rules that need to be followed before moving forward.

As a methodological principle, Matatika also encompasses:

- Maramatanga (awareness) - an understanding of what needs to be done
- Tikanga (customs) - what is the correct way to proceed?
- Maatauranga (knowledge) - finding, acknowledging, and sharing knowledge
- Whanaungatanga (kinship) - thinking about existing and initiating new relationships

- Whakapapa (lineage) - acknowledging all sources of information
- Maatai (observant) - being observant and aware of one's surroundings

Applied in practice, Matatika guided and informed my literature review and the recruitment, interview, and analysis processes.

3 - Setting Off

I've started to run, one step after another. I focus on my intention and awareness. I am aware of my energy and find a rhythm in my breath and movement. The beginning of the climb has my mind racing about what I want to achieve. As I ascend, mental challenges materialise; bouts of doubt surface and my energy fluctuates. My physical body senses the mental challenge and my muscles tighten. I stop to stretch and reassess. I refocus then continue on my way - conscious that I need to be alert and able to adapt if anything unforeseen appears or occurs.

Urutau

To be adaptable and able to change (Te Aka, 2003c).

Urutau is about being adaptable and flexible. Meaning that there needs to be a sense of flexibility in whatever is being undertaken. Unforeseen circumstances can occur, leading to a change in plans where one may need to adjust or pivot.

In taking a Kaupapa Maaori approach to this study, I place research participants and the community members at the centre of everything. They have autonomy and control during the recruitment process, the interview and over their stories and information, which means I'm not totally in control of the process but follow their lead. The semi-structured interview method for instance, allows the interviewee or storyteller to take the conversation in different directions (Kallio et al., 2016); while an inductive approach to my analysis of their koorero (talk) means they are at the centre of the meaning-making, as opposed to a deductive approach wherein one seeks to test a preconceived hypothesis (Saldana, 2021. p. 40).

Urutau is related to Jackson's (2013) *Ethic of Change* wherein, *"*... research should be dedicated to transforming or changing the realities in which people live" (p. 62). In my study, I too seek and welcome change and transformation. As a novice researcher, I have also experienced a personal transformation in the course of this study. I have had to learn the processes of conducting research, to plan ahead but also be prepared for unforeseen circumstances. An example of an unforeseen circumstance was COVID-19, which disrupted my story collecting when our community became an epicentre of the outbreak. Some of my participants contracted COVID, and many did not want to meet

face to face until the threat had passed. Many therefore ‘pivoted’ and opted to talk with me via the Zoom platform.

4 - Almost there

I can sense that I am almost at the top. I am excited even though doubts circulate. I can feel the burning in my calf muscles and my breath is struggling. This is where the real mental and physical struggle is felt; where courage, capability and endurance are needed. I focus on taking one step at a time and pushing through the pain. I feel a burst of energy knowing that I am almost at the top. I push through with confidence and integrity.

Maaia

To be brave, bold, capable, confident, courageous and with endurance (Te Aka, 2003d).
Maaia is about confidence and encompasses the spirit and concepts of love, respect, and well-being.

Maaia was present throughout the entire research process and encompassed the following:

- Atua (Deity) - a reminder to connect, and with connection comes…
- Mana (energy) - and power, and when your energy is restored you will be…
- Tika (correct) - in your path of work, giving you…
- Kaha (strength) - to learn and endure, adding to your…
- Matauranga (knowledge) - of how everything connects through…
- Aroha (love, compassion) - love of self-first and then others and everything else, which gives you…
- Oranga (well-being).

In application, maaia was reflected in the practice of karakia. Being honest when I didn't understand and seeking clarity from others. Pushing through the tough times because I am doing this for myself and my people.

In relation to research, maaia is about being brave and having the courage and belief in self to undertake the mahi (work). Connection to cultural and personal values and beliefs and using them as guiding principles in all areas of the research process. Maaia means remembering who I am as a Maaori researcher, my whaanau and my whakapapa. A commitment to the principle of Maaia guided my use of the participants' koorero - to use it honestly and ethically and being transparent and courageous in the hope that our mahi (work) will bring about transformation. I relate the principle of maaia to Jackson’s (2013) *Ethic of Courage.*

5 - At the top

At the top of my chosen peak or ridge, although I am breathing heavily there is a sense of accomplishment, and I feel a surge of energy kick in from knowing that the hard work is done. I feel strong and confident, and my energy is in balance. Again, I do a quick check on my surroundings and acknowledge the hard work of making it here, but it is not over yet. I walk along the ridge, listening and taking in the view.

Maatai

To observe, investigate, examine, inspect, note and be aware (Te Aka, 2003d).

Maatai means to be observant and is constant in everything one does. Being aware and always taking notice of changes in environments and people and places to name a few examples.

Maatai was constant throughout the research process. As a researcher, I was always watching, exploring, investigating, and examining literature, stories, reports in the media, the experiences of whaanau and people in our community and my own experiences and assumptions. As an example, I became aware that just because I am from the community it does not guarantee me 'right of way.' Regardless of my relationships with the research participants, I still need to follow and observe correct procedures and protocol. Maatai was also present during recruitment, during which I was observant of and responded to the personal, cultural, and spiritual needs of the participants. For instance, I was aware of tikanga, cultural practices and that the majority of my participants may have preferred to have a karakia and whanaungatanga before beginning their interview, and a cup of tea and kai (food) at the end of the interview.

The principle of Maatai is similar to Jackson's (2013) *Ethic of moral or right choice* and Linda T. Smith's (1999), *Kaua e takahia te mana o te tangata* and also titiro and whakarongo.

6 - The descent

I begin my descent down the other side of Kaakaamutu. I am aware of my foot placement. This is not the time to be complacent. I feel light and happy. I observe everything with excitement, gratitude and appreciation while staying focused. This is where I see Maatai-Whetu, and then Maatai-Ata. I acknowledge them in silent admiration and appreciation as I head down to the flats. I liken them to two guardians cheering me on.

Kia Tuupato

To go gently, slowly, carefully, clearly, deliberately, purposefully, intentionally and cautiously (Te Aka, 2003e).

Kia Tuupato is about being thorough and working with purpose whilst also being careful, cautious, and considerate.

In research, Kia Tuupato is relevant in all research processes. To be mindful of the people, their beliefs and values, the sharing of their time and aspirations and being careful with their information, stories, and wisdom. Examples include the protection and storage of the participants' identities and information, correct citation sources, choosing the right methodological framework and methods.

Linda T. Smith (1999) also includes Kia Tuupato in her methodological framework. She emphasises being careful with your work, with your participants, and with the information that they share with you. She also places an emphasis on recognising one's responsibility in protecting and sharing information.

7 - On the flat

Finally, I am at the bottom and am feeling excited because the end is near. A last burst of energy kicks in as I consciously begin to check in with myself - body, mind and spirit. Everything feels good. I then move my thoughts to my surroundings, always mindful that I still need to be vigilant because I am not quite finished yet.

Mauritau

Composed, relaxed, serene, unruffled, deliberate and without panic (Te Aka, 2003f).

Mauritau refers to the absence of panic (Williams, 2000), being composed, relaxed and at one with self, others, and one’s surroundings.

In research, Mauritau can be achieved through deliberate reflection and observation of self and the context. The personal reflections I have included in this thesis have been part of my Mauritau process. Another example of Mauritau in action, includes the idea of sending the participants the interview schedule before the actual interview, so they are fully aware of what we are going to talk about, which helps them to relax and trust the process. There is no mystery, deception or ambushing. Sharing a kai and cup of tea is a form of manaakitanga that builds relationships, trust and Mauritau. Sending the participants regular updates in the spirit of being open and honest is also about nurturing Mauritau.

Mauritau intersects with Jackson's (2013) *Ethic of honesty, and Linda T. Smith's* (2012) principle of Tino Rangatiratanga in the sense that honesty and self-determination create an atmosphere of tau.

8 - At the End

At the end of my walk/run I observe my surroundings and a feeling of satisfaction runs through my being. I am glad that the run/walk is over and I am proud of myself and my achievement today. I silently acknowledge the taiao and the atua, an act of reciprocity. I am sweating and tired, but I also feel proud and empowered.

Utu

To seek revenge, reciprocity, to pay, respond, and answer (Te Aka, 2003g).

Utu in this context means reciprocity, meaning that balance is restored and maintained through an exchange of values.

In research, utu is critical throughout. Any researcher or research project that 'takes' and doesn't 'give' back is unethical. If only one party is benefiting, the research is not kaupapa Maaori (L T. Smith, 2015). A common example of utu in research is to acknowledge and thank the research participants and anyone else who contributed to the project. In terms of value, utu is not always about money or paying people - which implies that you have purchased and now own what you have bought. Depending for instance on the situation and context and how much has been given, a homemade koha (gift) is more meaningful than a voucher or other cash-based payment. Therefore, to express my gratitude I made konae (small woven flax bags), decorated with either a small wooden kooauau (flute) or a polymer hei tiki (pendant in the shape of a person), and filled them with a voucher and chocolate bar.

Through utu other principles are enacted including aroha (respect/love), mana (power) and mauritau (energy balance). A more meaningful example of utu and koha occurs in research when the participants agree to contribute for the benefit of others, including future generations.

Summary

Kaupapa Maaori is about self-determination, change and transformation; it necessitates reflection and permits artistic expression. Creating the Te Pae Maunga o Kaakaamutu methodological framework has taught me a lot of difficult and interesting things. It is challenging to write about something that one has only ever understood or felt inherently, thus there were many worries and concerns about how people would react to it. However, I was able to face and conquer these difficulties by pursuing Oranga (well-being), and in doing so, I felt whakamana (empowered), and my

tangata oranga was restored (personal well-being). This was made possible by my connection to and relationship with Kaakaamutu, one of the special locations I visit for my own growth and welfare on the levels of the spirit, body, and mind.

Chapter 4 - Methods

As I begin this reflection I think about the steps and processes I have undertaken so far. As a novice with no experience in research, I had hoped that the process would be somewhat straightforward with very few challenges. I can hear you laughing as you read this. Some might say that I was naive because the research process is anything but straight forward. However, for this mature student who has been shaped by the world, I have somehow managed to find a method to all this madness. It has been an experience where my life is forever changed, and my mind is aware and thus expanded.

Introduction

The purpose of this chapter is to report the methods and processes that were employed in the course of the research and process. This chapter comprises two parts. In Part One the research design is described. In Part Two the processes used in the study are described; lastly the chapter finishes with a summary.

As a reminder, academics in Te Huataki Waiora School of Health at the University of Waikato commissioned this pilot study in order to understand the health needs and aspirations of Maaori (and Pacific peoples) living in a rural and remote community in the King Country region, with a view to informing the future curriculum of a third Medical School. The proposed medical school could make a meaningful and significant contribution to the failing health system and counter the continuing health disparities for Maaori and Pacific people (see Chapter 2), and these disparities bring a sense of urgency.

For the purposes of the study, the three major research questions are:

1. What are the health experiences of Maaori living in Te Rohe Pootae?
2. What does 'rural and remote' mean for Maaori living in Te Rohe Pootae?
3. What are the healthcare needs and aspirations of Maaori living in Te Rohe Pootae?

Within these three major themes, other topics explored included the participants' thoughts about a third medical school, and what we should be teaching and training student doctors (see Appendix A for the full interview schedule).

4.1 Research Design

In this section, I describe my research design including my selection of recruitment, interview, and analysis methods. How these methods were employed is described in Part Two.

Exploratory Pilot

As mentioned above, this is an exploratory pilot study. Exploratory studies seek to investigate an issue that has not yet been researched or needs to be studied more in-depth. This type of research combines both structure and flexibility (Ritchie et al., 2014). Strengths of adopting an exploratory approach; In-expensive; flexible and adaptable; lays the groundwork for future studies and saves time in determining the types of worthwhile research. Weaknesses of exploratory research; the interpretation of the information in the qualitative study is subject to biases; samples may not give an adequate representation of the targeted population (Ritchie et al., 2014). Therefore, as a pilot study, the project team intends to conduct further surveys of other rural and remote communities.

Research Design

This project was designed by a group of academics from Te Huataki Waiora School of Health. Emeritus Professor Roger Strasser is the lead researcher and came up with the topic. The research team, also comprising Dr Apo Aporosa, Dr Gloria Hinemoa Clarke and Dr Nikki Barrett then designed the basic plan to interview Maaori and Pacific peoples living in a 'rural and remote' community near Waikato. Guided by the Project Co-Managers, in the spirit of partnership the pilot was conducted by two Masters Students, Janina Galweski and Victoria Maikuku under the close supervision of the Maaori and Pacific research team members, who offered a Maaori and Pacific perspective and recommendations for our health curriculum. The research was grounded in both Kaupapa Maaori research methodology, guided by Tikanga Maaori practices and principles and a Pacific methodological framework to ensure the needs and aspirations of our participants are at the centre of this research project. Both Janina and I conducted and led our own research.

'Insider' Research

As a descendant of Ngaati Maniapoto and conducting research about my people, my positionality was that of an 'insider'. Meaning that I share common ancestry, identity and language with the group that I intended to research (Asselin, 2003; Kanuha, 2000; Robson, 2002;). Being an insider, who is Maaori and a descendant of Ngaati Rereahu/Maniapoto does not give me instant access to researching my

community (Smith, 2012).[12] Relationships must be made, trust and respect earned, and transparency and honesty about the use of information needs to be clear. Updating the participants throughout the entire study process is important and for Maaori it is tika (correct) (Mercer, 2007; Teusner, 2016). This needs to occur before data collection begins (Smith, 2012). Some strengths of being an 'insider researcher' include, not being seen as a stranger, you're not inclined to create stereotypes, easier to gain acceptance, and can have deeper and more in-depth discussions with the participants. Some of the limitations of being an insider is that the researcher may be seen as an advocate rather than a researcher by the participants, the researcher may be biased in their findings and interpretations. The researcher may rely on participants that he/she already has a relationship with, and he/she could have a conflict of interest in the roles of interviewer and interviewee (Coghlan & Brannick, 2005; Brayboy, 2000).

Recruitment Methods

The project team made the decision to interview 30 community members. Seeking a balance of experiences and opinions, I then made the decision to seek out a balance of males and females including a balance of rangatahi (young adults aged 18 - 35 years old), pakeke (adults aged 35 - 65 years old) and kaumatua (elders aged 65+ years old). This balance across the age groups was to get a real understanding of what everyone's health needs and aspirations were, leading to a better analysis and interpretation of information.

To participate in the study, community members were to be of Maaori descent, residing within the Waitomo or OOtorohanga districts and willing to talk about their health aspirations and needs.

To achieve this target, a combination of snowball and targeted recruitment methods were employed.

The snowball method is a referral method, and it uses a participant's knowledge of whether they know anyone else who fits the criteria that may be interested in taking part in the study. Then if they refer someone, that person is asked if they could refer someone else and thus the number of recruits grows just like a snowball (Hennink et al., 2020). Strength of the snowball method is that you are able to reach populations that would otherwise be hard to reach; it is not expensive, and recruitment is usually easy. Weaknesses are that the researcher does not have control over the recruitment process and is dependent on referrals, and this may lead to samples not being achieved (Crouse & Lowe, 2018; Hennink et al., 2020).

[12] Research is a dirty word for Indigenous people, who were subjected to being studied by ethnographers. Refer to 'Decolonising Methodologies' Smith 2012, for more information about research.

Targeted sampling method is not random, as it is a flexible and purposeful method of recruitment that requires a strategy in order to achieve the assumptions of the study (Watters & Biernacki, 1989). Targeted sampling can help with the recruitment of a specific population group (Crane et al., 2020). Strengths of targeted sampling; it relies on existing relationships, improves recruitment by targeting specific populations, including targeted sharing of the study information via email, telephone, and word-of-mouth. Weaknesses are that targeted word-of-mouth recruitment is not a desired way to recruit participants as it may cause clusters of cases, however, targeting actually increases trust and encourages those who may not have otherwise wanted to participate to take part (Crane et al., 2020). The mistrust stems from researchers in the past and is well documented in literature, especially for indigenous people (Smith, 2012).

The reason for using targeted methods for recruitment in my study was the arrival of Covid-19 and being a local and active member of the community (see to Ko Wai Au, Chapter 2) meant that I already had connections and relationships with the people within the area of interest. This established relationship proved invaluable in finding participants when the snowball method was unsuccessful due to the pandemic. COVID-19 caused problems for data collection and the whole research process.

Recruitment methods also included four documents: A short information sheet outlining the purpose and aims of the research (Appendix C), and a more detailed information sheet (Appendix D) that included the study topic, the rights of the participants to take part in the research, confidentiality of name and personal information and what their shared information would be used for. A consent form to participate (Appendix E) and also a demographic questionnaire (Appendix F).

Qualitative Methods

Exploratory studies suit the use of qualitative methods as the research does not need a large number of participants to meet the goals of the study; the focus is more on the quality of data being collected. Saturation occurs when no more new evidence is identified, or the participants are all saying the same thing. Strengths - qualitative data is inexpensive, has no defined structure and is flexible. Weaknesses - results are inconclusive, the qualitative data may be difficult to understand, and the analysis of the data may also be biased (Henninik et al., 2020).

A common qualitative research method is the semi-structured interview. Semi-structured interviews are based on a particular topic and an interview schedule allows for flexibility in the conversation between interviewer and participant. This means that the participant guides the conversation leading to more in-depth sharing of information (Rubin & Rubin, 2012). This can prove invaluable with earning

the participant's trust and aiding in transparency of sharing information between the interviewer and participant (Kallio et al., 2016). Some limitations to semi-structured interviews include a number of drawbacks: conducting an open-ended interview with responders takes a lot of time. It calls for a lot of resources. Can be difficult to perform the interview properly (Galletta & Cross, 2013).

The interview methods also included a demographic questionnaire (Appendix F) and in the spirit of the principle Maaia, the interview schedule was distributed before the interview took place so that the participant had an idea of the questions (Appendix A).

Analysis Method

For this exploratory and qualitative study, the chosen analysis method was thematic analysis. Thematic analysis summarises qualitative data using longer, rather than shorter codes in its phrases and/or sentences (Auerbach & Silverstein, 2003; Boyatzis, 1998; Smith & Osborn, 2015). The approach's adaptability and flexibility opens up a wide range of extra analytical possibilities. It is a simple to use method that is quick to understand, has a timely interpretation that is backed up by evidence. It is accessible for researchers with little or no prior experience in qualitative research, and pertinent to study topics that go beyond a person's specific experience. In contrast, although thematic analysis is adaptable, this adaptability may result in inconsistencies and a lack of coherence when creating themes from the study data (Auerbach & Silverstein, 2003; Boyatzis, 1998; Smith & Osborn, 2015).

For the purpose of my study, I adopted a combination of focused, in-vivo, holistic, and values coding methods (Saldana, 2021). The process is described in the next section. The analysis process also included a transcript release form (Appendix G).

Ethics

Ethics approval was granted for this study by the Human Research Ethics Committee of the University of Waikato on 12th July 2021 (Appendix H). All ethical requirements as specified by the Ethics Committee were followed during the study, as were the principles of whakatika, matatika, and kia tuupato (see Methodology Chapter). The participants' transcripts were stored on the University of Waikato password protected network, and their paper-based consent forms, transcript release forms, and questionnaires were stored in a locked office.

4.2 Research Process

Recruitment Process

People who showed an interest in being interviewed were sent by email (Appendix I) a short information sheet (Appendix C) outlining the purpose and aims of the research. Community members who then agreed to be interviewed were sent a more detailed information sheet (Appendix D) and a consent form (Appendix E) which stated that pseudonyms would be used to keep their identity confidential. Rather than gathering demographic information at the start of the interviews or as part of the interviews, a demographic questionnaire (Appendix F) was developed and included with the second information sheet and consent form. And in the spirit of whakatika, matatika, maaia and mauritau (see Chapter 3), the interview schedule was also included. This act of transparency engendered feelings of trust and demystified the process and event and meant that there were no surprises. Once the participant had set a day and time and whether they wanted a zoom, telephone or kanohi ki te kanohi interview a confirmation email was emailed out (Appendix J).

Interview Process

A logistics interview checklist (Appendix K) and planner interview schedule (Appendix L) were created to help with the interview preparation and process, which relates to whakatika (see chapter 3). In the spirit of matatika and mauritau (see Chapter 3), the one-off semi-structured interviews began with a karakia (prayer or incantation) and were followed by whanaungatanga (relationship building). When we were ready to begin the interview part of the visit, I explained the purpose of the research, briefly highlighted some key points in the consent form - including the option to withdraw themselves and/or their koorero (talk) from the research - and then participants were asked if they had any questions. This was how all the interviews were conducted both in person and via zoom or telephone.

At the end, and sometimes before the in-person interviews a cup of tea and kai was shared as reciprocity for the time and space provided by the participant. This relates to the principles of whakatika, matatika, urutau and utu (see Chapter 3).

The interviews were recorded with the permission of the participants and were transcribed verbatim. Two of the transcripts were transcribed using the Otter software, however I found it to be inefficient as it took just as long as transcribing it myself to check and edit the transcript. Each transcript was returned to the participant to review and check over, and they were asked to return it with a signed

release form (see Appendix G). All requested edits were actioned in the digital copies of the interviews. This met the principles of maatai and matatika.

In the spirit of utu (see Chapter 3), each participant received a small koha/token of my appreciation. This relates to the principles of mauritau and utu.

Research Participants

In total, I recruited and interviewed 30 Maaori community members who reside within Te Rohe Pootae. As outlined in Table 1, these community members lived across the rohe, including Te Kuiti (n=11), OOtorohanga (n=5), Waitomo (n=4), Tahaaroa (n=3), Hangatiki (n=2), Piopio (n=1), Mokau (n=1), Kinohaku (n=1), Oparau (n=1), and Kawhia (n=1). The two rangatahi who are currently studying in Hamilton and Christchurch, were both born and raised in Te Kuiti and were home when they were interviewed.

Fifteen of the interviews were conducted kanohi ki te kanohi (face to face); two were conducted via telephone, and 13 interviews were conducted online using the Zoom platform. Three of the interviews consisted of two whanau members each and they were conducted via zoom. The time for each interview varied from 30 minutes to two hours depending on the participant and what they shared.

The research group comprised 11 males and 19 females and included five kaumatua (65+), 17 pakeke (35-65 yrs), and eight rangatahi (18-35yrs).

Seventeen of the participants recorded that they were either married or in a relationship while thirteen were single.

Some of the participants had lived in Te Rohe Pootae all their lives, while others had moved around or moved into the area from somewhere else. The occupations listed in the questionnaire were diverse and ranged from kaiako (teachers), mining, farming, students, coordinators, healers, artists, railways, roading, pound control and media person. Two were retired and one person omitted to answer the question.

While the research focuses on tribal lands of Ngaati Rereahu/Maniapoto and Ngaati Mahuta ki tai, the participants' whakapapa is diverse. Seventeen of the interviewees had tribal affiliations to Rereahu/Maniapoto, three did not answer the question, while the remainder had affiliations to other tribal areas. Another interest was that some of the participants are immersed in Te Ao Maaori and speak Te Reo Maaori, while others have little or no connection to their culture.

Table 1: Participant demographic information (by order of age)

Gender	Age	Marital Status	Residential	Born/Raised	Tribal Affiliation
F	22	Relationship	Te Kuiti	Hamilton, TeKuiti	No answer
F	23	Relationship	Christchurch	Hamilton, TeKuiti	Maniapoto
F	23	Single	Te Kuiti	TeKuiti	Rereahu, Maniapoto
M	25	Single	Hamilton	TeKuiti	Rereahu, Maniapoto
M	30	Married	OOtorohanga	Marokopa, OOtorohanga	Ngati Maniapoto
F	31	Single	Waitomo	Blenheim	Ngati Maniapoto, Ngati Kuri
F	31	Married	OOtorohanga	OOtorohanga	Te Atiawa
M	34	Relationship	Piopio	OOtorohanga	Te Arawa, Tainui
M	40	Single	OOtorohanga	Huntly	Waikato
F	40	Relationship	Waitomo	OOtorohanga	Maniapoto
F	40	Married	Taharoa. Kawhia	OOtorohanga	Ngati Mahuta
M	41	Relationship	Te Kuiti	Te Kuiti	Maniapoto
F	43	Single	Te Kuiti	OOtorohanga	Maniapoto
F	43	Relationship	Te Kuiti	Taihape	Maniapoto, Tuwharetoa
F	44	Single	OOtorohanga	Raetihi	Rereahu, Te Ihingarangi, Maniapoto
M	45	Relationship	Hangatiki	OOtorohanga	Maniapoto
F	45	Relationship	Te Kuiti	Whanganui, TeKuiti	Ngati Rangi, Ngati Tuwharetoa, Ngati Kahungunu, Rongomai Wahine
F	46	Relationship	Waitomo	Rotorua	No answer
M	50	Relationship	Oparau	TeKuiti, Coast	Ngati Mahuta
F	51	Single	Mokau	Te Kuiti	Ngati Maniapoto
M	50	Married	OOtorohanga	OOtorohanga	Ngati Maniapoto
F	50	Relationship	Taharoa	Taharoa	Mahuta

Table 1 (cont.)

M	52	Married	Te Kuiti	Te Awamutu, Taharoa	Waikato, Maniapoto
F	53	Single	Te Kuiti	TeKuiti	No answer
F	59	Single	Te Kuiti	Te Kuiti	Ngati Apakura
F	60	Single	Taharoa	Kinohaku	Maniapoto
F	68	Defacto	Kinohaku	Te Kuiti, Te Anga	Ngati Apakura, Mahuta
F	69	Single	Waitomo	Te Kuiti, Waitomo	Ngati Maniapoto, Haua, Paoa, Tainui
M	72	Single	TeKuiti	TeKuiti	Tuwharetoa, Tainui
M	80	Single	Hangatiki	Te Kuiti	Maniapoto

Other demographic questions asked about their occupations, housing situation, health status and conditions and where they access healthcare. Occupations ranged from road, rail and farm workers to teachers, coordinaters and tertiary students amongst others. Ten participants were renting their home and others did not answer this question. The number of occupants in a home ranged from (n= 2-7) family members per household. The Healthcare providers that the participants were registered with were Te Kuiti medical centre (n=12), OOtorohanga medical centre (n=11) and Maniapoto Whanau Ora centre (n=2), while the 2 did not answer the question and the other 3 participants were registered elsewhere. Health status conditions that were listed by participants were diabetes and cancer, which are referred to as major health conditions for Maaori (Moxon, as cited in University of Waikato, 2022).

Analysis Process

Adopting a thematic approach to analysing the interview material, I employed the following coding methods as described by Saldana (2021).

In the first cycle of coding, I employed a focused coding method. Using coloured pens, I highlighted text/koorero on the printed transcripts that were related to each of the interview questions. Using a pen, I also wrote observations and thoughts in the margins. Next, I opened the digital copies of the transcripts, and copied and pasted the highlighted sections into separate Word documents for each

of the higher-level themes of Health, Rural, Remote, Healthcare needs, and their respective questions. Key to this was ensuring that every section of koorero included the initials of the speaker.

In the second cycle of coding, I read each of these documents and deleted and/or replaced with ellipses (...) anything that was not related to the research, that particular question, or had already been said. Using a combination of in-vivo, holistic, and values coding methods, interesting quotes were copied and added to the bottom of that question, where I also wrote a summary of what the different participants were communicating, and the patterns I was beginning to see, including the values the community members were expressing and referring to.

In the final round of analysis, I used my codes and notes to identify the emergent major and minor themes and using these began to craft my findings chapter. The very minor themes were saved in a separate file.

Challenges

In the original project timeline, the interview part of this study was scheduled to begin October 2021. However, in that month New Zealand was at the height of the COVID-19 outbreak pandemic, and thus posed the greatest challenge to completing the research and my thesis.

The first obvious challenge was the multiple lockdowns, which meant our initial plans to facilitate whaanau interviews could not proceed unless whaanau were willing to gather in a virtual space. A related challenge was the fear and stress that the pandemic has caused, particularly in our communities which at that time were reporting a high number of active cases. In short, the pandemic kept us home and the related stresses and challenges occupied our thoughts more than anything else. While some of the community members who had agreed to be interviewed were happy enough to do their interview over the phone or zoom, a number chose to postpone until a later date, and this was of course accommodated; while a small number of them actually contracted the virus and were too unwell to be interviewed for some time. On the upside, our small rural communities pulled together and did what rural communities do best - they helped and supported those that were in need. Produce was washed and delivered to homes, and notes were left in their mailboxes asking if the whaanau inside needed help. Thus, in the spirit of urutau, the project team adjusted the timeline, and I adjusted my approach and invited people to be interviewed online or by phone and took their lead on how they wanted to proceed. And while the entire process was drawn out by another three months, the project is now complete.

Summary

In the first part of this chapter, I identified and described the key elements of the research design. An exploratory study crafted to hear the thoughts and opinions of Maaori living in Te Rohe Pootae (see Chapter 6). The design included targeted recruitment, and the qualitative method of semi-structured interviews and thematic analysis. In the second part of the chapter, I described the research process including the recruitment of 30 community members, the interviewing process, and an analysis process that employed a combination of thematic coding methods. The greatest challenge was that this study was designed before and implemented during the early stages of the COVID-19 pandemic, which therefore required patience, understanding and empathy from all those involved.

Chapter 5 - Literature Review

As a new postgraduate student ready to tackle my literature review, I could relate to Indigenous writer Shawn Wilson (2008) when he said, "I find myself now in territory where I'm not sure how to tread" (p. 43). However, being a member in a project team meant that the first step was already completed for me. The original working title for the project was 'Creating Culturally Responsive Doctors: Health Aspirations of Maaori who live in Rural and Remote areas' and provided some ideas for the key terms and overall focus for the literature review. Breaking the working title down into its parts - the following questions came to mind. Why do we need to 'create' culturally responsive doctors? What are the health aspirations and needs of rural and remote Maaori? Do they want 'culturally responsive doctors'? As a school, are we 'creating' doctors or 'growing' doctors, or something else? These were some of the questions that I asked myself.

Introduction

This chapter has two parts. In Part One, I define and briefly explore the key concepts and terms that frame the research. In Part Two, I then reflect on the key themes that emerged during my review of the empirical literature related to the research question: What do Maaori who live in rural and remote areas want from their doctors?

5.1 Key Concepts

Before I explore the empirical literature, it is important to understand the key terms and concepts that underpin the study. These key terms/concepts are health and well-being, rural and remote, and health disparity, and health (in)equity.

Health & Well-being

Jones (1994, as cited in Henry, 2001) states, "Providing a clear definition of health is difficult due to the wide individual, social and cultural interpretations" (p. 1). Setting the standard for its member countries, the World Health Organization (WHO) (1948/2021b) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (para. 1). Working across the New Zealand health sector to deliver better health outcomes for New Zealanders, the Ministry of Health (2016a) states, 'good health' "start[s] in childhood and continuing throughout the life course, requires investment in prevention and interventions that make the environment in which children grow, learn and play a healthy one" (p. 4).

Often connected to the term health is the concept of well-being. The WHO (2021a) defines well-being as:

> … a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic, and environmental conditions. Well-being encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose. Focusing on well-being supports the tracking of the equitable distribution of resources, overall thriving, and sustainability. A society's well-being can be determined by the extent to which they are resilient, build capacity for action, and are prepared to transcend challenges. (p. 10)

Tangata Whenua have a different view on health. The common terms often used in reference to or in place of the English words and concepts of health and well-being are oranga, hauora, and whaiora. Oranga can mean livelihood, welfare, health, and living (Moorfield, n.d.a), while Ora refers to the state of being alive, well, cured, healthy, fit, healed, or in a state of well-being (Moorfield, n.d.b). Related to oranga is the term Hauora, which can mean to be fit, well, healthy, vigorous, and in good spirits (Moorfield, n.d.c). Hauora also encompasses physical and spiritual well-being and wellness (Hui Whakaoranga, 1984). Also related to oranga is whaiora. Whai means to chase, pursue or search for (Moorfield, n.d.d), and when joined to Ora, it refers to the pursuit of health and well-being.

From a Maaori perspective, hauora is holistic, and balance is necessary for true well-being to occur (Cram et al., 2003). Connected by whakapapa (genealogy), Maaori have a familial and spiritual relationship with the taiao, the natural world (Williams, 2004), and the lore of utu (reciprocity) and whakaute (respect) - when honoured - creates tau and painga (balance and well-being) for the tinana (body), hinengaro (mind), wairua (spirit), and whaanau (family) and hapuu (whole community) (Durie, 1994b).

To help Paakehaa healthcare workers understand the Maaori worldview in relation to hauora, Sir Mason Durie developed the health model known as Te Whare Tapa Whaa (Hui Whakaoranga, 1984). This conceptual framework was first presented in 1982 at a hui held at the Rahui Tane Hostel in Kirikiriroa (Hamilton) in discussion with the Maaori Women's Welfare League in relation to their research project, Rapuora (Durie, 1998c). Te Whare Tapa Whaa refers to the four (whaa) walls (taha) of a building or house (whare), and as a metaphor, uses the common understanding that a strong house has four strong and equal walls or sides (tapa/taha) (Hui Whakaoranga, 1984; Durie, 1998c; Heaton, 2015). However, if one or more of the walls are weak or its integrity damaged, this will have

a negative impact on the overall structure of the whare. The four taha of this Maaori health model are: tinana (body), hinengaro (mind), wairua (spirit), and whaanau (relationships). The image often used for Te Whare Tapa Whaa is a wharenui, the large (nui) house that stands at the centre of a marae (tribal meeting grounds) which are often a physical, metaphorical representation of an important ancestor (whare tuupuna). Te Whare Tapa Whaa thus represents the health status of both the individual and the collective, i.e., whaanau, hapuu, and iwi (families, clans, and tribes) (Durie, 1984).

While the term hauora is being increasingly used in place of the term's health and/or well-being in New Zealand society, there are tensions. For instance, Heaton (2011) argues that the use of the Te Whare Tapa Whaa framework and its concepts for the English-Medium Health and Physical Education (HPE) curriculum - which conspicuously excludes wairua - "need to go beyond their simplified interpretations'' (p. 1). She points out that 'the whare' is more than its four walls; at the least, it should include whenua (land) and the taiao (natural environment), while the walls represent a Maaori worldview in which whaanau, for example, is more than 'family' but also encompasses concepts such as "whaanau, hapuu, iwi identities located in geographical landscape" (p. 4).

Integral to a Maaori hauora perspective is rongoaa Maaori (Durie et al., 1993), "a traditional system of healing that [has been] passed on orally" (Jones, 2000, p. 1). Some Maaori continue to use rongoaa today, and with an increased interest in its revival and sustainability, there have been 'calls' to formalise rongoaa practices. Further to this, the announcement of a *Therapeutic Products Bill* to regulate pharmaceutical and natural health products manufactured, tested, imported, promoted, supplied, and exported (Martin, 2022) has been met with some resistance. Rongoaa practitioners have concerns about what the Bill means for them. For instance, rongoaa practitioner Charlotte Mildon (as cited in Martin, 2022) raises the point that "...they're only asking one person with one organisation sitting at the table with them doing the decision making. None of the other healers from other rohe. We have a right to say what it is we want for our healing and how it goes for each whānau, for each hapuu" (para. 3). In short, if rongoaa Maaori is to be formalised, there needs to be more hui conducted with iwi and practitioners because they will have their own views about what can and should not be 'formalised.'

For the purposes of this exploratory study, the project team uses the term 'health' in its most generic sense to include all the terms above, i.e., well-being, hauora, oranga, and whaiora. I also expect that my research participants will use all of these terms and refer to the use and/or practice of rongoaa.

Rural & Remote

Internationally, there is also no clear definition for the concept of 'rural and remote' (Whitehead et al., 2022). The American Census Bureau (2017) describes 'rural areas' as sparsely populated, with low housing densities that are far from urban centres (Whitehead et al., 2022). Statistics Canada (2022) classifies 'rural areas' as small towns, villages, and areas with populations that are less than 1,000 people and describes them as areas that contain agriculture and undeveloped lands and estate lots. Closer to home, the Australian Institute of Health and Welfare (2022) states that "the terms rural and remote encompasses all areas outside Australia's major cities" (p. 1); while the Australian Statistical Geography Standard (ASGS), employing census data and relative access to services, has divided the country into the following "five levels of remoteness": major cities, inner regional, outer regional, remote or very remote areas (Australian Bureau of Statistics, n.d.)

Here in Aotearoa, the original New Zealand Standard Areas Classification system (1992) focused on population numbers (Ministry of Health, 2012; Goodyear, 2005a). Populations of 30,000 or more were classed as main urban areas, areas with a population of 10,000 to 29,000 were referred to as secondary urban, populations between 1,000 and 9,999 were called minor urban, while communities or settlements with fewer than 1,000 residents were classed as rural (Goodyear, 2005a). There was no remote classification.

In 2004, the New Zealand Standard Areas Classification was replaced by the Statistical Standard for Geographic Areas 2018 (SSGA18). Statistics New Zealand SSGA18 classification allows for the location of statistical units, such as houses, persons, or enterprises, to be associated with those units' activities (Statistics New Zealand, 2004a). Characteristics of rural and remote communities in New Zealand can be identified using the following concepts: geographic isolation, population sparsity, access to healthcare services, and distance (Blattner et al., 2020; Fernley et al., 2016).

Without consistent definitions, there is a definite need for a review to gain clarity (Fernley et al., 2016; Hauora Taiwhenua, n.d.). Whitehead et al. (2022) state that "In health contexts, a fit-for-purpose definition permits the accurate monitoring of the health of rural populations. This may identify rural-urban health inequities, providing the impetus for targeted strategy, policy, and interventions for the equitable allocation of resources" (p. 24). The development team conducted a mixed methods study to develop a five-level geographic classification for health (GCH) "that embraces both the technical and heuristic aspects of rurality" (p. 35). Their research project is funded by the Health Research Council of New Zealand, and with the completion of the first level, the data will be thoroughly analysed

to uncover and identify any differences that may have been missed through general classification in the second phase, which will be focused on health outcomes (Whitehead et al., 2022).

For the purposes of this study, the research team conducted a survey of 'rural and remote definitions and classifications and made a list of rural communities in and around the Waikato region that service more remote communities. On the list, Te Kuiti and OOtorohanga were identified as rural and servicing remote communities such as Tahaaroa and Waitomo. In my interview for this project, I was asked to comment whether OOtorohanga (my community) is 'rural and remote' (yes). As a team, and from a kaupapa Maaori perspective, we also discussed and agreed that the research participants should be invited to comment on whether they consider their town or village as rural and/or remote (refer to Chapter 6).

Disparity & (In)Equity

The concepts of health disparity and health (in)equity are intertwined; are common terms used in the health sector and require greater clarity (Braveman, 2014). On their own, 'disparity' refers to a variation, difference, or inequality (Merriam-Webster, 2020a); 'inequity' refers to injustice or unfairness (Merriam-Webster, 2020b); while 'equity' refers to fairness, justice, and impartiality (Merriam-Webster, 2020c).

When applied to health, health disparity can be described as "a particular subset of health differences that are closely linked to social advantage and disadvantage" (Braveman, 2014, p. 38). In a similar vein, 'health inequities' are unfair "differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age" (WHO, 2018, para. 4).

In short, health disparities and health inequities are about social justice (Braveman, 2014; Ministry of Health, 2019). The goal, therefore, is health equity, i.e., a world in which "no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged" (Office of Health Equity, n.d, para. 1), and as a measure, "a reduction in health disparities… is evidence that we are moving toward greater health equity" (Braveman, 2014, p. 38).

Equity is also about tailored approaches and solutions. The New Zealand Ministry of Health (Ministry of Health, 2018b) acknowledges that "Equity recognises different people with different levels of advantage may require different approaches and resources to get equitable outcomes' ' (para 2). Regional healthcare provider, Te Manawa Taki (2020) states that equity for Maaori is "the integration

of Te Ao Maaori into policy writing health models of care and system designs, encompassing maatauranga Maaori, values, customs and beliefs'' (p. 2) and

> ...aligns with all Articles and Principles in Te Tiriti o Waitangi, in particular Article III (which has an Equity focus) and the Principle of Equity. It is also aligned with the United Nations Declaration on the Rights of Indigenous Peoples, which affirms the rights of Maaori to determine, develop, maintain, access, and administer their own institutions, programs, medicines, and practices that support optimal health and well-being. (Te Manawa Taki, p. 2)

This definition also aligns with the Wai 2575 principles from the Health Services and Outcomes Inquiry (see Context Chapter).

For the purposes of this study, I acknowledge that Maaori living in rural and remote areas are doubly disadvantaged. Maaori, in general experience greater health disparities and, therefore, poorer health outcomes than non-Maaori (Durie, 1998c; Elers, 2014; Nixon et al., 2021; Moxon, as cited in University of Waikato, 2022), while people who live in rural or remote areas also experience greater disadvantage than people who live in urban areas (Lawrenson et al., 2016; Kiuru et al., 2021) where they have access to a wider selection of employment opportunities and health care services (Ministry of Health, 2012; Lawrenson et al., 2016; Furtunescu et al., 2020). However, while these disparities exist, in the spirit of the principle of Urutau (see Methodology Chapter) I have come into the study with a strengths-based lens in the sense that I'm looking for solutions, ways to uplift our people, and to challenge the negative view of Maaori that is connected to such terms.

In the next section, I present my (selective) examination of the relevant empirical literature.

5.2 Exploring the Literature

In this part of the chapter, I describe the strategy used for the literature review and the key themes that emerged in the course of that review.

Search Strategy

In relation to the research question: *What do Maaori living in rural and remote communities want in their doctors?* my search for literature initially focused on Maaori health in rural and remote communities. When these searches revealed very little has been written about this topic, I extended my search by deleting 'Maaori' - which became inclusive of international studies. My primary sources

included Google Scholar and the University of Waikato's digital library discovery layer known as *Library Search*, which included relevant journals such as the Journal of Rural Health and the Journal of Rural and Remote Health. Filters included the date range of 2010-2022, peer-reviewed sources, and excluded reviews. Generic searches were also conducted using the Google search engine and led to the discovery of international and national government agency websites and their publications and media stories that referred to various reports and organisations. A sample of my key search terms and combined results are listed in Table 2 but do not include the thousands of Google 'hits'.

Table 2: Sample of literature search terms and results from Library Search

Boolean Search of University of Waikato Library Serach	**Combined results**
"rural and remote" + Maaori	101
"rural and remote" + Maaori + "want from healthcare professionals"	0
"rural and remote" + Maaori + "healthcare professionals"	8
"rural and remote" + "New Zealand Maaori" + healthcare	44
"rural and remote" + Zealand + "Maaori Doctor"	16
"rural and remote" + Zealand + healthcare	929
"rural and remote" + people + "want from doctors"	15
"rural and remote" + doctors + "community needs"	236
"rural and remote" + people + healthcare + attitudes	58

The review process involved four steps:

1. Exclude documents with headings that are clearly not related to rural and remote health and delete duplicates.
2. Read the abstracts of the remaining documents, exclude anything that is not relevant, and group similar topics and research.
3. Read the most relevant and/or interesting articles and use key information, such as location, participants, research methods, and findings, to populate tables.
4. Use the information in the tables to identify patterns and themes.

Key themes in the literature

My search revealed that the healthcare problems that Aotearoa New Zealanders face are global problems. The search also highlighted four themes of particular relevance and interest: our similar health and workforce issues, poorer health outcomes, concerns about the elderly, and what constitutes a 'good' rural doctor.

Workforce Shortages

Worldwide, there is generally a shortage of healthcare professionals (Scheffler & Arnold, 2019), and even more so in rural and remote communities where they struggle to maintain and keep a professional healthcare workforce (Dymmott et al., 2022; Dywili et al., 2012). In their physician workforce shortage forecast, Zhang et al. (2020) predict that current shortages in America will continue to increase and will reach a national deficit of 139,360 by the year 2030; while rural areas will have fewer than half the physicians available in urban areas (Redford, 2019). In the UK, there are currently an estimated 27.5 million appointments in general practice; however, the number of qualified full-time GPs continues to decline and stands at a mere 27,627 (United Kingdom Parliament, 2022); while only 13% of consultants appointed in England in 2021 went to hospitals serving rural and coastal areas (Rural Service Network, 2022). There are multiple reports that Australia is also experiencing and predicting impending shortages of GPs in both metropolitan and rural areas, with particular concerns about retiring GPs and the oversupply of specialists (Australian Government Department, 2021).

As mentioned previously, we find ourselves in a similar situation here in Aotearoa. In the 2021 GP Future Workforce Requirements Report (Grimmond et al., 2021), it is estimated that in 10 years, New Zealand will be short 300 GPs, and states that "10 extra GPs per 100,000 population reduces the probability of cancer, respiratory and cardiovascular deaths by around 1%" (p. 14), saving the economy 139.6 million annually. The Royal New Zealand College of General Practitioners (2021) states that specialist GPs are a workforce in crisis as well. Moreover, these current and impending shortages are pronounced in rural and remote areas (New Zealand Doctor, 2021). Servicing rural and remote communities has been identified as a priority by a number of agencies and education providers, including the New Zealand Rural GP Network (Williams, 2019), the Rural Health Network (Hauora Taiwhenua, n.d.), Royal New Zealand College of General Practitioners (New Zealand Doctor, 2021), Te Whatu Ora and Te Aka Whaiora (Te Whatu Ora, 2022), Otago Medical School (University of Otago, 2021), Auckland Medical School (Matthews et al., 2015), and in the Health and Disability System Review (aka The Simpson Report, 2020).

Serious consequences of medical workforce shortages are 'burnout' and a lack of retention (Tu et al., 2020; Royal Australian college, 2022). Struggling to fill vacancies and to meet the demand/need for health care, it is, therefore, common practice to rely on international medical graduates and overseas/foreign-trained medical professionals (Australian Government Department, 2021). It is estimated, for instance, that New Zealand recruits approximately 6,800 overseas-trained doctors (40% of our workforce) from more than 100 countries (Medical Council of New Zealand, 2021c) - although these figures have recently been curtailed by COVID-19 travel and immigration and visa restrictions. Likewise, Australia is importing trained doctors and nurses from India, China, the Philippines, Ireland, and the UK (Srivastava, 2022; Yeomans, 2022).

However, questions are being raised about the ethics of international recruitment - particularly from low and middle-income countries where they are struggling to meet the needs of their own people as well (Leaman, 2017; Wiseman et al., 2017; Visentin, 2022). One of the logical solutions to this international health workforce shortage is for countries to train more domestic doctors and health personnel (Visentin, 2022; Bremner, 2022; BBC News, 2016).

Poorer Health Outcomes

The shortage of medical healthcare professionals is a major contributor to health inequities in rural and remote communities (Strasser, 2020). Internationally, common themes or topics of rural and remote health studies include diabetes, cancer, and mental health (Glasson et al., 2017; Gorham, 2021; Gutierrez, 2020; Johnson, 2020; Mazumdar, 2021; Schoen et al., 2016). These conditions are also prevalent among Maaori (Reid et al., 2018; Beaton et al., 2019; Hamley et al., 2021).

Although Maaori are disproportionately affected by diabetes (Durie, 1984a; Ministry of Health, 2018), the literature indicates that the majority of studies examining diabetes in rural communities are focused on non-Maaori.[13] Also notable is that most of the rural Maaori studies I reviewed were conducted in Northland, where "a significant proportion of the population (35%) are Maaori, and over half reside in rural, isolated areas" (Martel et al., 2020, p. 277) and geographical barriers to accessing healthcare, and where Maaori "...are markedly disadvantaged across all socio-economic indicators including educational attainment, unemployment status, and income level" (Reid et al., 2018, p. 8). The review illustrates a balanced interest in males and females and the use of quantitative and qualitative methods, ranging from statistical analyses of clinical records (Chepulis et al., 2020; Ryan, 2021) through to semi-structured interviews (Harbers, 2022; Reid et al., 2020). A number of studies

[13] UoW library catalogue search: Zealand + rural + diabetes = 579 results + Maori = 96 results.

identify access as a major barrier to health care, including a lack of access to new diabetic pump technology (Chepulis et al., 2020), while common barriers to attending eye screening clinics include transport, work and family commitments, financial, health and a lack of appointment reminders (Harbers, 2022). On a positive note, Reti et al. (2011) found that the level of online access and literacy among Maaori living with diabetes in rural areas has increased.

Of particular interest, Chepulis et al. (2020) identified that Maaori (and men) attending a Maaori health centre in Hamilton are less likely to manage their glycaemic control; whereas Ryan (2021) found that both rural and urban Maaori attending an urban clinic in Northland manage their diabetes equally. However, I note Ryan (2021) defined 'rural' as living more than five kilometres from the clinic, which is not very far. Ryan (2021) also found that Maaori living in rural areas (26% of 372 patient records) are twice as likely to experience depression.

Another health issue of significance for people living in rural and remote communities is cancer (Jatrana & Crampton, 2021; Kidd et al., 2021). However, my literature search suggests that even less research has involved rural Maaori.[14] Except for one Kaupapa Maaori research project (Kidd et al., 2021), rural cancer studies focusing on or including Maaori employed quantitative methods and rely on analyses of regional or national data sets. The results of these studies indicate that no matter what the cancer is, Maaori men and women living in rural communities are more likely to be diagnosed with metastatic disease (cancer that has spread to another part of the body) (Lawrenson et al., 2016; Sharples et al., 2018) and are less likely to survive after being diagnosed (Kudela et al., 2019; Lawrenson et al., 2016; Obertova et al., 2015). However, a study conducted by Matthews et al. (2020) found no difference in colorectal cancer survival rates according to rurality and ethnicity. Sharples et al. (2018) also found no difference in bowel cancer survival rates by rurality, but there were differences according to levels of deprivation, with Pacific and Maaori experiencing the worst survival outcomes.

What I found most interesting was the qualitative Kaupapa Maaori study conducted by Kidd et al. (2021). The purpose of their study was to explore the barriers and enablers related to the early diagnosis and treatment of lung cancer in secondary care for Maaori. The study involved focus group hui with 108 community members and 27 individual health practitioners in five locations across the Midlands region (across the middle of the North Island). The identified barriers included delays in referrals and declined referrals by primary care providers, and long waiting times for specialist care. Vital to ensuring patient engagement and treatment uptake enablers included agency (i.e., whaanau

[14]UoW library catalouge search: Zealand + rural + cancer = 551 results + Maori = 36 results.

and supporters enacting their rangatiratanga), the importance of tikanga including whakawhanaungatanga, cultural respect and understanding, and culturally meaningful connections.

Another health issue of significance for rural and remote communities is mental health (Fuller et al., 2000; Jaye et al., 2022; Mathias et al., 2022). However, the literature search suggests that there has been very little research attention given to rural and remote Maaori.[15] To compensate for this gap, older and different materials were reviewed.

The research shows that Maaori are more likely to suffer from mental health problems (Baxter et al., 2006; Came et al., 2020; Jorm et al., 2017). In the Maaori Mental Health report for the WAI 2575 Health Services and Outcomes kaupapa inquiry, Gassin (2019) identifies transportation as a major barrier to accessing healthcare for rural Maaori, including mental health services, stating, "Maaori are twice as likely as non-Maaori to live in a household without a car" (p. 124). Gassin (2019) also notes that "Maaori report not having telecommunications access at rates several times higher than non-Maaori" (p. 125-126). However, in contrast to other reports, Gassin (2019) also asserts that "Maaori residents of rural areas do not have greater unmet needs for basic medical services" (p. 121). I also notice that Gassin (2019) uses data from the 2006-2007 New Zealand Health Survey, which is 16 years old.

In the recent State of the Rural Nation report, by Country TV and Bayer New Zealand (2018) also found that rural dwellers are "significantly less likely than urban dwellers to consider talking to a health professional if they experienced signs of stress or anxiety" (p. 2). This finding supports those of the 2003-2004 Te Rau Hinengaro survey (Baxter et al., 2006) in which participants living in "...rural centres and areas had the second lowest rate of healthcare sector consultation and the lowest rates of mental health specialty sector visits" (p. 129) - suggesting that the situation has not improved over the last 20 years. Although, because Country TV and Bayer New Zealand have not included their research methods in their report, including the number and ethnicity of the participants, it is not clear whether the studies are in fact, comparable.

The mental health of rangatahi or youth is of particular concern. In the Health of the Rural Nation report, rural youth indicate that they are significantly more likely to feel that mental health is an issue in rural communities, and their pressures include life, work, and relationship issues (Country TV and Bayer, 2018). In the Te Rau Hinengaro study, youth also reported especially high rates of substance

[15] UoW library catalogue search: Zealand + rural + "mental health" = 271 results + Maori = 10 results.

abuse, and younger age groups experienced higher rates of disorder than the older age groups (Baxter et al., 2006).

One study that stood out from the rest focuses on the development and implementation of YouthCHAT, a self-administered digital tool designed to screen young people for mental health concerns and risky health behaviours. The three-month pilot was conducted at a rural health clinic in Northland and involved 30 rangatahi under the age of 25 years, including 28 females and 27 Maaori (Goodyear-Smith et al., 2016). The App includes 13 domains (topics) and four possible responses: positive (yes), want help (yes/no), want help now, or want help later. Responses are sent to the patient's clinician just prior to their appointment and are then discussed during the appointment. The youth gave feedback about the App. via text and the overall experience in a post-consultation survey; also, clinicians were interviewed. The App. gives clinicians insight into what their patients were worried about and helps start the conversation. Completing the YouthCHAT survey also gives rangatahi something to do while waiting to see their doctors and encourages them to reflect on and identify their concerns and problems in privacy (Goodyear-Smith, 2016).

Since the pilot, YouthCHAT has been trialed in urban and rural areas by guidance counselors (Clare et al., 2021) at primary health clinics (Martel et al., 2019), high schools, applied to physical conditions (Thabrew, 2020), and compared with interview tools (Thabrew, 2019). The App. is a success story and has great potential in rural settings.

Kuia & Koroheke

Another topic raised in the rural health literature is the increasing number of elderly people living in rural and remote communities (Keelan et al., 2022). Again, however, I found there is almost no research about kuia and koroheke (elderly women and men) living in rural and remote areas in Aotearoa, New Zealand.[16] Only two studies were identified as relevant to the research and provided insight into the issues faced by kaumatua living in rural and remote areas. Both studies were published recently and were conducted in two very different locations and settings.

Gee et al. (2021) conducted a study in rural Canterbury (South Island). The aim of the research was to explore the understanding of frailty and it involved three focus groups. The first focus group included six kaumatua (65+ years; five females/one male) living in a 'Maaori model-supported living villa.' The second group comprised 14 medical professionals who work with the elderly (12 Maaori; 13

[16] UoW library catalouge search and *Journal of Rural and Remote Health* search combined: Zealand + rural + elderly = 344 results + Maori = 15 [date range was expanded to the last 20 years].

females/one male). The third focus group was open to the community and involved 19 participants (seven Paakehaa, and 12 Maaori). The research explored their thoughts about what frailty means and what makes frailty better or worse. The research team used the Meihana Maaori Health Model to guide a thematic analysis. Gee et al. (2021) conclude that the experience of frailty is "a dynamic balance between challenges/deficits and strengths/resources" (p. 18). As a challenge, frailty is associated with being "withdrawn" and feeling "lonely", especially after the death of a life-long partner; while feeling useful, having a purpose, whaanau support and health, interacting with their mokopuna (grandchildren) and being able to manaaki were identified as strengths and resources and important elements in maintaining one's health and well-being.

The other study was carried out in the rural settlement of Raanana, located 60km up the Whanganui River (Tinirau et al., 2011). The objective of the study was to gain an understanding of past health services of a rural hapuu community based on the perspectives of the local kuia and koroheke (n=63), and how these health services might influence present and future health decisions. The research participants shared stories and memories that revealed that when they were growing up, the first health providers were parents and other whaanau members who were supported by tohunga (specialists), while the Sisters of Compassion at the local Catholic Church possessed nursing skills and dispensed medicines. If more help was needed, they would travel to Whanganui (Tinirau et al., 2011).. While Western methods and practices became the norm over time, the interviewees preferred Maaori methods and practices including karakia and rongoaa. Of particular interest to me were their thoughts about health, well-being and culture being inseparable from the taiao, especially the Whanganui Awa: "Ko au te Awa, ko te Awa ko au" ("I am the river, and the river is me") (participant response) (Tinirau et al., 2011).

Health services along the awa are currently provided by the local Maaori Health Authority and services include rongoaa, diabetes, asthma, heart, eye and hearing clinics (Tinirau et al., 2011). This provider also assists with transport to doctor and hospital appointments. Concerns raised by kuia and korokehe included easier access to health providers, the high-turnover of doctors, the cost of healthcare and that rangatahi are not using the health services being offered including those that have been designed with them in mind (e.g. hapuu maamaa waananga/pregnancy workshops). Services that kuia and koroheke want provided locally include dental, optical, and aural care, emergency services and more regular transport to the urban health services (Tinirau et al., 2011).

These studies do not directly answer the primary research question but do provide context for the following and final theme.

Doctors: What do 'rural and remote' Maaori want?

As illustrated above, there is a lack of literature and research that focuses on rural health and even less research about the health needs or aspirations of Maaori living in rural and remote communities. I was therefore not surprised when I was unable to locate any literature directly related to the research question: What do Maaori who live in rural and remote areas want from their doctors? Hence the wide nature of my literature review.

In relation to the idea of what a 'good doctor' is or looks like, international studies provide a place to start.

In 2011, Woolley et al. (2013) conducted a pilot study with 13 indigenous health professionals, elders and community members in Mount Isa (Queensland, Australia). In 'Yarning Circles', they discussed what they felt are the desired medical graduate attributes. Their analysis points to a set of eight skills, knowledge and attitudes. The two skill-based attributes are quality patient care and communication skills. The former includes maintaining confidentiality, fighting 'for' patients' rights, always following up, and listening to a patient's story of their medical history; while the latter includes respect, honesty, being able to read body language, using simple language, taking time to explain and avoiding too much eye contact. The three knowledge-based attributes are medical knowledge, culturally appropriate knowledge (e.g., understand our culture, behave and dress appropriately) and knowing the local health system (so you can provide advice and guidance).

There are also three attitude-based attributes included. Personality includes a willingness to learn, patience, nice, passionate, tolerance, and non-judgmental. Working with Indigenous people includes look and listen (don't talk too much), willing to learn 'bush knowledge', respecting patient knowledge and experience and building rapport. Engaging with the Indigenous community includes respecting elders, learning about Indigenous politics, lobbying the government about policies affecting Aboriginal people and getting involved with community groups. In short, good doctors are willing to become active and invested community members. I found this study particularly inspiring because it is strengths-based, future-focused, collaborative (i.e., conducted for and with the local Indigenous people/community) and involved the co-creation of a holistic framework.

Supporting the findings of the Mount Isa study, Carter et al. (2021) conducted a participatory action study in rural Canada. This research created a space for a cultural advisory group and local Emergency Department (ED) medical staff to discuss culturally safe and unsafe practices. The resulting list consists of 20 culturally safe attributes including no assumptions or judgements, respect, mutual trust, plain

language, going the extra mile, relationships, and 'causing the patient to feel heard' (p. 77). In contrast, the list of culturally unsafe care provision comprises five points: Feelings of not being heard, believed, taken seriously; being pushed aside; not being checked thoroughly or misdiagnosed; and assumptions that 'we are all the same.'

In other studies, researchers have asked *doctors* to identify the attributes of 'good doctors.' Employing a Delphi survey consisting of 20 attributes derived from key UK medical regulatory documents, a group of five GPs and five medical specialists rated and ranked the following attributes as most important (Lambe & Bristow, 2010): Recognition that patient care is the primary concern of a doctor; probity (being honest, trustworthy and acting with integrity); good communication and listening skills; recognition of one's own limits and those of others; pro-social attitude (has empathy and is non-judgemental); ability to cope with ambiguity, change, complexity and uncertainty; commitment to lifelong learning, competence and performance development; compassion; motivation and commitment and Ability to be a team player. In a recent Australian-based study, Schnelle and Jones (2022) conducted semi-structured interviews with 13 English-speaking medical doctors who were asked for their opinion about, and experiences with, 'exceptionally good doctors.' Exceptionally good doctors were found to have up-to-date extensive medical knowledge and skills; relate well with patients; excellent diagnostic abilities and tend to be humble, approachable, inspiring, and are long-remembered role models.

In their conclusions, Schelle and Jones (2022) and Lambe and Bristow (2010) suggest that their findings can help in the design, implementation or reformulation of medical school curricula. Lambe and Bristow (2010) also raise the question about whether "...some attributes can be taught or acquired during medical education and differences of opinion as to the meanings ascribed to attributes and how they can be reliably and validly assessed" and recommend that longitudinal research be conducted to "ascertain whether the selection of students with key non-academic attributes do indeed produce doctors with the defined personal qualities and behaviours" (p. 353).

What is notable in these two studies is the absence of cultural safety attributes.

Other literature related to this topic[17] includes books with "Good Doctor" in the title; a study in which German medical students were judged by their supervising GP on their suitability to become 'good doctors' (Kotter et al., 2020); and a study in which Australian midwives and doctors working in rural and urban settings commented on what makes a good doctor or a good midwife (Reiger & Lane, 2009).

[17] UoW library catalogue search: Zealand + "good doctor" + rural (excluded reviews) = 22 results.

The search did not reveal any New Zealand studies about what constitutes a 'good doctor' in rural practice.

I did, however, find literature about cultural responsiveness. In their publication, *Maaori cultural responsiveness in practice*, the MidCentral District Health Board Maaori Cultural Responsiveness Project Team (2010) defines cultural responsiveness as "an awareness of Maaori cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds" (p. 6). They also assert that Maaori cultural responsiveness acknowledges that "A health provider's acceptance of Māori people and their culture, values and beliefs will impact on the effectiveness of a provider-client/family relationship" and "A positive client outcome is achieved when a health provider and client have mutual respect and understanding and positive health experiences" (Maaori Cultural Responsiveness Project Team, 2010, p. 7). However, the document only refers to rural health once, with "responsive rural health services" being one of their six goals. In Australia, the Agency for Clinical Innovation (2022) describes cultural responsiveness as having an open mind to new ideas that may be at odds with the principles, beliefs, and standards of your own culture and the capacity to treat these disparities on an equal footing. As an illustration, spiritual practises have a significant role in the general well-being of many societies. Being respectful of someone's background, beliefs, values, customs, knowledge, way of life, and social behaviours entails understanding them. It enables you to offer assistance and care that are culturally appropriate, empowering people to take control of their own health (Agency for Clinical Innovation, 2022) .

Other related terms found in the literature include cultural competence and cultural safety. The Royal New Zealand College for General Practitioners (2007) defines cultural competence as "an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds" (p. 5). This is beneficial for Maaori because research shows that Maaori can feel "uncomfortable or unwelcome within the health care system", which can lead to "poor doctor–patient interactions" (p. 7). The Medical Council of New Zealand (2019c) states that cultural safety involves a "commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided" (p. 2).

Summary

The worldwide shortage of healthcare workers is highlighted in the literature and is worse for rural and remote areas who struggle to attract and keep doctors. Inequities exist for these communities and are worse for Indigenous peoples. Not surprisingly, the same health issues that Indigenous peoples of the world experience also affect Maaori.

The literature highlights the needs of people living in rural and remote areas as: Available healthcare workforce, access to critical services, and treatment and care for the elderly. Moreover, there needs to be more research in relation to rural and remote community's health needs and aspirations.

The lack of research literature about rural and remote communities in Aotearoa New Zealand also highlights the need for more studies. Still, a number of the studies reviewed have proved to be insightful and some were inspirational. I was particularly inspired by the pilot study conducted by Woolley et al. (2013), in which they identify three types of attributes - skill-based, knowledge-based, and attitude-based - and I will consider whether that framework can be applied to my findings.

Further to the literature search the research question has identified a significant gap in the literature. Nonetheless, the review has revealed that 'rural and remote' Maaori are concerned about the following:

- healthcare that recognises that hauora/health is holistic and includes a balance of physical, mental, spiritual, relationships and familial and environmental well-being.
- early diagnoses
- prompt referrals
- shorter wait times for specialised care
- mental health services and medical services
- access to diabetes, asthma, heart, eye and hearing clinics
- emergency services
- doctors that understand and appreciate the importance of rongoaa Maaori
- affordable transportation to attend doctor and hospital appointments
- easier access to health providers
- the cost of healthcare
- healthcare professionals who listen, are empathetic, are thorough, knowledgeable, and culturally aware.

The concerns and aspirations raised by Maaori and other Indigenous peoples reflect a holistic view of health and well-being, and I expect that my research participants will raise a number of these issues and needs as well.

In the next chapter, I present the major themes that emerged during the story collection with Maaori living in Te Rohe Pootae.

Chapter 6 - Findings

Introduction

The purpose of this study is to identify and explore the health aspirations and needs of Maaori who live in rural and remote areas. The findings will inform the curriculum for a new medical school that will train doctors to specifically service rural and remote communities. This new medical school could be part of the solution to a failing health system and counter the continuing health disparities for Maaori.

In this chapter I present the findings of one-off semi-structured interviews with 30 Maaori community members living in Te Rohe Pootae (see Chapter 2). Following the focused thematic analysis (see Chapter 4), the chapter consists of three major sections: Health, Rural & Remote, and Needs and Aspirations. Each section begins with short reflections that connect to each other to form a short narrative. The quotes included in this chapter have been selected for their illustrative power, and all true names have been replaced with pseudonyms. In the first instance where a participant appears their name and square brackets with age indicator and either wahine (female) or tane (male) will be shown e.g., Maaia [Pakeke, wahine].

The findings are briefly presented and are discussed in more detail in the following Discussion Chapter.

6.1 Healthcare Experiences

As the analysis process began, the health and well-being question caused me to reflect on my master's journey so far; analysing my progress of how far I had come, where I was at in this moment, how much further I had to go and more importantly, what did my own health and well-being look like right now? I experienced many personal changes and challenges throughout this journey, some positive and some negative. A positive aspect of this journey is that my mind has changed; I now process information differently. I now have a better understanding and wider knowledge base which helps me to participate in interesting and enjoyable conversations with like-minded people. In terms of the negative, I have not been able to balance my body, mind and spirit for a balanced health and wellbeing, but with this imbalance I have learned a lot about myself and what I am capable of, what I hope to achieve and more importantly it has given me some clarity of what my strengths and weaknesses are…

The first part of the interview focused on the participants' health and included four questions. The first question explored what health and wellbeing mean for them, while the other questions asked

about their health-seeking strategies: Where they go when they are ill or injured, and what services they have access to.

What does health and well-being mean to you?

This first question was designed to introduce the topic of health and to get the conversation started. As expected and highlighted in the literature review, there was no consensus on what health and wellbeing mean. However, while a couple of the participants pointed to the differences between the terms, most talked about the relationship between the two.

> *I think health and wellbeing is a combined thing, health being the medical term and wellbeing being a more holistic framework for wellness, really - Te Ami [pakeke, wahine]*

> *For me our health and wellbeing centres around our Te Ao Maaori… it's everything, it's your wairua, it's your tinana, your whakaaro, how your marae runs, it encompasses everything… - Wai [Kaumatua, wahine]*

> *I think health and wellbeing can be two separate things, but I think it's one together. Health to me is definitely the physical side of the tinana side and looking after that side of you and the wellbeing side is both tinana and wairua, hinengaro as well and I think that these days it's probably one of the biggest things especially in the last two years with COVID - wellbeing is very important to all of our whaanau and all of our people. Because times are hard, times are difficult, times are struggling for our whaanau, times are scary and that can be real hard hitting for people's wellbeing and can lead to physical unhealthiness as well. I think they hold hands; they need to hold hands and they can't go separately. That's my whakaaro anyway - Teao [pakeke, tane]*

Even more so, at least a third of the interviewees - including the rangatahi doctor in training spoke of holistic health, and the link between and the importance of physical, mental, emotional, and spiritual health.

> *It's a whole holistic thing… I think wellbeing is informed by your health but it kind of can't be the other way - you can't be well within your being if you're not holistically healthy. So, it's a whole lot of things, its mental health, its physical health, its emotional health, spiritual health, you know and if they are all good then you're well-being, but if not then you're just being - Whakaotirangi [pakeke, wahine]*

…people underestimate how much it [health and wellbeing] is spiritual and mental too, everyone will look at health and well-being and they'll be just thinking about the physical… if I sort my eating, if I sort my physical I'm good and I'm gonna be happy, but health and well-being is a lot more than that... - Ani [rangatahi, wahine]

… I see it as more of a holistic view, health is not merely just physical, it's also spiritual, it's mental and social. It's a way of looking at the whole individual and that's how I see it. I think that's important for me as a future doctor - Te Ata [rangatahi, wahine]

To explain and expand on their thoughts about holistic health and wellbeing, a third of the participants referred to Te Whare Tapa Whaa without being prompted - the Maaori model of health that was introduced by Mason Durie in the 1980s and features four the taha (sides/walls) of health: te taha tinana (physical health), te taha wairua (spiritual health), te taha hinengaro (intellectual/mental health) and te taha whaanau (healthy relationships).

I like the Te Whare Tapa Whaa model of health and wellbeing; it really resonates with me. Western medicine has a lot to answer for… Te Whare Tapa Whaa looks at your… tinana, hinengaro, whanau and wairua, it encompasses your health… - Atiria [pakeke, wahine]

… I found the model Te Whare Tapa Whaa and I was able to relate to the idea… a physical, spiritual, emotional, mental and wairua connection to the whole self… - Nina [pakeke, wahine]

A number of those who referred to Te Whare Tapa Whaa, also referred to Te Ao Maaori as their puna (well) of health and well-being. Te Ao Maaori or Maaori worldview can be broad by definition as it is holistic and cyclic. Te Ao Maaori is Maaori identity and whakapapa, and this encompasses beliefs, customs, language, culture, people, place and time (Kai'ai & Higgins, 2004). This whakapapa interconnects with everything including the natural environment and the universe, therefore Maaori are connected to and have an interrelationship with all things living and non-living (Ka'ai & Higgins, 2004).

I suppose if I'm thinking about health, if I'm being honest its sustainability, its whakapapa, it's an intrinsic type of connection that we as - well for my whaanau as Maaori - that we need to look after, so I think health in this forum is whakapapa for me. … You know those underlying hereditary issues that we all as Maaori whanau have - to help eliminate them or minimise them going forward, a healthier iwi and a healthier people - Te Ami [pakeke, wahine]

It is, it's a huge part of our culture, once you understand what that is you know, you're set for the rest of your life, it becomes embedded and you know how to look after whanau, whether it's just in your house whether it's just 10 people - where you're doing dinner for 10 people or you're cooking for hundreds. So, a lot of the things you do, you learn here at the marae, so for me it centres around Te Ao Maaori. I mean, before we were just talking about that - being children being brought up here, so you learn how as a kid how to pick up the rubbish, help with jobs, then you get a bit bigger and you graduate into the kitchen - you know, you take the meat over there, take this over there - You're part of a team and it's fun, it's fun and you get to see your mates. Then you get to be a teenager and you've got to serve the tables and all that stuff. So, it's a gradual thing you don't get to by passing those steps. It's about sharing, it's about caring for others, it's about caring for you all those things - it's that stuff we learn by being on our marae, but our families don't get a chance to do that. I hope that a lot of our young ones now are starting to create Maaori businesses and they centre around their own - to me that's health and wellbeing - to be standing on your two feet in your own culture - If you know the reo that's okay and if you don't that's okay too – all good - you know - but if you've got your two feet in Te Ao Maaori - pai tena - because you know you get to hear your reo and then Te Ao Maaori is huge as you and I know, we live by the stars, live by the moon - I was taught to get kai by the tides and the moon - my dad lived like that so my whole family know about that - so, a lot of our young ones now are getting to understand that too - you know - get your kai by the moon and planting - some have absolute beliefs in planting by the moon - so that's all part of the wellbeing - I don't - we don't see it as anything else - that's part of health and wellbeing - Wai [kaumatua, wahine]

Health and well-being for me are very vital in your hinengaro, tinana, wairua, ahuatanga, the way you express yourself, your emotions… Kaitiakitanga - the care of all living things, people, and places. Spiritually - things from all realms of our Ao - Rina [pakeke, wahine]

…for me, health and well-being is everything, or all of those aspects wrapped up in that, not only for yourself but for everybody. We know that aye? We know that within our taha Maaori that those sort of things are just intrinsic, it's who we are, without all of those atua that feed into us you know, if one is a bit titaha, we acknowledge that and we find ways around it - Tiki [pakeke, wahine]

An important dimension of Te Ao Maaori in relation to health and wellbeing is rongoaa.

Rongoa is a traditional system of healing that includes herbal remedies, physical therapies, and spiritual healing. To quote Jones (2007), our tupuna understood that “illness was often spiritually based… rather than a medical problem, “rongoaa practitioners view[ed] sickness as “a symptom of disharmony with nature” (p. 1). This topic was raised by eight of the interviewees, who talked about rongoaa as medicine, as whakapapa and as a way of being.

> *I think our people have different needs because we have different treatment I think, and because we still use rongoa Maaori, that's our medicine and I think a lot of us are going back to rongoa Maaori as well I think that our Pakeha professionals just need to maybe understand that as well and possibly get a little bit more info and understanding on rongoa Maaori because it works - me and you know that it works - Teao [pakeke, tane]*

> *Rongoaa for me means Papatuanuku. It means a connection with atua. It means a connection with our creator and how the fruits of this beautiful creation has helped us to be able to naturally heal, you know it's given us - rongoaa to me is something that's very traditional and cultural and it reflects a person's identity, you know - Teia [rangatahi, wahine]*

> *Aunty could pick up straight away if something was wrong with me, and she'd go “come here” and take me into the room and she goes “no you’re not it's your hip… I'm very particular as to who I allow to touch my tinana, but aunty already knew it, straight away and was able to give me the rongoa that I needed, and be able to do her karakia, which was our karakia and be able to lay her hands on me and know that I was safe, I was safe with my aunty - Kaia [pakeke, wahine].*

> *I got to look after my body, and well I started going on my rongoaa doing my own kawakawa and kumarahou because the olds back in Kaawhia, they said get on the kawakawa that will look after your kidney and you don't have to go to the Paakehaa. And I thought, oh yeah okay, so I stayed on it for years and then once I got my mahi down the mine site, well I was still a bit thin, they said I couldn’t start work until I had my levels done properly, so I had to go to the doctors - Anahera [pakeke, wahine]*

> *But there's a lot right with what we used to eat, it's mostly natural, it's mostly you know - even how we prepare our kai, even how we do that, even how we share our kai - that's part of rongoaa Maaori, an understanding and sharing your kai - Wai [Kaumatua, wahine]*

> *Tiki - If only our people would get back to you know, that rongoaa and I've seen some of our cousins on Facebook now getting more and more into that, so that's cool, that is so cool. I wish*

I was that way inclined but I just don't have that time, but I wish I could do that you know, and be that rongoaa for myself do that rongoaa

Kaia - He kai! mo te ngakau, mo te wairua mo te hinengaro, mo te tinana[18]

Tiki - yeah It's not just a medicine, because rongoaa I guess it's those feelings it's those emotions that go with it aye

In the old days we were all taught like uncle and them. We were all taught to have karakia and then mehemea ka whara koe, someone will come in and do a hono on you and that used to happen all the time out at [remote village] with Aunty and them and my mum, they come, and they do their own type of hono. So, whether it be with a paraoa, or riwai, or a ring they would still do their hono and I vouch for that I have faith in that, that does work if you have the belief in it, those are the old days, you get scorned upon if you see it now - Paia [kaumatua, wahine]

Four participants (three male and one female) also said that "finding happiness" or "being happy" was the key to their health and well-being. Happiness was described as something everyone should look for in all areas of one's life.

Where do you go when you feel unwell or when injured?

These two questions were designed to move the conversation from health and wellbeing to the interviewees' healthcare experiences.

Looking at the demographic information, a third of the interviewees are registered with the OOtorohanga Medical Centre, a third with the Te Kuiti Medical Centre, two are registered with the Maniapoto Whaanau Ora Centre, one with the Mahoe Medical Centre in Te Awamutu. One sees a GP in Kawhia, and the students see GPs in the cities where they study. No one spoke about the Hillview Rest Home, Marae Pact Trust, or the Te Kuiti Hospital. When asked about Te Kuiti Hospital, it was interesting to discover that some community members were not sure what services they offer. Some knew about blood tests, x-rays, and specialist day visits, but no one mentioned their 24hr emergency service. In relation to transportation, only three interviewees talked about travelling to Waikato Hospital for regular treatments.

[18] Kaia's translation: food for your heart/liver, your spirit, your mind, and your body.

Te Kuiti [residents] has to wait for the Taumarunui bus to go through, which is true because a lot of us still can't get transport and it's a lot easier than bothering other families to take you, and you still have to get someone to take you if your appointment is for cancer treatment, but they're still giving more support [Waikato Hospital] for all cancers, but I thought with diabetes a cousin of mine and I were traveling with them [on hospital bus] for my appointments… and what we said, we got Te Kuiti Hospital and to save travelling it should be there, the dialysis and that. It [Te Kuiti staff] just needs to um upskill with nursing and everything for the dialysis machine, because that's a big hospital where they could use that facility. Yeah, because …they [the bus] don't get back till about half past six, and that's a long way and you don't have many stops. It's just over an hour to get here and we get picked up after nine so they must leave before 8 o'clock. But you know dialysis, once you get up there it's wonderful, but it's just a long day and if you're doing the machines and that's three days a week, and then when it's a long holiday and you got to do Monday, Wednesday, Fridays. Mondays are usually a holiday… [so] you got to find someone to take you up there… like us Maaori a lot of us, especially older ones, we don't ask for help we try and find another way - Kai [kaumatua, wahine]

…at the moment he's on chemo, so he's up there once every three weeks, so that impacts our family because I've got to drive him, lucky I don't work. If I worked it would be me having to take a day off work, there are buses that go up like the Taumarunui bus, they cater to the whaanau going to the hospital, but if dad's appointment is at 8 and the treatment takes three hours, he's got to wait there till 5, so after chemo you don't want to be waiting around till 5 with sick people if you've just had chemo, so we prefer not to have our father exposed to those things but we can, so we're in a position where I can, or even if I was working I could take a day off, I have a vehicle and so does my dad, we have means to do that, money means and a decent vehicle to do that – Whakaotirangi [pakeke, wahine]

My analysis also identified three types of groups: Those who will go directly to their doctor (the 'doctor first' group); a group who will try other things before they go to a doctor (the 'doctor second' group); and those who will try other things and are less likely to see a doctor (the 'doctor never' group). When ill or injured, a third of the participants (n=11), both males and females, go directly to a doctor. Their experiences are included in the next section. The 'doctor second' group (n=12) have a "process" that they follow before they decide what they should do next. Some participants give their body time to rest, and others spoke about going home, to see whaanau, to the water or the ngahere, and karakia - and only then they would see the doctor - if they "really, really needed to" Te Ami [pakeke wahine]

If I'm not feeling well I'll go and exercise, that's what I do. I will exercise, I'll go out and walk, go out on nature walks… that type of thing…and then at the end of the day rest - Amaia [pakeke, wahine]

… I head back to the marae, back to the whenua and it's always been back to the whenua – Tiki [pakeke, wahine]

I've gone towards a more natural, more Maaori supportive type of hauora. So, for me, our wai is everything and growing up in a little remote town or village like Taharoa we had lots of wai, one in particular is Mitiwai - he wai ora…he wai oranga… we use it for cleansing, drinking, blessing for a more holistic type of practice of wellbeing… so if it's something that we can fix through our own process…we do. But yes we have sourced medical help - Te Ami [pakeke, wahine]

I normally go home first and if I'm not feeling good there I'll go to my mum's house. If I really have to go somewhere, I'll go to the doctors as a last resort - Mateo [rangatahi, tane]

I normally retreat home for a bit, yeah just retreat and then probably just see whanau, what they say. And then its doctor - Manu [pakeke, tane]

I do go to my doctor. I've got an aunty who does hono, she lives in Te Kuiti and she does hono, so I'll go to her if I think it's something else that I need to do. But if I'm injured like if I've fallen off a ladder then I'll go to a doctor and get it sorted and the [medical centre 2] is where I go and they're really great, they listen... Not that I have to go that often but I'm healthy – Wai [kaumatua, wahine]

First of all, I go to the wai, I have a karakia, me te tuatahi, me ka reo tia ana te raatou, which is always first and foremost, then I go to the doctor… - Paia [kaumatua, wahine]

However, when injured, Paia will go directly to a doctor or the nearest emergency department.

I definitely go to the doctor, mehemea wharana ahau, ae. Kaore au i te hono i te era too mea, na, mea nga Maaori me mai raa noa, (you can't hono it, you have to go to the doctors and get it done and get an x-ray). e ra te mea, (well that's when I go into the doctor), mehemea mauiuiana, (well if I've got the flu well I don't go) – Paia [kaumatua, wahine]

The remaining number of participants (n=7), the 'doctor never' group, indicated that they don't rely on or avoid western medicine and doctors. One male and one female see a healer but do go to the

doctors for routine check-ups such as prostate checks, cervical screening, and to get blood tests if and when needed. Two waahine turn to Te Taiao for their healing and will only go to a medical doctor if absolutely necessary.

> *I don't go to the doctor, because I do my own rongoaa, it's not that I don't trust what the doctor says, but I know my own body, not the doctor, so for years I've trusted myself when it comes to my healthcare, like I know when I'm out of synch like when somethings wrong, like the other day I was having twinges in my back, so when I start for instance, when I get twinges over here and when my eye starts twitching I know that I need magnesium so I go off get myself some magnesium, no more twitchy eye, no more, so I make a conscious effort. I normally notice about 10 - 14 days later, magnesium all good, so because I know my body I know what I need, I don't want to pay a doctor to tell me what's wrong with me but, in saying that I have been to the doctor, and when I do need allopathic treatment I'll go. I have no thyroid, I had a goitre, and I had it for years and it was pronounced az, it sat out for years - Whakaotirangi [pakeke, wahine]*

When injured, a third of the participants reported that they seek relief and treatment from other health modalities/practitioners including physiotherapists, osteopaths, chiropractors, acupuncture, and healers. Some of the female participants also mentioned massage (rubbing and kneading), mirimiri (bodywork that focuses on tissue, muscle, bones, blood) and/or romiromi (bodywork that focuses on internal organs and body systems).

> *It might be as simple as your mahi bub. Massage therapy for our people because our people need that, you know, romiromi. They're simple but our people connect with it – Tiki [pakeke, wahine]*

> *I'm getting into rongoaa. And I really am interested in it because I like the mirimiri side, that's natural, that feels good. And you can feel the energy. And it helps everything, which is really cool. So, I am getting into that stuff, and I do use the Kawakawa balm – Amaia [pakeke, wahine]*

> *Mia: if we've pulled a muscle or things like that, we don't go to a physio or places like that or a chiropractor or someone like that, we go to somebody else where she realigns our bodies, its probably for me, it's more like a mental thing as well, because she just like does your whole body and things like that and once you're finished with her, it's just like a relief a sense of relief and all that, yeah, we've known her for quite a while, …but yeah she's our go to lady …instead of going to like a physio*

Me: Do you know what modality…

Mia: ...she guides your muscles into place where they're meant to be. She used to come into the gym and she used to see people, and she could see if they were off balance or if something was out in them, like their hip, or knee or their ankle and that, so yeah. She'll do the main part that you go in there for and then she'll do the rest of your body, sometimes she has to do something else, it could be something that you think is the problem but that is not the problem, it's something else that's the problem so yeah.

Taimana: She's very spiritual, she's kinda got everything in one mix, like rongoaa mirimiri, physiotherapy, you know and spiritual, um she knows the body, and she knows what's wrong with the body as soon as she sees you. She can practically read your mind, when she knows there's something wrong with your elbow, aww your elbows out, or your hips are out your neck's out. So, she's into realigning without all the click, click, click.

Another observation was that those who don't rely on doctors said that they had not needed a doctor for some time.

To be honest I haven't been to the doctor in years, like I've never had a reason to go to the doctor, I suppose I've never been ill enough or unwell enough that I needed to get help - Teina [pakeke, tane]

What kinds of services do they offer?

The intention of the original paatai - what kinds of services and healthcare workers do you want and need in your community - was to identify what types of services are and are not available in our rohe. However, most of the participants focused on their experiences rather than the services themselves - which has provided some very useful insights.

In relation to the group who rely on mainstream medical professionals, most said that they have a really good relationship with their doctor and the other staff at their medical centre. Their koorero describes what good and bad healthcare relationships look and feel like.

I just love going there… you don't even have to say who you are, she's like "aw hi [Atiria], go sit over there." So really [the receptionist] is the one that's kept me there - Atiria [pakeke, wahine]

I've got a really good relationship and I thank them every time when I go down there, yeah, I think it's the personal touch that they do, because they know me and my whaanau. I think it's really important that they do have a personal relationship on the mahi that they do because sometimes and I know whaanau they hate going to the doctors and it's really purely because they have had a really unpleasant time there, or they don't get the answers that they're after, but for me the relationship that I have, it's really helped me …. it's about having the confidence in knowing that they know what they're doing, it's about having the confidence that they've done everything possible to come to their diagnoses. So, with my relationship with my doctors and nurses I know because they tell me, "Okay so this didn't work this time, so what we've done is this, this, and this", and that's how it works. So, they fill me in on all the processes and that's important to me. ….they know when I haven't been in for my tests and stuff, the nurses ring me up, they're like my aunties, "hey you haven't been in for your last test" - "oh I've been really busy" - then they go "I know you've been busy but if you don't do this then you're going to be non-busy" – Teao [pakeke, tane]

Taimana: Yeah some of them you feel like you're just a number, you go in and they give you this diagnosis and then you're out of there, and not being too thorough. The doctor we're with now, she's lovely; she'll explain everything, and she'll go through everything you know, then if she has to go online to be able to describe what she's actually talking about with physical photos, pictures and even reading and all that.

Mia: Even phone calls you know, like home phone calls to let us know

Taimana: Yeah to check our well-being

Mia: You know she found out about something, so yeah we're really appreciative

Taimana: Just wanting to know what our well-being's like, and how we've been and how we really are. Yeah, that phone call like that, that means a lot. Even with my mother passing she was really cut up about that too, she was visiting my mother and she was calling her and yeah, and even us to see if we were alright you know, with all this, yeah she's lovely.

mia: She's really good, really good.

I was enrolled at [1st] medical centre for many years. When I moved to [2nd] medical centre, I found that they were more ah, te iwi Maaori friendly to be honest and they were more consistent and more caring and understanding as I've advocated many whaanau through

OOtorohanga, Te Kuiti, and Waikato DHB. What I've found throughout the consensus is that [medical centre 2] the doctors there actually take the time and they understand the contributions to the failure in our health system and also the health of our people and so if we go in there with pneumonia they understand that whaanau isn't working, that whaanau are living in a damp whare that whaanau can't feed because they got no puutea coming in. They see the whole picture, where the [medical centre 1] is a lot more clinical; tick boxes bang, bang answer these questions now out you go - Kaia [pakeke, wahine]

When we first moved here we were with, I think they were [Maaori provider], yeah, at first. Yeah, we were there, and it was only because we never had a vehicle and so they were in town. So, yeah, if I needed to get [my daughter] to the doctor, it was easy to walk uptown to get her done, but then we changed to the [medical centre 2] when we got a vehicle and then we were with a doctor there because we had heard that she was really good but then she um left. Within the last maybe, geez, seven years, we changed doctors, yeah we changed doctors because I felt that some of the diagnoses she was saying or some of the things she was giving, not just myself but …especially when it's your kid, you just don't want to keep putting them through stuff, so, yeah we changed doctors and it was probably the best thing for us that we did that, she's a lot better, the one we've got now, not saying the other one wasn't but yeah, there were just a few inconsistencies with some of the stuff – Mia [pakeke, wahine]

Three community members felt that the doctors seemed to be in a rush or pushed for time and wondered if that was due to a heavy workload. Related to time and a lack of staff, Tiki talked about the problem with locums.

With the new doctors that are in there now, there's no connection to the whaanau…. You don't even see the same doctor anymore, I mean I'm still with [medical centre 1] and have been since mai ra noa, but yeah there's no connection to any one doctor aye, as we know we're passed to the next locum, to the next locum, so, of course, our people when they go and see the doctor they get hoha, because I told that doctor the story - I've got the same mamae on the same leg - and now I've got to go and tell the next doctor the same mamae, the same korero, that's why some people don't want to go into clinic, aye because of that. They just get passed on and if there are places like [medical centre 2] that take the time and really connect and see the wider picture to that person, aye, that shows a real genuine concern to want to heal our people, to make right what had seemed previously as something that they had initiated. I just wish [medical centre 1] would just - rather than ticking boxes for us and have a 15-minute consultation and over and here's your script, you know, not even a follow-up call aye to see,

are you alright is there anything else you need. So if I'm making an appointment, and you're hardly likely to see the doctors these days, it's all over the phone now a phone consultation, so, our kaumatua aren't going to do that, unless there is someone by their side saying this is what they want of this is what they need from you aye, they gonna be hoha aye, it's just referring to our mum again, if the doctor prescribed her medication, she's going to take all the medication that he's prescribed her, that's her undying belief that the doctor is standing next to our atua so yeah, she's good at that, she's made connections with her doctor, but anyone else you know, it's a battle it's a struggle to really connect with a doctor these days – Tiki [pakeke, wahine]

Another issue that was raised specifically by two rangatahi, was the feeling that they had been stereotyped because of their ethnicity and body type.

When I was a high school student I couldn't walk properly, or was sore walking, so I went to the doctors. He goes 'oh you're just too fat you need to lose some weight.' Another week, it was unbearable to walk, so I went back to the doctors but he wasn't there and his wife had filled in, and his wife had way better community relationships in communication skills and she goes, 'aw tell me… what's happening' she goes 'have you had an x-ray?' I said 'nah.' She said 'do have an x-ray and when x-rays done go home and lie on your bed and don't walk anywhere.' And then sure enough an hour later … 'You need to go to Waikato; you need to have an operation asap.' So, I was like 'what the heck!' yeah. And it was her like going, aw 'actually. I think, well you've come back, there must be something wrong and you sort've just been kicked out last time?' Yeah' and she's like 'yeah, don't move' and I end up with like a big surgery and couldn't run or walk for three years and I was in a wheelchair for like four months – Mateo [rangatahi, tane]

…yeah there's a difference when… you go to the nurse to get your … the depo, and then you get called obese because your BMI is, ah concerning to them, yeah I think that there's a difference for them – Ani [rangatahi, wahine]

One participant emphasised the importance of extra support for kaumatua (the elderly); they need people who care, understand, and take things at their pace.

I can talk, I can ask for what I need, but I do feel for some of our whanau who don't - like I recently took my uncle to Waikato for his earphones check, he had to have his earphone check and he had to have an injection so that they could do a scan of him, so he had his injection, he was fearful of the needle, but I'm pleased I was there, he's 90 years old… and when he got

dressed he asked that I went in and helped him get dressed. I'm really grateful that I was there for him, so I went in and helped him with his things. Then when he got up on the table I felt the girls - I told them "No, you're speaking too fast, please don't speak so fast you're talking to my uncle he's 90 years of age, and he'll understand you better if you speak a bit slower." Because they know what they're doing, it's at speed and I just asked the lady to speak a lot slower, because he's 90. I would have hated it if I wasn't there and lying down he's scared with that thing coming down. I said "you're scared aye uncle? I could stand beside you though, but it's gonna be alright" – Wai [kaumatua, wahine]

Well, they don't necessarily have to talk Maaori, I think it's that kanohi, cause when my mum saw an Indian, she went "aish, aish" [well look it's an Indian]. That sort of thing, but if they see the kanohi mehemea he paraone [brown face] whatever, they sort of relax I think, because they think that they might understand them – Paia [kaumatua, wahine]

Another theme that emerged was 'being thorough.' In several interviews, community members spoke highly of the doctors who listen, give clear and honest information and guidance, and telephone their patients to check on them.

The doctor we're with now, she's lovely, she'll explain everything, and she'll go through everything… - Taimana [pakeke, tane]

I've had some really good experiences with my doctor that I'm seeing, she's so thorough and I like thorough… Just checks everything out and she embraces natural medicine, and she gives you alternatives you know, she is honest with you…what I appreciate about her is the transparency - Teia [rangatahi, wahine]

… I found that they were more te iwi Maaori friendly to be honest and they were more consistent and more caring and understanding - Kaia [pakeke, wahine]

As expected, some interviewees also shared negative experiences. Four spoke about being "treated like a number." Also mentioned was the time it takes to get an appointment, waiting for long periods in the waiting room, being rushed through appointments, being prescribed medications as a quick fix, the locum experience, and the absence of a genuine relationship.

With the doctors that are in there now, there's no connection to their whanau, you don't even see the same doctor anymore, I mean I'm still with [Medical centre 1] and have been since mai ra noa, but yeah there's no connection to any one doctor - Tiki [pakeke, wahine]

…they are pressured for time; they need to get through a lot in a day... In a way, they've kinda lost how you say that people person - Tiipa [pakeke, tane]

… they look after you but it's always like here's the pills go take those, take these 3 times a week, here's the prescription go take these, there's no investigation into why you're ill or why things are happening to your body and that kind of stuff, until you push it – Teina [pakeke, tane]

Only three interviewees either mentioned or talked about Maaori health providers. Above, one talked about moving from the Maaori health provider to the main medical centre because they couldn't offer the specialist care they needed, while the other two felt that these providers couldn't provide what they needed.

So, I got sick last year and the Maaori one just wasn't up to the standard that I needed them to be at, they weren't giving me the stuff that I needed and as soon as I switched to the medical centre I got all the tests that I needed, and I got all the medicine that I needed, kind of stuff. As much as I love the Maaori one and its Maaori based, it just wasn't right for me – Ihi [rangatahi, wahine]

... Because it's very whaanau, you know, as soon as you tell one person it's just like wildfire, which is really good I think for kaumatua, you know, they go to the doctors they just want help with all the stuff. But I think for rangatahi - I don't want to go "oh, man, I'm feeling like I'm suicidal." And then you know the whole wall of the health providers in the King Country know, and they're trying to help me, and I didn't want that 'I just need some happy pills' or whatever. But yeah… I'm a bit iffy about confidentiality and stuff which I think is good with like [Te Kuiti] hospital and stuff, is going to be confidential and it's more private. Like your stuff is kept, yeah, private and I can totally understand that Maaori side as well, of sharing it aye. It's like that whole whaanau, the whanaunga. Yeah, but you don't want that. … I think it works for kaumatua. They don't know all of the services; they just want to get to the one-stop shop. I think for some younger people that sort of, yeah, I don't want to go there because I don't want everyone to know – Mateo [rangatahi, tane]

6.2 ‘Rural and Remote’

This particular set of questions acknowledges and upholds the rangatiratanga of our people, our haapori, to define or describe themselves and their whenua. As illustrated in the literature review (Chapter 5), the concept of ‘rural and remote’ has largely been debated and discussed by academics, doctors, and government agencies rather than the people and lands they are defining. So, with their healthcare experiences in mind, with this second set of questions we set out to hear the opinions of the people who live in Te Rohe Pootae.

What does ‘rural and remote’ mean to you?

Similar to the ‘rural and remote’ literature, people differ in their opinions about what is rural and remote (Whitehead et al, 2022). In this study, the two major measures that emerged were distance and access to services.

Of the 30 people interviewed, 22 agreed or stated that Te Kuiti and OOtorohanga are rural towns. Others, in comparison to OOtorohanga and Te Kuiti, described their homes in places like Tahaaroa and Kinohaku as remote. The question about what is rural and what is remote proved to be a great topic of conversation with each of the participants taking time to think about and share their ideas about their location in the rohe. Their responses also highlight other relevant topics of interest.

> *It means the distance or drive to the amenities that you need - the further you’ve got to drive the more remote you are – Emere [rangatahi, wahine]*

> *I would describe Te Kuiti as rural; I would describe Piopio as rural; I would describe Tahaaroa as remote, Marokopa as remote – Nina [pakeke, wahine]*

> *We’re definitely rural, we’ve got all the facilities, you know it’s just a few footsteps away to get medical attention – Taimana [pakeke, tane]*

> *I would describe Te Kuiti and the surrounding as rural but not remote, except once you go beyond Waitomo, even going out that road once you go past, and climb into the hills, it starts getting remote - Uirai [kaumatua, tane]*

> *… to get into town you've got to travel two hours one way so you can travel two hours back the other way just to get a jab, and then it costs money and you’re driving over roads that you could break your neck on, you know just that, I don't know but that's what remote feels like for me, it’s when you’re in donkey land… rural is more accessible – Nina [pakeke, wahine]*

Well of course we're rural and remote in all of our areas, the reason being is the limited services available to the people…You take Waikato, they've got how many medical centres? How many practitioners are going on up there?. whanau can actually have a choice whether it be Maaori practitioners, whether it be mainstream… whereas down here we're isolated, we have two medical centres between OOtorohanga, and Te Kuiti and the surrounding areas have to travel in, like Tahaaroa, Benneydale… - Kaia [pakeke, wahine]

I believe OOtorohanga is rural, where you have lots of access to lots of services, for me that's the real trait. Remote is Tahaaroa where you only have necessities, well even Kaawhia I think is a bit more rural than Taharoa - Te Ami [pakeke, wahine]

….we would often get [Nurse] coming with a medical student or doctor coming out [to Tahaaroa] and they would just be blown away with the distance they would have to come from Te Kuiti, they have to come out there just to have a look at the community and what they would have to contend with in access to medical health assistance and just realising that this is a long way out and there are old people out here. Who is here to provide that care for them, it's an hour away – Tiki [pakeke, wahine]

Rural and remote to me is sort of where I live and even where I work out at Tahaaroa and Marokopa, you're out of the way from town. I would think that OOtorohanga would be a town because of where it is - kaihana [pakeke, tane]

One participant explained living remotely meant that careful planning was needed and how one day in town meant that errands were packed into that day. She compared it to a person who lived in town being able to pop down to the shops, but a remote person needed to be extra organised.

… you have to plan, 'right I have a town day today, yes I got to make an appointment to make it fit for this day because I'm in town that day and sometimes that's a big hurdle too, that one day that they've got to do many things… - Te Ami [pakeke, wahine]

While some of the villages are an hour or two away from the nearest rural town, the locals explain that it is not always an easy journey.

…Marokopa and Tahaaroa, those are remote places… It's hard to get to those places even though they're only an hour's drive from OOtorohanga and Te Kuiti… but you know the roads out there aren't the best and sometimes, like last week, there were slips all over the place. So those to me… are remote places – Teao [rangatahi, tane]

I think that these days Tahaaroa and Marokopa are definitely remote, especially when the rivers flood out there, cutting them off completey – Hemi [pakeke, tane]

… you are driving over roads that you could break your neck on, you know just that, I don't know but that's what remote feels like for me, it's when you're in donkey land… rural is more accessible – Nina [pakeke, wahine]

We're only an hour away… but for medical attention, depending on what it is, then you have to put them in an ambulance… or maybe a helicopter that's why it makes us remote - Tiipa [pakeke, tane]

Taharoa would be remote to me because the access thing there's only one way in one way out sort of thing, it's not a place that is easily accessible and it's not a place that a lot of people go to and it would be hard to hold on to your services out there you know, that's what I'd say is remote… Whakaotirangi [pakeke, wahine]

As mentioned above, these community members considered access to services as another measure rural and remote. A comment that really grabbed my attention was that Te Kuiti is a rural town but because it can only offer limited healthcare services it is also/actually remote.

yeah I believe it [Te Kuiti] to be a rural town and as the opinion of the work mates I work with they all think the same, like [daughter] said, we're only an hour away in travels not very far, but for medical attention , depending on what it is then you have to put them in an ambulance to get them from A to B alright, for that same thing depending on how bad it is, maybe a helicopter that's why it makes us remote, because of those aspects because we don't have those facilities here in TeKuiti – Tiipa [pakeke, tane]

Well of course we're rural and remote in all our areas, the reason being is the limited services available to the people. So, you take Waikato, you've got how many medical centres, how many practitioners going on up there that whanau can actually have a choice of who they want, whether it be Maaori practitioners whether it be mainstream practitioners, whereas down here we're isolated we have two medical centres between OOtorohanga, and Te Kuiti and all those surrounding areas have to travel in, like Tahaaroa, like Benneydale Rereahu, to come in from those areas. So, for me it's about the lack of services available within the region that can supply the services to the whanau, of what makes it rural and what makes it remote – Kaia [pakeke, wahine]

A lack of access to specialised care such as cancer and dialysis treatment was also raised as a measure of being rural and remote.

> *And seeing my health from diabetes and cancer, they've got [Waikato Hospital] a lot of support. OOtorohanga they're starting to pick up and take passengers straight up to Waikato, whereas Te Kuiti has to wait for the Taumarunui bus to go through, which is true because a lot of us still can't get transport and it's a lot easier than bothering other families to take you and you still have to get someone to take you if your appointments for cancer treatment, but they're still giving more support for all cancers, but I thought with diabetes, a cousin of mine and I was travelling with them for my appointments on the same buses and what they said, we got Te Kuiti hospital, and to save travelling - it should be there, the dialysis and that, it just needs to upskill with nursing, and everything for the dialysis machine, because that's a big hospital where they could use that facility – Kai [pakeke, wahine]*

> *…I think my experiences with health have been good. Yeah, it'll only be the distance, travelling to Waikato at the moment I'm travelling about three days a week. So there, you do get reimbursed for travel, but yeah, still we go back because you need their treatment at the hospital. So, I understand that. Otherwise, it's either keep travelling move, move closer, or there is what we call alternative treatment and that is to have the treatment at home. Well, we're sort of working on that at the moment - Ngawai [pakeke, wahine]*

Do people living in rural and remote communities have different healthcare needs?

Most of the community members (n=25) interviewed agreed that in comparison to people living in the cities, rural and remote communities have different healthcare needs and challenges. In terms of healthcare needs, mental health and caring for the elderly were important topics, while challenges were directly related to the issue of distance.

A number of interviewees raised concerns about the need for more mental health care. A third of the interviewees (n=11) talked about their own mental wellbeing in relation to COVID-19 and the lockdowns; two spoke about a family member; and a teacher in the group talked about needing more support for rangatahi. One interviewee who works in mental health explained that the time it takes to reach clients is particularly challenging.

…to do mental health properly in rural areas you've got to have the capacity, you've got to have the staff, you've got to have the knowledge, you've got to have the ability to reach those sorts of people, because I think that's the biggest outreach barrier. So, we were based in Te Kuiti, and we had a [rangatahi] that we needed to go and visit but … to get to her was almost an hour and a half drive, to then to organise to have time with her and then come back. So, what I'm really trying to say is that when you really nail it down to detail in terms of employment you're spending more time in a car than what you are actually working with your clients, and [they are] only one, you know we had lots, all over the place and that was just the youth and we could only get to them once a week, and that's not including all the adults that we had to try to get to, and so my point really is that we're not equipped I would say, especially in that mental health space, to meet the immediate needs of the clientele that we have, because generally when we look at it, it comes down to contracts, it comes down to money, not just how much you're going to pay them, but the capability in your area. … I'm not too sure if that marries up with the theory itself of the system around how were providing the health services to some of these people and you know with rising suicide rates, rising addiction rates, rising violence, kids in family violence rates. So, potentially you could correlate those two; we're not actually resourcing enough in these areas to be able to address what we've already got, but also try and prevent, so we don't put any money into prevention really – Nina [pakeke, wahine]

Other community members raised concerns about the elderly (Maaori and Paakehaa).

… for me, rural and remote starts to get really difficult for the older ones who are living on their own… Wai [kaumatua, wahine]

… all my neighbours are pretty elderly and there's always an ambulance flashing in the night, and I feel sorry for those ambulance staff you know because a lot of these people are living on their own and like I said they probably think 'I don't want to trouble them' and by the time it really gets bad… yeah. - Maimoa [kaumatua, tane]

… a lot of people here are single [and] the biggest issue sometimes could be transport and advocacy for those whanau, and Paakehaa whaanau too, not just Maaori whanau… we've got 'Bob/Sue' up the road. I've seen [him/her] drive to things. You know, I do worry about people like [him/her] but there's a lot of single people. …. So, for me, rural and remote and remote starts to get really difficult for them, especially for the older ones who are living on their own,

it's getting the medication you know. Luckily a lot of our whaanau will come home and take care of their older ones – Wai [kaumatua, wahine]

Related to distance, the need for mobile doctors, nurses, carers, and more clinics was raised by a number of community members.

I'm sure we can find a way, you know… Even if it was a nurse that… drove to each whare at least once every month, if they were able to visit all those people once a month and able to access their needs, you know I think that's one of the answers - Wai [kaumatua, wahine]

There's so many people who have been living rural and living there their whole lives and have found ways to get through their ailments or anything, you know, then you only go in when they're really bad and they reach out there I feel, like mobile clinics and things like that isn't always easy for people, a lot of kaumatua I know … they're not always able to get picked up…. I think that would be amazing… outreach clinics. I think that there are a lot of health care clinics doing that, but they're just doing that now, you know, which is cool but more awareness about that, for the people who are secluded and are just getting by day by day, the people and their families around them you know, just to have that awareness that we can come to you if you need us to – Teia [rangatahi, wahine]

… we could benefit more from smaller clinics, making it more readily available, just like children's ear clinics and all that and more often, for things like that so that we don't have to travel all the way up there, but at the same time I know that the community support is better than the big cities when you're unwell, everyone seems to come together to help you out – Emere [rangatahi, wahine]

Interviewees also raised the issue of limited services in their rural and remote locations, which means they must travel either to one of the rural towns to see a doctor, or to the main centres for specialist treatment, which can be expensive and is more challenging than it is for urban dwellers.

Yeah, we don't have a hospital, we don't have all those facilities like Hamilton… I know we can go and have an x-ray at Te Kuiti. There's limited services at the hospital there, but we still have to travel – Whakaotirangi [pakeke, wahine]

…a lot of the people can't get there [Waikato hospital], they need an ambulance. They have to pay for it, for the old people … it's about $90 or something to go by ambulance… I paid my sub

the other day, it was $55. So yes. There's a difference and we need something for the rural areas - Uira [kaumatua, tane]

The people that are born in the cities and the towns I think are completely different. I can only speak for people who live in Kinohaku, Tahaaroa and Marokopa for the health care needs and travelling into town, because our rural bus... the new bus driver that's taken over from the Perrys doesn't hold a passenger licence, so she can't take passengers, whereas before we could get on the bus… - Paia [kaumatua, wahine]

Because we don't have that easy access to things like, for instance, cancer treatment, or even dialysis treatment. Yeah, because to get cancer treatment, again, you have to travel to Waikato – Ngawai [pakeke, wahine]

when you address inequities to rural communities, you also need to take into account things that are associated with rural and remote areas, such as lower socio-economic status, possibly ah, definitely decreased access to health care, because they have got limited options when it comes to primary, secondary, and tertiary care, so that creates further inequalities on top of the primary healthcare inequities, ah so yeah, I could go on and on… - Te Ata [rangatahi, wahine]

Te Ata, also highlighted a positive about living in rural and remote areas,

…I don't have exact statistics, but in comparison to a large city where there are… extensive different GP practices in all different suburbs to - for example in Te Kuiti with one GP practice and 5-10 doctors with a population of 5000 in the community - the access to healthcare is restricted compared to if you lived in a city with more options and less distance to travel. But then on the other hand, I could also argue that if you live in a city, access would be decreased by the cost of an appointment with a GP. Price of primary health care in cities is more expensive compared to primary health care in lower socioeconomic rural and remote towns such as Te Kuiti. There are pros and cons on both sides of the scales, but the place that needs the most attention are rural and remote areas due to other reasons such as lack of resources and the community ethnic populations - Te Ata [rangatahi, wahine]

Do Maaori living in rural and remote communities have different health needs to Paakehaa living in rural and remote communities?

More than two thirds (n=21) of the interviewees agreed that the healthcare needs of Maaori are different to Paakehaa, but their answers were more about Maaori and Paakehaa in general, rather than in rural and remote communities.

> *Yeah, I'd say that they are different, they operate differently too, support wise - Manu [pakeke, tane]*

> *There are so many differences in health care. Academically, the way that I relate this to is looking at marginalisation data, this is data that depicts inequity in health compared to non-Maaori. First and foremost, Maaori have lower life expectancy, we have higher mortality rates, we are more likely to have more chronic and acute illnesses than non-Maaori and there… for example, Maaori are about 1.5 more likely to have type 2 diabetes than non-Maaori. So then once you know that marginalisation data you realise that there is the need to address those issues. We can't address these issues equally between Maaori and non Maaori, there are different needs and predispositions between the ethnic groups, therefore they require different management. This is the difference between equality and equity - Te Ata [rangatahi, wahine]*

> *Yes, there is, totally different. Our Maaori people are very whakama people just in general… so some of those very minor issues that could be fixed, end up being some of the biggest issues medically in their lives because on the onset they were whakama to go to the doctor to have the doctor examine them in their tinana… So, we are a very whakama type of people and I think asking for help is another thing that's hard for Maaori to do, you're initially doing two things that are out of your norm, so you're showing vulnerability… exposure and then you're having to ask for help, you're putting two real hard things for Maaori to do. So, I do think it's harder for them and I think too that economically it's also hard - Te Ami [pakeke, wahine]*

> *I've seen a documentary on TV about Maaori not getting the proper health care and not getting the proper… medical assistance with their medications and things like that because these medications are actually quite expensive, so they weren't prescribed to Maaori for some reason… I don't know why, but it's definitely a big issue, Maaori and Paakehaa obviously, what's the word for it, not equal you know. Taimana [pakeke, tane]*

Nina made the observation that different cultures have opened their own medical centre's, so they feel safe.

> *Different from Maaori living in towns yeah, and that's clear with… you know our Asian whaanau who have started creating medical centres and things and groups, our Pasifika whaanau, our Muslim whaanau… they're not trying to segregate themselves from society they're actually trying to find the safe spaces that they need to go through whatever it is that they are going through, so… where as we are so mono cultured in New Zealand, well we were, we're shifting slowly, but in the first instance Maaori are the partners, they are the only partners by right not by law but by right, and then its all of our other whaanau, that come along with that, so yeah people are treated differently, with the services – Nina [pakeke, wahine]*

A smaller number of participants (n=8) stated that Maaori and Paakehaa have the same health needs. Particularly interesting were the views of the interviewees who lived in remote locations, who talked about having the same health needs as the Paakehaa villagers and that their remote communities are inclusive and rely on and help each other.

> *You know it's hard to imagine differences. We don't. My family doesn't experience them… whether there's a difference in treatment, I don't know because I've never experienced that so it's hard for me to. But I should imagine some have, but not us – Uira [kaumatua, tane]*

> *Yes and no, because I know a lot of the whanau tribes like the …. Have heart problems and specific needs for that, so different families do, but then again everyone's all the same again as well, same health issues, so yeah, yes, and no there – Emere [rangatahi, wahine]*

> *… technically no, because everybody has the same needs, though it's probably different levels of care. I don't think they have different needs. Females… have different needs from males, but we're both human, we both suffer for the same things, so I don't think we have different needs - Kauri [rangatahi, tane]*

Other participants made comments that highlighted some particular health issues:

> *That's hard to answer, I think I've got the same… in my whaanau background we have a lot of diabetes… but I'm not sure if Paakehaa families have that too. I don't know – Atiria [pakeke, wahine]*

… Maaori are more likely to live in rural and remote areas, than they are to live within cities… so that's important when we think about on-going issues such as access to health care which can then become inequitable because we don't provide… better access to healthcare and distance wise, and other factors - Te Ata [rangatahi, wahine]

I think so… firstly due to our high representation of the healthcare statistics, the negative ones. Maaori obviously need more focus in terms of healthcare due to colonisation, e raa mea. I think if I'm having depression and I go rock up to a Paakehaa doctor and they go - Nothing's wrong then I go to a Maaori doctor, and he's said - cool you're probably getting in touch with your spiritual side which is te ao wairua. A concept that some Paakehaa doctors might not have a grasp of – Mateo [rangatahi, tane]

6.3 Healthcare Needs and Aspirations

After reflecting on their healthcare experiences, and health in their rural and remote communities, the final set of questions turned the participants attention to the future: Their thoughts about the proposed medical school, the types of services and healthcare professionals they need, and what the curriculum for a medical school might include.

A new medical school in the Waikato

When asked to comment on the proposal to establish a medical school in Hamilton, most of the participants were excited about the idea, and some referred to the other medical schools.

Go for it! It will be awesome! A medical school based at Waikato 'ka mau te wehi' – Rina [pakeke, wahine]

In terms of Auckland University and Otago University, if they don't have enough placements for the students that are applying... well that would tell you that there is a need for another school – Atiria [pakeke, wahine]

We definitely need another medical school, doctors and nurses… not just Auckland and Otago - it doesn't make sense …you have to choose to go south or all the way up to Auckland – Ngawai [pakeke, wahine]

Yeah, I think that would be absolutely brilliant because 1- all of our people are going out of the rohe to go to med school and a lot of them when they go out of the rohe to study it a lot of them go out of the rohe to work in the industry as well, so, I think it will be very important for

us to have our own right here in our rohe, so that we can retain all of our medical professional that are pursuing the profession and have our tikanga mixed in with those learning as well, because we know that rongoa Maaori is huge and there's heaps of our tuku iho that have been passed down from our Tupuna to all our Rangatahi. Our Rangatahi these days are way more on to it than I ever was in my rangatahi days, and I know that they have the key and the knowledge to mix in all of that knowledge from our Tupuna today, yeah so, I think it would be really important for us to have our own kura here in the Waikato, definitely – Uira [kaumatua, tane]

Another interviewee suggested *"...the medical school [be] closer to Te Kuiti and Taumarunui, to encourage rural people to become doctors and it might be able to open an oncology ward – Maimoa [kaumatua, tane]*

On this note, two interviewees talked about family members who wanted to be doctors but were put off by the distance and the cost of living away from home.

I've got a niece in Hamilton, and she was looking at doing medical studies and you know her only options were Otago or Auckland and you know she ended up doing a psychology course now, ended up doing neither, so maybe if there was a medical school in Hamilton she might have found that less of a barrier – Atiria [pakeke, wahine]

I reckon you'd get a lot more people from rural places if you actually took it [the information about courses] to them. … just having that option would get a lot more interest – Teina [pakeke, tane]

In a similar vein, a medical student in her final year at Otago said she would have loved to study closer to home.

I mean personally, I'm kind of disappointed to have not seen it happen earlier because I would have really loved to have been a part of a rural medical school, in my whenua, in my home… - Te Ata [rangatahi, wahine]

Thinking about the rangatahi who leave home to study and don't return, Teao stated:

I'd love for Te Whare Wananga o Waikato to have its own medical school because we've got so much potential right there in our own rohe and it would be a shame for them to go away and maybe not come back. So, I think to retain our own people and to retain all the knowledge

from our Tupuna, I think that it's really important that we have our own kura here in Waikato. Kia ora – Teao [rangatahi, tane]

A number of community members shared their vision for the medical school, including a focus on rural and remote communities, training Maaori healthcare professionals, and being different to the existing medical schools and Western medicine.

I think it would help… to have a specialisation of rural… like what rural healthcare actually looks like, because it's not like when you're in the city – Mateo [rangatahi, tane]

I love it, I love the idea… you'll start getting more Maaori doctors, more Maaori practitioners, whether they're physios, whether they're nurses, whatever, I love the idea – Nina [pakeke]

Cool! But I think you should have at least 50 percent Maaori – Wai [kaumatua, wahine]

Is it just based on western medicine? If it's going to encompass everything that hauora means to Maaori and Pacific people then beautiful, but if it's just going to target the mainstream people and common needs, then what's the point? – Teia [rangatahi, wahine]

Oh, I'm all for it as long as it's with us, by us, for us – Manu [pakeke, tane]

I think the time couldn't be more perfect! There's been a huge change since COVID… a lot of mainstream people within the government contract now, they have to have that element of kaupapa Maaori … [but] it won't just be kaupapa Maaori, it will be Te Ao Maaori - it won't be a learned reality it will be a lived reality – Kaia [pakeke, wahine]

Another community member asked if the University would be working with iwi and emphasised the importance of including them in the consultation and planning process.

I love it, I love the idea. Waikato Tainui are such a powerhouse in that area, what I feel you'll start creating if that happens, if you build a relationship with Waikato Tainui you'll start getting more Maaori doctors, more Maaori practitioners whether they physios whether they're nurses whatever, so, I love the idea – Nina [pakeke, wahine]

What kinds of services and healthcare workers do you want?

In addition to the need for more doctors and nurses, local dialysis and cancer treatment as mentioned above, interviewees also highlighted the need for allied healthcare professionals.

> *We need more doctors… and more nurses, but even clinicians, I don't know if they get trained in medical school – Atiria [pakeke, wahine]*

> *We need more counsellors and psychologists in this area, especially for our teenagers – Ihi [rangatahi, wahine]*

> *… and another big one… only because we used to hold this contract with Podiatry - the reason we would travel was because of something as simple as nail cutting, because our whaanau suffer one of the highest statistics of diabetes, here it's huge and it can be all started by something simple as in-grown toenail and they don't understand that actually it might not be that ingrown toenail that has caused all the havoc, maybe you need to go to the doctor and you need to find out if you've got diabetes. Footcare is huge, how many of our people are getting their toes, their waewae, and their legs cut off? That's a service that is very expensive and very hard to access in Te Nehenehenui – Kaia [pakeke, wahine]*

One community member was particularly concerned about nutrition and obesity.

> *I probably think physical [health is] quite a high priority, because a lot of people these days and the kids these days they're all … overweight, it is a bit of an issue…. It's been going on for years and you notice it in your towns you know, as they are growing up as little kids, and they start getting older and they start putting on weight. So, I think maybe something like nutritional advice and physical wellness advice, and more sort of possibly family-related sort of physical activities, something like that, but I don't know specific to a health professional as such, like a health professional or doctor or something like that… but some sort of health expert or ambassador or someone from the public to the hospital or something like that, yeah something definitely – Kauri [rangatahi, tane]*

In addition to what was mentioned above in relation to single adults living in remote communities, Uira asks that the concept of travelling doctors be reinstated.

> *They were caring. They didn't care where they came from. If your house wasn't flash, they didn't care about that. It didn't worry them. All they were worried about was you and then they came back again if they had to. They didn't say 'catch a taxi and come in' because we*

couldn't get out.' … That's what we need, something like that, instead of lining up in the office from 9-3 and going home. I mean they don't do operations at the Te Kuiti hospital aye. It's not as though they don't have time. They have time in the rural area, especially the number they've got there. Mind you we might not get the numbers. …. But make it whoever comes to the rural areas that they pledge to do that sort of thing; must be something incorporated into their contract, that they do go out and visit. It helps with your wellness – Uira [kaumatua, tane]

Concerns about the ageing population of our rural and remote communities were also raised again.

Well with the way the country is… going with its ageing population… those guys are going to end up in mobility scooters, crutches within the next 10 years… You're going to end up with a bigger Beatie home with doctors and nurses not just caregivers, you know, because these guys are going to come in with unbelievable ailments, but they won't be the life-threatening ones, they're just going to block up the system – Maimoa [kaumatua tane]

Characteristics and Attributes

After thinking about what kinds of services they want; when asked what kinds of characteristics and attributes they wanted their doctors to have, the participants said: caring, compassionate, genuine, awhi (supportive), and nurturing. Also mentioned in the literature (e.g., Tinirau et al., 2011; Worley, 2019), a number of interviewees stated that they want doctors and healthcare professionals who are "culturally understanding" - i.e., doctors who understand Maaori, Maaori culture, rural and remote communities, and New Zealanders in general. Some of these comments are directly related to experiences with doctors from overseas, but also apply to New Zealand-born doctors.

Having a specific school in Waikato would probably help with cultural barriers… like if you come from overseas, it's going to be completely culturally different from where you lived… Kauri [rangatahi tane]

… it would be nice to have a doctor that would understand the community… Ani [rangatahi wahine]

I think we need more Maaori and Pacific doctors, because they understand the way our bodies work and know that it could be something to do with wairua instead of just giving us antibiotics… - Ihi [rangatahi wahine]

They definitely need to learn personality differences because they're going to come across different cultures, different aspects, different everything, definitely have to have some

understanding of different races, and just have a friendly outlook about things, you can't approach people with a stuck-up attitude – Taimana [pakeke tane]

… like being up in A&E in Auckland, there were a lot of foreign doctors and nurses and, yeah it can be a little bit uncomfortable for like New Zealanders and that, but yeah, just be a bit more approachable – Mia [pakeke wahine]

yeah you've got to understand where these doctors come from, where are these new doctors from, because what are our people doing in today's society, because I think that, with technology and the internet and things like that some of our children are really whakama and its not their fault, it's their parents' fault, you know … we've got quite a lazy generation coming up through the ranks and all that you know, we've got to keep them motivated, from a young age and all that – Taimana [pakeke tane]

They should probably learn and understand some form of tikanga, in terms of what's appropriate… how you approach the body, the head you know all those things that are tapu, in amongst our culture – Atiria [pakeke wahine]

… its connection you know, it's about whakapapa, it's knowing who I am when I walk through the door, it's knowing who you are and where you have come from… - Te Ami [pakeke wahine]

What do we need to teach our medical students?

Placing an emphasis on the desired characteristics and attributes above, the interviewees stated that in addition to their medical training the proposed medical school should also prepare new doctors to work with Maaori and people of other ethnicities.

… like cool, you've got all this medical stuff but there needs to be another… year of learning about people, learning about cultures, religions… learning about personalities… everyone has different personalities, there needs to be a whole year… dedicated to learning about people and peoples' cultures, history just to have that understanding - Ani [rangatahi wahine]

… there should be a compulsory component for Maaori tikanga and Maaori culture. Otherwise, you're gonna be producing the same doctors that actually lack the understanding that they need for the contemporary world – Mateo [rangatahi tane]

Teach them respect, aroha, manaakitanga and ahurutanga, as each individual is different – Rina [pakeke wahine]

A female participant said that there was a need for cultural advisors in the training of new medical staff and mentioned how it would be a good idea to utilise Waikato Tainui in that process of a new school. She went as far as saying that a paper about cultural or Maaori perspectives could be included in the curriculum.

> *Well, it could even be something that you could build in that relationship negotiation with Waikato Tainui. Do you have cultural advisors that could come into our curriculum and provide a part of or a paper of cultural or whatever you want to call it? And I know that we come from a Maaori perspective, maybe you can share it around with Pacifica and Muslim and yeah, all these different groups that need to be considered; disability is a big one – Nina [pakeke wahine]*

The participants who prefer healers, would also like to see rongoaa included in the curriculum.

> *I think there should definitely be an aspect of rongoaa, and tikanga of all practices, especially tikanga you can put into everything – Manu [pakeke taane]*

> *I think rongoaa practitioners need to go in there, again it's because they are so connected to the environment and how that helps people. …. I feel that that should be taught … not a one size fits all, like western, but it's another opportunity and another way to help people live and to help people – Teia [rangatahi wahine]*

Summary

As I reflect on the experiences shared and expressed by the members who took part in this study, one thing is clear – there are differences. Rural and remote people are different from urban people, Maaori are different to Paakeha, and everyone has differing thoughts to what they what in terms of healthcare. The term different was used many times by all participants. However, in contrast to the differences a common theme that occurred was the shared thoughts about health and well-being. Although each participant described their thoughts on this topic the link and connection to Te Ao Maaori was a prominent and occurring theme. For Maaori, Te Ao Maaori means whakapapa and is holistic health and wellbeing, which encompasses the whole being and is not limited to - body, mind, spirit, emotions, marae, culture, rongoaa, ngahere, whenua – These are essential components that connect with a person and and are a part of their identity. Key to Te Ao Maaori is Rongoa Maaori, and although some might say that rongoaa is only for Maaori, there still needs to be an understanding of what it is and why it is important to Maaori. Rongoaa is not just plant medicine, it encompasses everything and is a part of Te Ao Maaori, Te Whare Tapa Whaa and makes up a persons health and wellbeing.

Health and wellbeing go together, there is not one without the other and the concept of spirituality was mentioned often. In terms of the latter it is mental health which was highlighted by the participants' awareness of how it affects our people. The general consensus regarding this was the need for more psychologists and counsellors to counter the ongoing issues. Also, considered important by our rangatahi participants, was the need for confidentiality in mental health situations; even though Maaori are more whanau and community orientated some things still need to kept private.

- While a thrid of the participants went directly to the doctor when sick or injured a third had a process before they planned what they would do next. The remaining third had other practices, for instance rest, going home, seeing whanau or they found help from other holistic health providers and practitioners e.g osteopaths, chiropractors, physiotherapists, and healers.
- Ideas of having more mobile clinics, travelling doctors and nurses, who visit people in rural and remote communities, especially with the growing number of kaumatua who live rurally.
- Forming good relationships, having a connection, understanding cultural barriers, and having staff that genuinely care were some of the characteristics that the participants wanted to see and feel from their healthcare professionals.
- Having doctors that made you feel comfortable, having doctors that are approachable and aware of people, values, feelings and personal and cultural beliefs.
- Rural and remote mean different things to different people. Limited healthcare services and access to service, and the barriers of cost, travel, and distance are some of the problems that need to be addressed.
- Growing up in a remote community and later living in a rural town, I believe rural and remote people, are kind, friendly, caring and more family oriented. They also seem to have a happy outlook on life.

For the new medical school, the inclusion of a partnership with Waikato Tainui is important as is the inclusion of Te Ao Maaori, which encompasses everything from people, place, environment and more. Students need to spend time on the marae and in rural communities to fully appreciate and connect with the people, the culture and the community. It is clear that cultural responsiveness, cultural competence, and cultural safety all have a place in a medical school curriculum.

Chapter 7 - Discussion & Conclusion

As I reflect back on my journey thus far, I acknowledge the many challenges and sacrifices that were met along the way. Challenging me in many ways has helped me to grow. Challenges are what shape you; they help you to recognise and uncover hidden fears and talents within yourself. In terms of sacrifice, as mentioned in the last reflection I have been out of balance in my body, mind, spirit and family and community spaces. Sacrifices teach you how to be caring and kind and they teach you about humility and not taking things and people for granted. Sacrifice teaches you to appreciate everything and everyone who comes into your life. I have a newfound appreciation for everything and everyone in my life…

Introduction

Following on from the Literature Review (Chapter 5) and the Findings (Chapter 6), in this chapter I discuss a selection of key points and in relation to the overarching purpose of the study, which is to gather information that will inform the curriculum for the proposed third medical school that will have a particular focus on training rural GPs. In Part 1 and Part 2, I briefly reflect on how the research participants describe 'rural and remote', and the key services they have identified as lacking in Te Rohe Pootae. In Part 3, I discuss the three health strategies that emerged in the findings, and what they might mean for a medical school curriculum. In Part 4, I present and discuss an adapted version of Woolley et al.'s (2013) desired attributes for the medical graduates' framework. In the Conclusion (Part 5), I offer some concluding thoughts, recommendations for a rural health curriculum, outline some of the limitations of the study, make suggestions for future research, and close with a final reflection.

7.1 Rural & Remote

In sum, the research participants said that the towns of Te Kuiti and OOtorohanga are rural because they are closer to the bigger towns, and they have some basic healthcare provisions; although three community members felt that these towns are actually remote because they do not have all the services that are available in the larger towns and cities. In contrast, villages, and settlements such as Tahaaroa and Marokopa were considered remote because of the longer distance between them and the nearest rural town, and the absence of healthcare providers including critical emergency services. Their explanations support the rural and remote classifications that are based on distance, access to services, and geographic isolation (e.g., Blattner et al., 2020) - but not those that focus on population

numbers (e.g., Goodyear, 2005b). These findings compliment Whitehead's (2022), statement that "People construct themselves as being rural, and rurality is in the eye of the beholder" (p. 25).

7.2 Services

While GPs are by definition generalists, certain populations and communities have specific or greater needs than others. Medical students being trained to serve in rural and remote communities should therefore develop clinical competence in those particular health areas (Woolley et al., 2013). In Te Rohe Pootae, the interviewees identified the following needs. To ensure everyone has access to healthcare, the community needs a mobile health workforce including clinics, carers, doctors, and nurses. To address the higher rate of mental health issues, they want more mental health services and support with the time and resources needed in order to reach their patients. A number of the interviewees also spoke specifically about diabetes and the difficulties and costs associated with travelling to Waikato Hospital for dialysis and related services such as podiatry. The possible solutions include regular, consistent, and affordable transportation services being provided locally; and/or mobile services and treatment. Thinking prevention, a couple of community members also suggested the creation of a Community Wellness Advisor role; someone who will promote healthier lifestyle choices for Maaori and their extended families, including counselling about diet and exercise. Rural medical students may be eligible for this position as an intern.

7.3 Healthcare Strategies

Most of the research participants associate health and well-being with Te Ao Maaori (Maaori World view) (Curtis, 2016; Pihama, 2011). Some of the interviewees talked about the power of karakia (prayers and incantations) (Tinirau et al., 2011), wai (water), the ngahere (forest/bush), rongoaa (physical and spiritual healing) (Williams, 2004; Tinirau et al., 2011), going home to the whaanau, and going home to the marae (Williams, 2004). The aim being to heal or (re)establish the balance between them - and when all the dimensions of health are in balance, one will experience well-being or hauora (Durie, 1994b). In other words, if one dimension of health (tinana, hinengaro, wairua and whaanau, hapuu, iwi) is weak or damaged it is likely to affect the other dimensions - and at the same time - the other dimensions are also sources and places of healing (Durie, 1994b).

During the analysis, three healthcare strategies were identified. When ill or injured, one-third of the group go directly to their GP. What is interesting here is that these community members described having very good relationships with the medical staff including receptionists, nurses, and doctors. Another third of the participants try other things before seeking medical assistance, including going

home to their parents and/or to their marae for comfort and advice; 'going bush' to (re)connect with nature, which is itself a form of rongoaa; and forms of pure (cleansing ritual) which often involve visiting and utilising natural bodies of water. The remaining group of community members are registered with medical centres - but do everything they can to avoid seeing a doctor. Instead, they rely on rongoaa and other 'complementary and alternative' treatments such as physiotherapists, chiropractors, osteopaths, and other healers. What is interesting here is that these community members also shared stories of being ignored, misdiagnosed, or 'treated like a number' by doctors (in the past).

The critical 'issues' here appear to be trust and faith. In the case of the first group, trust has been developed and nurtured in an environment where the patients feel welcome and comfortable and have received good or excellent care. In contrast, a lack of trust is stopping people from utilising doctors. However, there is also a sense of rangatiratanga amongst these community members. A sense of self-reliance and confidence in themselves, their people, and maatauranga Maaori (Maaori knowledge.

7.4 Desirable Attributes for Medical School Graduates

The research participants support the idea of a medical school in Hamilton/the Waikato, and a few of them offered some suggestions. One participant recommends collaborating with the local iwi, Waikato Tainui. Under the Treaty of Waitangi (see Chapter 2) and given that the University of Waikato stands on tribal land, one would expect that the proposed medical school is already being discussed with iwi. In a similar vein, another interviewee recommended that the medical school have a cultural advisor from Waikato Tainui, someone who could offer support and guidance in accordance with iwi processes. Another community member was adamant that 50% of the students enrolled in the medical school be Maaori; while another was excited by the prospect of local Maaori having the opportunity to become doctors. More doctors and more importantly more Maaori doctors, would "…produce the diversity in health workforce outcomes that our country needs [and] our reliance on the recruitment of foreign-trained doctors…" (Professor Quigley, as cited in University of Waikato, 2018, para. 3).

With the curriculum for the proposed medical school in mind, I have adopted and adapted Woolley's framework (Appendix J) to create Table 2. The process for constructing this table included following steps:

1. Focusing on the participants' expectations of doctors and healthcare providers, the Findings chapter was coded using the terms (desired) skills, knowledge, attitudes, and anything else the research participants want or need in relation to healthcare.
2. The resulting list was then grouped according to the headings in Woolley et al's table.
3. Where appropriate, common themes were combined, and other emerging themes were grouped together.
4. The attributes were then summarised and truncated, and where appropriate the words of the research participants have been used.

The final table features three sets of desirable attributes for medical graduates (and other healthcare professionals). 'Knowing the local health system' was excluded as this topic did not arise in conversation, while 'working with the Indigenous people' and 'engaging with the Indigenous community' have been combined and renamed. Two extra categories were also identified: Services, and suggestions for the medical school - and are discussed above.

In the process of constructing the desired attributes framework, it became apparent that the Mount Isa and the Te Rohe Pootae community members share some similar priorities and expectations (e.g., make sure of your diagnosis, confidentiality, always follow up). A number of the attributes are self-explanatory, but for clarity I will discuss each one and make connections to the literature. A number of these attributes overlap and intersect with each other.

Guiding the classification process, attributes are understood to be "qualities or features of an object, event, concept, schema or person" (Coleman, 2015). Skills are behaviour that is acquired through training and practice, and include motor, cognitive, perceptual and social skills (Coleman, 2015). Knowledge is "anything that is known" and includes declarative knowledge (knowing that), procedural knowledge (knowing how) and acquaintance knowledge (knowing people, places and things) (Coleman, 2015); while attitude can be defined as a "...learned predisposition to respond to certain things in a certain way and includes a cognitive (belief) aspective, an affective (feeling) aspect, and a conative (intention) aspect (Stratt, 2003). I also relied on Woolley et al.'s (2013) table for guidance (See Appendix J).

Table 3: Desired attributes for medical graduates and other health-care providers

Skill-based attributes		**Knowledge-based attributes**		**Attitude-based Attributes**	
Quality Care	**Communication**	**Medical knowledge**	**Culturally appropriate knowledge**	**Personality**	**Community Engagement**
Provide continuity of care - we don't like repeating ourselves	*Manaaki - be friendly and welcoming*	*Know your medical stuff - I want to be confident in your diagnosis*	*Learn about Te Ao Maaori - including the significance of whakapapa, tikanga, and karakia*	*Have integrity*	*Come to the marae - learn about us, our culture, our history*
Be thorough and investigate	*Build a relationship - know me, know my whaanau*	*Know that health is holistic - treat the whole person*	*Understand that Maaori are whaanau orientated*	*Be a 'people person'*	*Promote health in our schools*
Explain everything and follow-up	*Listen to me*	*Embrace rongoaa Maaori*	*Understand that (some) Maaori are whakamaa*	*Kia aroha ki te tangata*	*Be mobile - come to those who can't come to you*
Protect our confidentiality	*Don't speak too fast*	*Embrace complementary and alternative medicine*	*Learn about different ethnicities, religions and personality types*	*Appreciate that one size does not fit all*	

Skill-based attributes

The skill-based desirable attributes raised during the interviews were related to quality care and communication. Six of the eight attributes are derived from negative experiences, and two from positive experiences.

Quality of Care

The **Provide continuity of care** attribute is related to conversations about locums. One of the implications for patients is a lack of "connection" because "we're passed on to the next locum, to the next locum" - repeating the same story, about "the same mamae," to a different doctor - "which is why people don't want to go into the clinic" – Tiki [pakeke wahine]. The **Be thorough and investigate** attribute is related to descriptions of 'good' and 'not so good' doctors. Some community members like their doctors because they "check everything" while others do not like the way doctors simply prescribe medications rather than taking the time to investigate "why you're ill and why things are happening to your body… until you push it" – Teina [pakeke tane]. Another 'good doctor' attribute is **Explain everything and follow-up**. Some community members were very complimentary of doctors who "go through everything", explain all procedures and processes, and call them at home to check on them.

The **Protect our confidentiality** attribute may be more specific to rural and remote communities, where it seems that 'everyone knows each other.' In the Woolley et al. (2013) study, the comment was to "be aware when speaking aloud" (p. 94), but in this study the attribute is directly related to concerns about personal circumstances being shared with family members or other healthcare workers who may be related to them. Interesting some of the participating rangatahi mentioned how small towns people talk. Meaning that everyone knows or are related to each other, and they worried about their private information being shared with other whanau due to this. They felt that their information would be kept private if they sought care with non-Maaori medical practices.

Communication

The attribute of **Manaaki** places an emphasis on doctors being friendly and welcoming. Based on what the participants said, this desired attribute also extends to other staff members, especially the front desk receptionists. Feeling "comfortable" was mentioned several times by different community members, and Taimana [pakeke tane] stated, "you can't approach people with a stuck-up attitude." Related to Manaaki, **Develop a relationship** is derived from conversations in which community

members described having a good relationship with their doctor, which includes knowing their name and the names of their children. Teao [rangatahi tane] described it as the 'personal touch'.

The other two communication attributes are **Listen to me** and **Don't speak too fast.** The Listen to me attribute is about giving patients your full attention. 'Good doctors' listen actively when their patients are speaking; while community members do not like it when their doctor faces their computer during the consultation, "... they sit on the computers and they're not really listening, they're busy typing" - Uira. Related to the skill of active listening, one participant pointed out that doctors sometimes speak too fast: I told them "no, you're speaking too fast, please don't speak so fast you're talking to my uncle he's 90 years of age, and he'll understand you better if you speak a bit slower" – Wai [kaumatua wahine].

Summary

What is interesting here is that a number of these attributes feature in the Good Medical Practice standards for New Zealand doctors, which suggests that some of the doctors in our region have perhaps become complacent (Medical Council of New Zealand, 2021b), which might be related to the workforce shortage, leading to some doctors being inundated with patients. But this does not explain the experiences of the interviewees who said their doctors provide excellent care and communication. In the study conducted by Schnelle and Jones (2022), exceptionally good doctors relate well with patients and tend to be humble and approachable.

Knowledge-based attributes

The knowledge-based attributes embedded in the interviews are related to medical knowledge and culturally appropriate knowledge. Woolley et al., (2013) table included three sets of knowledge-based attributes; however, my interviewees did not mention the local health system. Other than 'Make sure you know what you're doing', these attributes are about being culturally responsive (Maaori Cultural Responsiveness Project Team, 2010; Agency for Clinical Innovation, n.d.).

Medical knowledge

The first 'medical knowledge' attribute is **Know your medical stuff**. This desired attribute is directly related to the expectation that medical graduates will be trained in everything they need to be a general practitioner. Specifically, however, the interviewees placed an emphasis on the importance of diagnosis. One community member changed doctors because she wasn't confident in the GP's diagnosis skills and knowledge, while another felt "… fortunate, because I went straight from diagnosis to specialists" – Nina [pakeke wahine]. On this note, I refer back to the study involving

Maaori women from rural and remote areas, some of whom were denied diagnoses or screened too late, were more likely to develop metastic cancer due to being diagnosed too late, and therefore having a lower chance of survival (Lawrenson et al., 2016a).

The **Know that health is holistic** attribute emphasises the well-being of the whole person - body, mind, spirit, relational. On this topic, a number of the interviewees referred to Te Whare Tapa Whaa. One participant explained, "wellbeing is informed by your health but it can't be the other way - you can't be well within your being if you're not holistically healthy" – Whakaotirangi [pakeke wahine]. Related to this attribute, **Embrace rongoaa Maaori** means to accept and support the revival and use of rongoaa Maaori, which may be stronger in rural communities because they are closer to the natural resources and knowledge keepers than urban Maaori. Although, this hypothesis would need to be investigated. Likewise, **Embrace complementary and alternative medicine** means to accept different approaches to health, well-being, and healing.

Culturally Appropriate Knowledge

To **Learn about Te Ao Maaori** means to have an understanding of the Maaori worldview, which includes our customs, traditions, language, and value system. Of particular significance to the research participants are whakapapa (genealogy/lineage), tikanga (customs), and karakia (incantations and prayer). A number of the interviewees referred to Te Ao Maaori as their puna (well) of health and well-being: "... it's everything, it's your wairua, it's your tinana, your whakaaro, how your marae runs, it encompasses everything…" – Wai [kaumatua wahine]. Part of understanding Te Ao Maaori is understanding the significance of the whaanau (all our living relatives). **Understand/ing that Maaori are whaanau orientated** will help doctors to understand why (some) Maaori may bring other whaanau members to their appointments, to speak on their behalf, or to translate or interpret what the doctor is saying or meaning. This attribute is closely related to **Understand that (some) Maaori are whakama**. Medical students need to understand that some Maaori are too shy or embarrassed to ask questions, or to have a stranger look at their body (Jansen et al., 2008). A doctor who knows and understands this will be able to work with and support Maaori with empathy.

The last attribute in this column is **Learn about different ethnicities, religions and personality types**. This attribute is about accepting and appreciating difference and being knowledgeable about the things that are important to their patients and that inform how they live their lives, including their health and well-being needs and perspectives. Ani suggests that medical students learn about other cultures, religions, personalities and histories in their first year of study.

Summary

Together, these attributes place an emphasis on cultural responsiveness, cultural competency and cultural safety, in the sense that we are asking doctors to expand their knowledge and to be open to new ideas and thoughts and processes. A good place to start will be to learn about Maaori and their cultural values and beliefs and also having an awareness of other cultures and their cultural backgrounds" (Pitama, 2013; Academy for Clinical Innovation [ACI], 2022). ACI (2022), state that the "evidence shows that when there is a lack of cultural responsiveness, health outcomes are much poorer" (para. 3). They go on to say that "Improving cultural responsiveness can not only remove barriers to accessing healthcare but may also reduce inequitable health outcomes for marginalised and vulnerable groups" (para. 3).

Attitude-based attributes

Personality

The last set of attributes include personality and community engagement. Personality can be described as "... the behavioural and mental characteristics that are distinctive of an individual" (Coleman, 2015). In saying that, it is possible to learn and practice these attributes, although people generally know or feel if someone is not being genuine. These personal attributes are what are important to these community members and overlap with their desire for their doctors to become members of the community

To **Have integrity** means to be morally consistent and honest with yourself and with other (Integrity, n.d.). If an individual has integrity, others will trust and believe in them, "we know that you're not a charlatan or someone who bullshits… It's not about what you have, like a PhD or doctorate" [Ngawai, pakeke wahine].

A '**People person'** is someone who is friendly and enjoys meeting and talking to (Cambridge University, n.d.). This attribute overlaps with the Communication attribute, Manaaki. Tiipa [pakeke] commented that doctors are so busy that they have lost their people skills.

Also overlapping with Manaaki (communication attribute), **Aroha ki te tangata** is a well-known kiianga (saying) that means 'love the people.' A number of the interviewees said they want their doctors to be caring and kind - genuine feelings that make people feel cared for and welcome. [Kaia, pakeke wahine] wants a doctor who is "understanding" - someone who understands "what a person's needs are or might be and where they come from and what barriers they may have had to overcome to seek health-care."

Appreciate that one size does not fit all places a specific emphasis on the attributes that speak to embracing different understandings of and approaches to health, well-being, and healing. For this acceptance to be part of your aahua (personality), one must genuinely accept and embrace difference - which is at the heart of equity, especially for Maaori in regard to cultural responsiveness and safety (Pitama, 2013).

Community Engagement

Wai [kaumatua wahine] would like doctors to **Come to the marae** to learn about Te Ao Maaori and what it means to be Maaori. Others said that doctors should also learn our history and our culture. Concerned about obesity and diabetes, another community member would like to see the local doctors p**romote health in our schools**, engaging and interacting with our tamariki (children), the next generation of patients. Finally, and arguably, the greatest impact that doctors could make in rural and remote communities is to b**e mobile**. To close the distance between those who find it financially or physically difficult to come into the service towns. Having mobile doctors and satellite clinics would help meet the challenges of the underserved communities - where for some, they "...only go in when they're really bad…" – Teia [rangatahi wahine]. In his message to the project team, Uira [kaumatua tane] suggests that young doctors be bonded to rural areas for a period of time.

Summary

This set of attributes includes a combination of cultural responsiveness and practicalities. As mentioned multiple times, one specific challenge and barrier to health for Maaori living in rural and remote communities is the distance they live from medical services and access to transportation (Gassin, 2019). One of the practical solutions the interviewees proposed is for doctors to become mobile. The personality traits have also been identified as the ideal for doctors (Medical Council of New Zealand, 2021b); while the appreciation that one size does not fit all and coming to the marae to be immersed in Te Ao Maaori, speaks again to the importance of cultural responsiveness.

7.5 Conclusion

In this study, I set out to investigate the healthcare aspirations and needs of 30 community members who live in the rural and remote communities of Te Rohe Pootae – what they want in and from their doctors, with a view to their voices informing the curriculum for Aotearoa New Zealand's third medical school. These are the main points I would like to leave with the reader.

One. These community members have a firm understanding of what rural and what remote mean for them, and geographical isolation, distance, and access to services are the defining features. An interesting observation is that some community members living in rural Te Kuiti acknowledge that they are rural, but made the argument that they are actually remote because of the lack of healthcare services. How many people live in their respective communities was not a defining measure.

Two. Drawing on the literature and the findings, it is clear that doctors serving rural and remote communities need to be competent in the health issues of significance to these communities. *In this study*, and in the literature, these issues included diabetes, cancer and mental health. In other words, this is not to say that every rural and remote community will have the same issues.

Three. Access to healthcare is clearly a concern for these community members – in terms of both distance to the nearest GP, and the availability of specialist care and treatment. While affordable and more regular transportation options would be definitely be helpful, these community members would also like mobile healthcare – particularly for the elderly. This possibility and the benefits of being mobile were clearly demonstrated during the height of the COVID19 pandemic lockdowns, and how to be a mobile doctor could be included in the curriculum.

Four. The three well-being strategies highlight a couple of very important points. First, the attitude and communication skills of healthcare workers is critcal. The 'doctor first' group indicated that they have an excellent relationship with their healthcare provider, while the 'doctor second' group and 'doctor never' group have faith in alternative/complimentary treatments such as rongoaa – but also reported having negative healthcare experiences. This emphasises the importance of both basic and culturally appropriate communication and attitudes (as highlighted in Table 3), and *suggests* that some doctors (and receptionists and nurses) have become complacent. However, I acknowledge that the workforce shortage has placed doctors and nurses under immense pressure, and could suggest that a lack of welcome and communication could be signs of stress and *perhaps* depression. This observation and these suggestions warrant further investigation.

Related to the previous point is the importance of being open to 'alternative and complimentary'

healthcare approaches and accepting that there is not ONE way to care for people. The next generation of doctors need to understand that health is holistic and encompasses the whole person including their family, community, and a connection to the natural environment. For these community members, in addition to communication, the willingness and openness of doctors to other health modalities influences whether they like and utilise healthcare providers. This is one of the most important points in Table 3.

Five. Comments made by a couple of rangatahi suggest that they are worried about confidentiality in small towns where healthcare staff may be relatives or friends with one's relatives. This conflicts with the idea that Maaori communities want Maaori doctors and local Maaori doctors, in the sense that our greatest strength (whanaungatanga/relationships) may stop our young people from utilising their local healthcare providers. This is an interesting and unique finding that requires further investigation.

Recommendations

Based on the findings of this pilot study, if the proposed medical school is going to place an emphasis on serving Maaori (and Pacific) living in rural and remote communities, I recommend the following.

- From the outset, the school should work in partnership with iwi, including the mana whenua, Waikato
- The school structure should include a cultural advisory committee
- The curriculum places a strong emphasis on a Maaori worldview and introduces students to Te Ao Maaori through marae and the environment
- The curriculum should include rongoaa and other 'alternative and complimentary' healthcare and treatment perspectives
- The curriculum includes a strong emphasis on communication and personal attitudes
- Students also learn about other cultures, and their values, beliefs, and healthcare practices and preferences
- Cirricululm includes an emphasis on cultural responsiveness, cultural competence and cultural safety
- Iwi, schools, and kura be involved in promoting and encouraging Maaori to become doctors
- Medical students from rural and remote communities feature in marketing, promotions and recruitment
- That this study/thesis be read in conjuction with the sister Pacific study conducted by Janina Galwski
- That this pilot study be followed by further research conducted in other rural and remote

communities

Limitations of the study

This study has a number of limitations that need to be acknowledged.

- Due to the COVID-19 pandemic the timeline for data collection took longer than expected
- COVID-19 also meant that my plan to conduct waananga (group discussions) was not able to proceed and was replaced by semi-structured individual interviews, most of which occurred via Zoom
- Most of the research participants were women. I would have liked to have more representation from rangatahi, kaumatua, and taane (males)
- This study is not generalisable and should not be applied/compared to other rural or remote communities in Aotearoa New Zealand. While it provides some insights, it is important to understand that not all Maaori and not all communities are the same
- I acknowledge that I am not a medical student and may have therefore missed some important and vital information about medical training and medical systems
- The University of Waikato does not subscribe to some key medical peer-reviewed journals, meaning that I would have missed important and relevant literature
- Due to time constraints and other issues, I did not have a chance to discuss my findings including Table 3 with my research participants. This should be a priority in future studies

Further Research

- When seeking the opinions of rural and remote community members about what is rural and remote, provide them with a selection of classifications to discuss
- Woolley et al.'s (2013) table and my table could be used to frame and for discussion in future studies
- Include the research participants in the co-creation of a desirable attributes' framework
- Include or specifically focus on the experiences of doctors and other health professionals serving rural and remote communities
- Explore the comment made by one participant about Paakehaa and Maaori in their remote community having the same healthcare needs
- Explore the point made by rangatahi about confidentiality

A final reflection

I begin this final reflection by looking back to the beginning. I have a different mindset from when I first began this journey, meaning that I have learned so much about myself and the topic and kaupapa of interest. I have to admit that this journey has been very challenging, and at times I wondered what I had gotten myself into. However, with all that said, I remember the reason why I wanted to undertake this study; to learn about the health aspirations and needs of my people so as to inform the curriculum for future medical graduates of the proposed third medical school.

The original name for this project was Creating Culturally Responsive Doctors: Health Aspirations and Needs of Maaori who live in Rural and Remote areas. From a kaupapa Maaori perspective, this title felt like a hypothesis; a statement that preempted what our community might actually want or say. Once the data had been collected, the analysis followed and revealed that we want more than just culturally responsive doctors. We/They want doctors who not only know their medicine but are also people people. In addition to being culturally responsive, culturally competent and understanding cultural safety - in the sense that they are willing to step outside of their worldview to truly appreciate our worldview (and that of others). They also want doctors who are kind, caring, friendly, open and welcoming. Doctors who take the time to listen and to follow-up. Doctors who join and engage with their community. Doctors who are mobile and who are willing and resourced to travel to rural and remote locations.

As I write this reflection, my husband is lying in a hospital bed, and what I observe while visiting him is how friendly and caring the nurses are. I said to my husband that these nurses embody the type of doctors described in my 'desirable attributes' table. Personally, I think many nurses would make amazing doctors.

Another topic I want to share in this reflection is my observation of how rural and remote people appear to be happy with life. The literature gives the impression that people living in rural and remote areas are sick and therefore sad and waiting to be saved. But what I have noticed is that they are people who have a can-do attitude, a positive outlook and are genuinely happy. They know what they want and need. Just go and ask them; listen to them, talk with them - not about them. They'll tell you what their aspirations and needs are and they'll also tell you that they want their doctors to come from their rural and remote communities, because homegrown doctors know what the community needs.

In closing this thesis, I want you to think about a new and different medical school that will produce a new type of doctor who encompasses all of these attributes. For me, I think about my 'one step taken', as advised by Linda Tuhiwai Smith, and in the end I hope that I have been able to do work that will be of benefit to and uplifting for my people.

I leave you with the words from my first reflection from nanny Te Puea Herangi:

'Mahia te mahi hei painga mō te iwi'

Do what is needed for the benefit of the people

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Appendices

APPENDIX A: INTERVIEW SCHEDULE

Questions will be delivered slightly differently depending on whether it is an individual interview, or a whanau group discussion, or a community group focus group. Questions are grouped into three sections or themes.

(1) HEALTH: we're interested in learning more about how you view and experience health

- What is health and wellbeing? What do these words/concepts mean to you and your whanau and community?
- Where do you go when you're injured or not feeling well?
- (if not already discussed) What kind of care/range of services do they offer
- Are you happy with the care you receive? What have been some of your positive and negative experiences? (no names please)

(2) RURAL AND REMOTE: we also want to understand the unique needs of rural and remote Maaori and Pacific communities

- The government and other agencies and organisations refer to some places as 'rural and remote'. Would you describe Te Kuiti and the surroundings as rural and remote? [we could provide some definitions from the literature and ask them what they think of them]
- Would you agree or disagree that the healthcare needs of rural and remote communities are different to people living in the larger towns and cities? Different from Maaori living in towns and cities? Different to other ethnicities? (how you ask this question will depend on the participants)
- Do you have different or the same healthcare needs as your Pakeha community members?

  Prompt - so why do you say that - I don't quite understand that, can you explain.

(3) YOUR HEALTHCARE NEEDS: The ultimate purpose of this study is to grow culturally responsive healthcare workers, and doctors in particular.

- What do you think about the idea/plan of a new medical school located in Waikato/Hamilton (not sure if this question should go here, but will try it, I may move the next two questions, depending on how the interview flows).
- What kinds of services and healthcare workers do you want and need in your community?
- What are some of the skills and characteristics that you want to see in the different healthcare workers in your community?
- Finally, what do we need to teach/grow in our medical school students so they can best serve Maaori/Pacific peoples living in rural and remote communities? Pakeha students? International students? Maaori and Pacific students?
- Is there anything else that you'd like to tell us about this topic?

APPENDIX B: RURAL AND REMOTE LOCATIONS

Mokau

Distance to Te Kuiti: 78 km

Services and shops: 2 dairies, 2 cafes, 1 butcher, and a satellite doctor twice a week.

Marokopa

Distance to Te Kuiti: 56.2km

Services and shops: 1 shop, mobile nurse as needed. Nearest petrol stations are located at Te Kuiti and OOtorohanga.

Maniaiti

Distance to Te Kuiti: 34.2km

Services and shops: 1 petrol station, 1 dairy, and 1 backpacker accommodation.

Piopio

Distance to Te Kuiti: 22.6km

Services and shops: 1 petrol station, small number of dairies and cafes, and a motel and pub.

Waitomo

Distance to Te Kuiti: 19km

Services and shops: 1 dairy, 1 cafe, 1 bar.

Tahaaroa

Distance to OOtorohanga: 69 km

Services and shops: 1 shop, a mobile nurse as needed, a once a week passenger bus service to Te Awamutu, a daily non-passenger bus service (can deliver parcels and medications) to Te Kuiti. Nearest petrol stations are located at OOtorohanga, Te Kuiti, and Oparau.

Kinohaku & Te Waitere

Distance to OOtorohanga: 65.6km; distance to Te Kuiti: 66.9km

Services and shops: a daily non-passenger bus service to Te Kuiti, a boat club, and the nearest petrol station is located at Oparau.

APPENDIX C: PARTICIPANT INFORMATION FORM (SHORT)

Title: Growing Culturally Responsive Doctors: From the Health Aspirations and needs of Maaori and Pacific peoples who live in rural and remote areas.

What is the study about?

We're interested in hearing about your interpretations, aspirations, and perspectives of health. We will ask you questions about health and what it means to you?

Who is doing the study?

The study is being conducted by a small group of researchers, including two Master of Sport, Health, and Human Performance students from the University of Waikato. The information collected will be used for the purposes of informing a culturally aware curriculum for new doctors, and will also form the basis of the students' Masters theses.'

The Project team is:

Victoria Maikuku (Masters student), supervised by Dr. Gloria Hinemoa Clarke

Janina Galewski (Masters student), supervised by Dr. Apo Aporosa

Professor Roger Strasser, Project Leader

Participant: What will we do?

As an individual, or in whaanau or community groups, we would like to talk with you about your health needs and aspirations, and what you think we should be teaching the medical students who will be working in rural and remote New Zealand communities. We would do this at a time and place that suits you. We are happy to come to you or we can find a comfortable venue where we can talk privately. The discussion will take anywhere between 30-90 minutes. You will be sent the list of questions in preparation of the interview.

Who can take part in this research?

Victoria Maikuku will interview the Maaori community members, aged 18 years and over, who live in the Waitomo/OOtorohanga District. Janina Galwski will be interviewing Pacific community members who live within the Waitomo/OOtorohanga District.

We'd like to hear from a variety of people including men, women, rangatahi and kaumatua. We would like to interview approximately 30 people each.

If you fit these criteria and would like to participate, please contact either Victoria or Janina:

Victoria Maikuku

021 1193905

maivictori14@gmail.com

Janina Galwski

022 6789949

ninatangataevaha@gmail.com

APPENDIX D: PARTICIPANT INFORMATION FORM (LONG)

Title: Growing Culturally responsive doctors: From the health Aspirations and needs of Maaori and Pacific People who live in Rural and Remote areas.

What is the study about? We're interested in hearing about your interpretations, aspirations, and perspectives of health as a Maaori or Pacific people.

What are my rights as a participant? Your participation in this project is entirely voluntary. As a participant in this research project, you have the right to:

participate voluntarily knowing that refusal to participate will not affect you in any way.

ask questions about the project at any time.

provide information on the understanding that your identity will not be disclosed at any time, in any way, shape or form, unless you give us permission to do so.

decline to answer any questions in the study.

If you take part in the one-on-one interviews, the information you share will be transcribed. You have the right to withdraw your data from the study up to three weeks after transcript release.

If you take part in one of our focus group sessions, due to the collaborative nature of group discussions, you won't be able to withdraw your information, but you will be able to read it and edit anything you have said.

You are more than welcome to have family/friends present during the interview/focus group. At the conclusion of the interview/focus group session, we would like to show our appreciation by offering a koha.

Confidentiality and Results

All responses and discussions made during the project will remain confidential. A pseudonym (another name) will be used in my publication, so that you remain anonymous. Only the research team will have access to the shared information. Signed consent forms and participation forms will be kept in a safe, inside a locked office of our supervisors on the University of Waikato campus, and digital copies will be stored on the University of Waikato's password protected computer system. Our talk will be recorded to ensure the accuracy of the information shared then the information will be transcribed. The results of your transcript will be analysed, and we will look for common themes and patterns. An overview of the findings will be reported back to you by one of the research team members. We will use the findings from this study to write our theses' and also an article of findings for publication.

If at any time you feel uncomfortable, unsure about your participation in this study or if you have any concerns, please let one of the project team know.

Victoria Maikuku - (Maaori) Email : maivictori14@gmail.com Phone : 021 1193905

APPENDIX E: CONSENT FORM

Title: Creating Culturally Responsive Rural Doctors: Maaori and Pacific peoples' Health Aspirations and needs.

I have read the Information Sheets that were provided for this study and have had details of the study explained to me. This includes the right to:

Ask any further questions about the study during participation.

Refuse to answer any particular question.

For one-on-one interviews, can withdraw from the study up to 3 weeks after transcript receipts are given. (To do this, please phone, text or email the lead researcher; whose contact details are at the end of the information sheet).

Focus/whanau Groups; (cannot withdraw from the study).

Be given a copy of the main points of the study findings when they become available.

Data collected in this study will be used to write two master's students' theses and will also be used by the Masters students to write two research articles for publication.

I agree to provide information to the researchers under the conditions of confidentiality as set out in the Information Sheet.

I wish to participate in this study under the conditions set out in the Information Sheet.

Participant Consent :

Name : **Signature :**

Date :

Researcher :

Name : **Signature :**

Date :

APPENDIX F : QUESTIONNAIRE

Name:	Phone Number:
Address:	Email Address:
Age – 18+:	Gender:
Tribal affiliations:	Marital status:
Occupation:	Renting or own:
Number of family members living in your home: …….. and their ages: ……..	
Where were you born/raised:	
How long have you lived in this community?	
Where did you live previously?	
Current health status:	
Any health conditions:	
Any health conditions of those living in your whare:	
Who are you enrolled with for health care?	
Any other relevant information:	

I …….. confirm that these details are correct.

sign/date: …….

APPENDIX G: TRANSCRIPT RELEASE FORM

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

Title: Creating culturally responsive rural doctors: Maaori and Pacific perspectives and aspirations.

I confirm that I have had the opportunity to read and amend the transcript of the interview conducted with me regarding my health aspirations and needs.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the transcript.

Full name – printed: ……

Signature: ……

Date: ……

APPENDIX H: ETHICS APPROVAL

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

12 July 2021

Victoria Maikuku & [redacted]
Te Huataki Waiora School of Health
DHECS
By email: maivictori14@gmail.com
[redacted]

Kia ora Victoria & Janina

HREC(Health)2021#40 : Creating culturally responsive rural doctors: Maaori and Pacific peoples' perspectives and aspirations for health

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee

APPENDIX I: LETTER/EMAIL

First Initial letter

27 August 2021

Tena Koe,

Following on from our conversation today I wanted to thank you once again for your interest in this study. I have attached the information sheet, a copy of the consent form, and a list of the interview questions. If at any time you are unsure or need more information, please email, or text me and I will be happy to call you back as soon as I am able to.

As mentioned in our conversation today I will call you in a week's time or (set a day and time of participants choice) to see if you are still keen to participate in the study. If you choose to take part in the study I would like to know some general information about you and what days and times suit you for an interview.

I look forward to talking with you soon

Ngaa mihi

Victoria Maikuku

Ph: 021 1193905 E: maivictori14@gmail.com

APPENDIX J: CONFIRMATION EMAIL/LETTER

Confirmation Letter

27 August

Kia ora ano Tipa,

I have penned you in for day - time - venue. I will send you a text reminder 48 hours before the interview. If you have any questions, or days and times do not suit due to a change of plans, please let me know.

Your participation in my study is very much appreciated.

Ngaa mihi mahana

Victoria Maikuku

Ph: 021 1193905 E: maivictori14@gmail.com

APPENDIX J: DESIRED ATTRIBUTES FOR MEDICAL GRADUATES[19]

TABLE 1: *Desired attributes for medical graduates, as reported by the Indigenous community of Mount Isa, Northwest Queensland*

Skill-based attributes		Knowledge-based attributes			Attitude-based attributes		
Quality patient care	Communication skills	Medical knowledge	Culturally appropriate knowledge	Knowing the local health system	Personality	Working with Indigenous people	Engaging with the Indigenous community
Confidentiality with a client history – be aware when speaking aloud	Show respect and honesty	Make sure of your diagnosis	Behave and dress appropriately	Be able to provide health and parenting education for men, families and children	Be passionate – have a 'can do' attitude	Build rapport and make us feel comfortable	Respect elder's knowledge and experience
Treat patients how you would want to be treated	Introduce yourself, and tell us where you are from	IF possible, give Indigenous patients a choice of health professionals	Have sensitivity to patient finances	Know where patients can access health services and support groups	Encourage trust, but be aware it is a long process – do not rush it	Do not talk loud – we are not deaf; just trying to understand you	Provide health education for children during school hours
Be willing to fight for a patient's rights	Take time to explain diagnosis and processes – more than once if necessary!	Know the appropriate treatment – and be aware of barriers	Know when to listen and when to talk	Know where to attend a cultural awareness course	Have patience, and be nice, considerate and caring	Respect the knowledge and experience of patients	Be willing to ask HOW to work with the community
Always follow up – do not leave us hanging	Be able to read body language	Know who to, and when to, refer patients	Know how to talk to black people – understand our culture	Attend the local health services orientation day	Be willing to learn	Look and listen – do not talk too much	Take time to find out the Indigenous politics in each community
Have the flexibility to include collective decision making with other health professionals	Use simple language, and break down jargon if you do use it	Document the right information, and keep files safe	Be respectful of the land	Know the policies of local hospitals	Be non-judgemental	Accept that the consequences of your actions are community wide	Be prepared to lobby government to help change local policies affecting Aboriginal people
Know the patient's journey, and listen to the full story of the medical history	Check back to us by paraphrasing	Keep improving your skills	Know the different cultural groups in community – all Aboriginal people are not the same	Know all about drug and alcohol education	Show tolerance, understanding and open-mindedness	Sit down a while with 'grass roots' Aboriginal people	Get involved with community groups
Provide continuity of care	Not too much eye contact	Be aware of child safety principles	Understand the social determinants of health	Use all available health services	Genuinely want to work with rural people	Be willing to learn 'bush knowledge'	Know racism exists

[19] Source: Woolley, T., Sivamalai, S., Ross, S., Duffy, G., & Miller, A. (2013). Indigenous perspectives on the desired attributes of medical graduates practising in remote communities: A Northwest Queensland pilot study. *Australian Journal of Rural Health*, *21*, page 94.

APPENDIX K: LOGISTICS INTERVIEW CHECKLIST

Whanau discussion groups and individual one-on-one interviews as my method for collecting data.

Logistics/Supplies for Kanohi ki te kanohi Individual Interviews

Plans/Steps	**Resources/Other**	**Notes**
Who is being interviewed		
Location for interview		
Space		
Time		
Day		
Food		
Koha	Kete, flute and voucher	
Forms/Stationery		
Check that Consent forms are sent out and returned		
Print extra copies of information & consent forms		Just in case extra forms are needed
Print extra copies of Questionnaire		The copy for the participant to sign
Check Recording devices phone/dictaphone/video	Extension cord/batteries	Make sure that all equipment is working and ready to go
Stationary/Equipment	Pens/MarkersPaper	
Health and Safety	Sign in sheet	

Notes:

Whanau Group Discussion Interview

Plans/Steps	Resources	Notes
Arrive early (set up)	Space and key	Only if I have to organize a venue.
Meet and Greet	Offer refreshments	Only if I have to organize the venue.
Welcome/Karakia		Check with the whanau group.
Housekeeping/health and safety (if in a space other than their home)		Only if I have to organize the venue.
Forms explained and signed	Questionnaire, consent,	
Introductions		I start with introducing myself.
Explanation on how the interview will run		
Participant Questions/Answers		
Opening Questions		
Closing/Questions/Concerns		
Thankyou - Karakia		
Cuppa Tea and or koha		

Notes:

Logistics/Supplies for Whanau Group Discussions

Plans/Steps	Resources/Other	Notes
Who is being interviewed		
Location for interview		
Space		
Time		
Day		
Food		
Koha		
Forms/Stationary		
Check that Consent forms sent out and returned		
Print - extra copies of information & consent forms		Just incase extra forms are needed
Print off Phone Questionnaire		Copy for the participant to sign
Check Recording devices phone/dictaphone/video	Extension cord/batteries	equipment - working and ready to go
Stationary/Equipment	Pens/Markers Paper	

Notes:

APPENDIX L: PLANNER INTERVIEW SHCEDULE

<table>
<tr><td colspan="3">Interview Schedule for Whanau & Individual</td></tr>
<tr><td>Date:</td><td>Time:</td><td>Location:</td></tr>
<tr><td>Lead Interviewer:</td><td colspan="2"></td></tr>
<tr><td>Support:</td><td colspan="2"></td></tr>
<tr><td>Participants:</td><td colspan="2"></td></tr>
<tr><td colspan="3">QUESTIONS: 3 Main Themes and Questions</td></tr>
<tr><td colspan="3">HEALTH: we’re interested in learning more about how you view and experience health</td></tr>
<tr><td>What is health and wellbeing?

Where do you go when you’re not feeling well? Or injured?

Are you happy with the care you receive? What have been some of your positive and negative experiences? (no names please)</td><td colspan="2">What do these words/concepts mean to you and your whanau and community?

Do you go to a medical doctor?

If you go to a medical doctor… have you ever been to a doctor</td></tr>
</table>

RURAL AND REMOTE: we also want to understand the unique needs of rural and remote Maaori and Pacific communities	
The government and other agencies and organisations refer to some places as 'rural and remote'. Would you agree or disagree that the healthcare needs of rural and remote communities are different to people living in the larger towns and cities? Do you have different or the same healthcare needs as your Paakehaa community members? Explore.	Would you describe your community as rural and remote? (we could provide some definitions from the literature and ask them what they think of them) Different from Maaori who live in bigger towns and cities?
YOUR HEALTHCARE NEEDS: The ultimate purpose of this study is to grow culturally responsive healthcare workers, and doctors in particular.	
What kinds of services and healthcare workers do you want and need in your community? What are some of the skills and characteristics that you want to see in the different healthcare workers in your community? Finally, what do we need to teach/grow in our medical school students so they can best serve Maaori/Pacific peoples living in rural and remote communities?	This is a great opportunity to do a brainstorm activity and then ask them to rank their answers. Pakeha students? International students? Maaori and Pacific students?

MAAORI HEALTH AUTHORITY: Have you heard about health reform?	
What are your thoughts on/about the reform?	
ENDING: That concludes our focus group today	
Do you have anything else you would like to share? Lastly, do you have any questions?	

INTERVIEW SCHEDULE: ONE ON ONE INTERVIEWS		
Date:	Time:	Location:
Interviewer:		
Interviewee/s:		
QUESTIONS: 3 Main Themes and Questions		
HEALTH: I'm interested in learning more about the way you view and experience health can you please tell me.		
What is health and wellbeing to you?	. Do you feel that you have this? Why do you feel or think that?	
Where do you go when you're not feeling well?	Do you visit a doctor when you're not feeling well? Are you happy with the care you receive? What have been some of your positive and negative experiences?	
RURAL AND REMOTE: We also want to understand the unique needs of rural and remote Maaori and Pacific communities.The government and other agencies and organisations refer to some places as 'rural and remote'.		

Would you describe your community as rural and remote? Would you agree or disagree that the healthcare needs of rural and remote communities are different to people living in the larger towns and cities? Do you have different or the same healthcare needs as your Pakeha community members?	Some of the literature define rural and remote as… would you agree? Why do you think this is? Different from Maaori who live in bigger towns or cities? Why do you think this is? Why do you think you have different health care needs when compared to pakeha? Do you think that there is a way in which we can achieve this? What might that be/ why do you think that?

YOUR HEALTHCARE NEEDS: **The ultimate purpose of this study is to grow culturally responsive healthcare workers, and doctors. Building better doctor-patient relationships.**	
What kinds of services and healthcare workers do you want and need in your community? What are some of the skills and characteristics that you want to see in the different healthcare workers in your community?	Why do you feel that this is important I can see that these are important characteristics that you want to see. Can you tell me why this is important to you and…..

Finally, what do we need to teach/grow in our medical school students so they can best serve Maaori/Pacific peoples living in rural and remote communities?	Do you think it is important for Pakeha and International students to learn about these? What are your thoughts for Maaori and Pacific students in health studies?
MAAORI HEALTH AUTHORITY: The government announced a health reform in March this year, did you hear about the changes?	
What are your thoughts on the reform? Why do you think that is?	
ENDING	Do you have anything else you would like to share? Lastly, do you have any questions?

Glossary

This is a basic glossary of kupu (words) to help with understanding the Maaori kupu used throughout this thesis. However, it is important to note that Maaori kupu are expansive, meaning that they can have multiple/different meanings for different iwi and hapu (ref).

Aata Haere	Moving on, move carefully, surely
Aroha	Love and respect
Atua	God
Hei tiki	
Hinengaro	Mind, thought, awareness
Kaakaa	Native parrot - Aotearoa New Zealand
Kaha	Strong, capable, courageous, energetic
Kai	Food, to share a meal
Kaumaatua	Elder, person of status
Kaupapa	Topic, plan, issue
Kia tuupato	Be careful, exercise caution
Konae	A woven basket
Kooauau	Flute - a traditional Maaori instrument
Koorero	To talk, discuss, speak
Koroheke	Elderly man/men, person of status
Kuia	Elderly woman/women, person of status
Maaia	Brave, courageous
Maha	Many
Mahi	Work
Mana	Prestige, authority, control, power, spiritual power
Mana Motuhake	Autonomy, Self Determination
Manaakitanga	To provide hospitality
Maatai	Observe, gaze, awareness
Maatai Ata	Observe, gaze at the morning
Maatai Whetu	Observe gaze at the stars

Matatika	Correct, Ethical
Matua	Father
Maatauranga	Knowledge, wisdom, understanding
Maunga	Mountain
Mauri tau	Balance, bring back into order
Mirimiri	Maaori healing modality
Ngaa	Many, two or more
Ngaati	Tribal group
Ngaati Maniapoto	Tribal group of Tainui from the King Country area, descendants of Rereahu-Maniapoto
Ngaati Apakura	Tribal group of Tainui
Ngaati Mahuta ki tai	Tribal group of Waikato
Ngaati Hikairo	Tribal group of Tainui
Noa	Made good, allowed
Ora	Alive, well, safe
Oranga	Health living
Pae Maunga	Mountain range
Painga	Well-being, gain, good
Paakehaa	European, whiteman
Pakeke	Adult
Papatuuaanuku	Earth Mother - Maamaa
Rangatahi	Youth
Ranginui	Sky Father
Rereahu	Ancestor and father of Maniapoto
Romiromi	Maaori healing massage
Rongoaa	Maaori medicine - body, mind, spirit and environment
Taha	Side or to pass by
Taiao	Natural Surroundings, natural environment
Tangata	Person, human being

Taangaa	People
Tangata Whenua	Indigenous person of the land
Taonga	Treasure, something of great importance, resources
Tapu	Sacred
Te Ao Maaori	Maaori World View - how we view the world
Te Kuiti	Rural service town in the Waitomo district
Te Rohe Pootae	The area of the hat
Te Nehenehenui	The great forest, a place of beauty
Te Whare tapa Wha	Maaori model for health
Tikanga	Custom, Correct procedure or method
Tika	Correct, true, fair, accurate
Tino Rangatiratanga	Sovereignty
Tinana	Body, torso
Tupuna	Ancestor
Tuupuna	Ancestor, plural meaning
Wairua	Spirit or soul
Waitomo	Rural village in the Waitomo District
Whakapapa	Lineage
Whakatika	Preparation, plan,
Whaanau	Family
Whanaunga	Relation, blood relation
Whanaungatanga	Sharing genealogy, making family connections
Whaea	Mother
Whenua	Land - to Maaori it represents the placenta as well.
Urutau	Adaptable, flexible, changeable
Utu	Reciprocity