A Critical Examination of the effectiveness of Te Tiriti o Waitangi and Treaty of Waitangi Training Programmes in Health Services

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Abstract

The overall aim of this study was to critically examine the effectiveness of te Tiriti o Waitangi and Treaty of Waitangi based training in the publicly funded health system in Aotearoa as a tool for addressing health inequities, and to contribute to the broader Kaupapa of improving Māori health through systems that honour te Tiriti partnership. The research was conducted during a period of significant restructuring of the health system, a result of reforms that were framed as opportunities to strengthen Māori voices in health decision-making and to uphold te Tiriti o Waitangi obligations. However, the reforms and subsequent amendments have also been marked by contestation over the place of tino rangatiratanga and the privileging of Treaty principles over the text of te Tiriti. This study set out to examine the role of Tiriti o Waitangi training within the publicly funded health system, exploring how training currently, or could, more effectively respond to legislative change, address inequities, and position health professionals and organisations in relation to their Tiriti responsibilities. Three training programmes were examined; an online e-Learning module, a kanohi-ki-te-kanohi cultural awareness workshop that included Tiriti o Waitangi and Treaty of Waitangi learning, and a Critical Tiriti Analysis workshop delivered as part of a wider scaffolded training programme by a Public Health and Rautaki team at Te Whatu Ora, Waikato. A mixed-method approach was selected to capture learning across groups. The research framework for this study integrated Kaupapa Māori philosophy, te Tiriti o Waitangi and Critical Tiriti Analysis to guide the research. In Chapter 4, post training surveys of the e-Learning module were analysed covering two separate periods – between July 2021 and August 2023. This is followed by an analysis of post training surveys over four different periods between May 2021 to March 2023. Interviews were conducted with 15 participants made up of staff in training at Te Whatu Ora and training providers of the two kanohi-ki-te-kanohi programmes. The use of multiple data sources enabled methodological triangulation

and strengthened the credibility of findings. The study makes a significant contribution to scholarship on Tiriti training, Kaupapa Māori research, and evaluation in public health. It demonstrates that while training is a necessary process in addressing inequities, it is insufficient for transformation to occur. Enduring progress toward health equity for Māori requires systems that honour te Tiriti, not only in learning spaces, but in governance, policy, and everyday institutional practice.

Dedication

To our mum and dad who taught us to imagine future possibilities.

To honour your legacy; a lifelong legacy of stewardship, obligations and responsibilities. A legacy of ensuring our voices are not silenced, no matter what the circumstances.

[1]Gather around and listen to my story…

[1] This is a waiata our father learned when he was serving in the 28th Māori Battalion, World War II. He sang it often accompanied by other veterans and our mum. It is now known as "Dad's song" and has now become our whānau waiata.

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Ko Kaiaiō te tīpuna

Ko Te Whānau-a-Kaiaiō te hapū

Ko Apanui Ringamutu te tangata

Ko Te Whānau-a-Apanui te iwi

He uri hoki ahau nō Ngāpuhi

Kotahi taku huata ki runga Hauruia, te mano, te mano, te mano (Kaiaio, n.d.)

For every kūmara I plant in my garden at Hauruia there follows a progeny of thousands

This whakatauki of our eponymous tipuna, Kaiaio, reminds me of the importance of people and the part that kai (in many forms) plays in contributing to their well-being. I wish to acknowledge all of the people who fed me during this journey.

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Glossary

This is a glossary are of Māori words or terms used in the text, that have not already been translated in text. The translations have been sourced from '*Kuputaka*', compiled by Benton (2021) and Te Aka Māori Dictionary (accessed 2026, August 16).

aroha	affection, compassion, love
aroha ki te tangata	affection, compassion, love for another (person)
hapū	a locally based kin group, descended from (and often named after) a common ancestor, usually but not always a subdivision of a larger iwi traditionally the basic political unit in Māori society
iwi	kin-based grouping of hapū united by custom or legislation to form a single tribe, with a name often denoting a founding ancestor; also, general term for a nation or ethnic group.
kaitiaki	guardian or trustee
kaitiakitanga	the art or responsibilities of guardianship
karakia	ritual chant or set of words to give effect to or affirm a process
karanga	call': traditional chant to welcome visitors to a marae
kaupapa	agenda, plan, objective
Kaupapa Māori	Māori way of proceeding
kawa	protocol, appropriate ceremonial procedures
kanohi ki te kanohi	face to face, in person, in the flesh
kaumātua	older person, especially a respected member of the community
kōrero	talk, discussion, narrative
mahi toi	'do or produce art': an artistic venture
mana	inherent power, authority and worthiness of respect
manaaki	treat with respect, accord mana to, care for
manaaki ki te tangata	the act or state of caring for person(s)
manaakitanga	the act or state of demonstrating manaaki
marae	plaza in front of a meeting house where rituals of encounter take place; also, the complex (meeting house, dining hall, etc.) associated with the marae proper.
mauri	essence which gives a being or object its specific natural character
mihi/ mihimihi	(to give a) formal greeting or acknowledgement
mihi whakatau	speech of greeting, official welcome speech – speech acknowledging those present at a gathering. For some tribes a pōhiri, or pōwhiri, is used for the ritual of encounter on a marae only. In other situations where formal speeches in Māori are made that are not on a marae or in the wharenui (meeting house) the term mihi whakatau is used for a speech, or speeches, of welcome in Māori.
mokopuna	person two generation younger; grandchild, young child
mokopuna tuarua	person three generation younger, great grandchild, young child
noa	to be free from the extensions of tapu, ordinary, unrestricted, void
ōritetanga	equality, equal opportunity

Pākehā	English, foreign, European, New Zealander of European descent.
pepehā	tribal saying; tribal motto
pou	post, upright, support, pole, pillar, goalpost, sustenance; support, symbol of support, metaphoric post
rangatira	chief, leader, noble person
rangatiratanga	the attributes of leadership; sovereignty
rohe	district, territory
pōhiri	(alternatively appearing in text as, pōwhiri or poohiri); to welcome, invitation, ritual of encounter, welcome ceremony on a marae
tangata whenua	person of the land'; Indigenous person
tangata Tiriti	'people of the Tiriti'; referring to Te Tiriti o Waitangi, the Treaty of Waitangi. It is a political and social term used in Aotearoa New Zealand to describe all non-Māori who live in the country and derive their right to be here from the Tiriti or Treaty
taonga	anything precious or greatly valued
taonga tuku iho	heirloom, something handed down, cultural property, heritage
tapu	under spiritual restriction; sacred; set apart from everyday interaction or use
tauiwi	foreigner, stranger, non-Māori, outsider, person coming from afar
te ao Māori	the Māori world
te reo Māori	the Māori language
tikanga	'what is right': Māori custom and customary rules of action
tikanga Māori	'what is right' according to Māori
tipuna	(also tupuna; plural tūpuna or tīpuna) person of grandparent's generation or beyond, ancestor
uri	descendant, offspring
utu	action to redress an imbalance in a relationship, as in paying a bill, returning a favour, or avenging a wrong
waiata	sing; a song (often but not exclusively in the Māori language)
wairua	spirit
wānanga	advanced learning; also, a seminar or workshop, especially one devoted to traditional knowledge; institution of higher learning
whakaae	(agreement)
whakaaro	to think, plan, consider, decide
whakapapa	genealogy, line of succession; establish a genealogical connection
whānau	extended family, family group
whakataukī	proverb, significant saying; a traditional proverb whose original speaker is unknown
whakatauākī	proverbial saying or quote attributed to a known person, ancestor, or leader
whakawhanaungatanga	establishing kin-like relationships (see whānau)

Chapter 1: Introduction

The persistence of inequities in Māori health and the Crown's ongoing attempts to address these through successive health reforms, is the context in which this doctoral research is situated. Of particular concern are the socioeconomic and racial inequities that underpin Māori health disparities, reflecting the influence of wider social determinants of health including income, education, employment, housing, and exposure to racism. This thesis sets the premise that addressing these inequities requires a health system that not only provides equitable access to healthcare but also supports Māori participation in decision-making and responds to the broader structural factors that shape health and wellbeing.

The study period coincided with significant restructuring of the health system, following the Waitangi Tribunal's *Hauora Report* (2019) and the enactment of the Pae Ora (Healthy Futures) Act 2022. These reforms, and subsequent amendments, were framed as opportunities to strengthen Māori voices in health decision-making and to uphold te Tiriti o Waitangi obligations (Waitangi Tribunal, 2024). However, they have also been marked by contestation over the place of *tino rangatiratanga*, the privileging of Treaty principles over the text of te Tiriti, and the extent to which Māori perspectives genuinely shape policy and practice. Against this backdrop, this thesis examines the role of te Tiriti training within public health and health services, branches that make up the health system (Ministry of Health, 2026), exploring how training currently, or could more effectively, respond to legislative change, address inequities, and position health professionals and organisations in relation to their Tiriti responsibilities.

1.1 Health Reforms – From 2001-2022

In Aotearoa New Zealand (hereafter, referred to as Aotearoa), Māori continue to experience the poorest health outcomes of any population group (Waitangi Tribunal, 2023). The Waitangi Tribunal's Interim *Hauora Report* (2019) confirmed that these enduring inequities are not incidental but reflect systemic breaches of te Tiriti o Waitangi[2] (te Tiriti) obligations within the health sector. This recognition by the Waitangi Tribunal (the Tribunal), highlighted the need to examine how health professionals are trained to engage with te Tiriti, equity and cultural safety, a central focus of this study. As a Tiriti educator at the time this report was released, I wanted to understand why Māori were continuing to experience inequitable health outcomes given that over the past two decades, successive governments have introduced new structures, strategies, and legislation to address these known inequities. The landscape of health reform in Aotearoa provides the essential backdrop to this thesis.

In 2001, the Labour-led New Zealand Government introduced the New Zealand *Public Health and Disability Act 2000* (NZPHD/the Act) reforming the structure of New Zealand's health and disability sector. The Act required that the Ministry of Health reduce disparities by improving the health outcomes of Māori and other population groups (Section 3(1)(b)). The establishment of District Health Boards (DHBs) under the Act was to have been the vehicle to enable that to occur (Section 22 (1)(e)). Section 4 allowed for the recognition and respect of the principles of the Treaty of Waitangi (the Treaty) with a view to improving health outcomes for Māori. However, despite all of this, Māori health did not improve**.** The Waitangi Tribunal investigating claims that the Crown had breached the Treaty of Waitangi,

[2] Throughout this thesis, I use 'te Tiriti o Waitangi' and 'te Tiriti' to refer exclusively to the Māori text and 'the Treaty of Waitangi' and 'the Treaty' to refer to the English text, except when referencing or citing some other works that use these terms – e.g. the Waitangi Tribunal often refers to the Treaty. At times I will be using these terms alongside each other as in Treaty/Tiriti to denote that both the Treaty and Tiriti are being considered – e.g. Treaty/Tiriti o Waitangi education.

reviewed statistical evidence to show that despite the reforms, Māori health inequities persisted in the two decades since the NZPHD Act had been introduced (Waitangi Tribunal, 2023). In 2022, midway through my research, statistical data on the rate of Māori deaths continued to present inequitable health outcomes. Māori mortality rate was 1.7 times that of non-Māori with the leading causes of death being cancer, ischaemic heart disease and chronic lower respiratory diseases (Health New Zealand, 2025).

The Waitangi Tribunal had received numerous health-related claims alleging breaches of the Treaty of Waitangi. After hearing from both the claimants and the Crown, the Tribunal decided to hear the claims in three stages; stage one focused on the legislative and policy framework of the primary healthcare system. A draft stage one report was released in 2019, followed by the Tribunal's final stage one report on 19 October 2021 with the finalisation of Chapter 10. Stage two (yet to be concluded) addresses nationally significant system issues and emerging themes - mental health and suicide, Māori with lived experience of disabilities, and alcohol and substance abuse (including tobacco). Stage three (also yet to be concluded) will address the remaining issues of national significance including eligible historical claims (Waitangi Tribunal, 2023). Stages two and three are ongoing. In the meantime, the Tribunal has had to deal with other health related inquiries during its inquiries into stages two and three.

1.2 The Waitangi Tribunal and the Principles of the Treaty

The Waitangi Tribunal, established under the *Treaty of Waitangi Act 1975*, is a permanent commission of inquiry tasked with hearing claims by Māori and investigating alleged Crown breaches of the Treaty of Waitangi. Importantly, the Act requires the Tribunal to consider not just the texts of the Treaty and te Tiriti, but also the principles of the Treaty.

This statutory requirement marked the first articulation of the phrase "the principles of the Treaty", although the Act itself provides no definition (Turei et al., 2024).

Over time, courts, Parliament, and the Tribunal itself have developed several Treaty principles, including partnership, active protection, consultation, redress, and recognition of Māori authority. Many more principles that have evolved over time, and these principles have become precedents that continue to shape Crown–Māori relations and policy decisions, particularly in areas like health. The practice of referring to the principles was intended to resolve the difficulties of interpretation resulting from the Māori text (te Tiriti o Waitangi) and English language versions usually referred to as the Treaty of Waitangi.

This reliance on "principles" rather than the actual text of te Tiriti has been widely criticised. Prominent legal scholars such as Professor Jane Kelsey (1990), Professor Ani Mikaere (2011), and the late Dr. Moana Jackson (2019) argue that this approach allows the Crown to reframe its obligations, avoiding the stronger commitments contained in te Tiriti itself. Mikaere (2011), for example, describes the adoption of Treaty principles as "*the latest attempt to brainwash [Māori] into believing in the myth of Crown sovereignty"* (p. 145).

This myth that Mikaere refers to is the idea that Māori *rangatira* (chiefs) ceded sovereignty to the British Crown. In its *Wai 1040 Te Paparahi o te Raki* report (Waitangi Tribunal, 2014), the Tribunal rejected the Crown's long-standing claim that Māori ceded sovereignty. This finding affirmed not only that rangatira did not relinquish tino rangatiratanga when they signed te Tiriti in 1840, it confirmed that the government was illegally formed (Waitangi Tribunal, 2014). Despite this, the Crown continues to privilege the English-language Treaty and its associated principles to ensure political legitimacy. Notably, over 500 rangatira signed te Tiriti compared to just 39 who signed the English-text of the Treaty. In Aotearoa, it is the English version that carries more weight, contrary to the legal

rule of *contra proferentem*, which requires ambiguities to be interpreted against the drafter. This privileging of principles over text has enabled successive governments to define, reinterpret, and limit Crown obligations on their own terms, rather than grounding them in te Tiriti's articles. As Turei et al. (2024) note, this is widely seen as "*a government device to avoid acknowledging and addressing the Crown's obligations to Māori as stated in the text of te Tiriti"* (p. 43).

Nevertheless, in its discussions surrounding the Treaty clause in the NZPHD, the Hauora Tribunal expressed, on multiple occasions concern with "watering down" (Waitangi Tribunal, 2023, pp. 79 - 82) the true meaning of Treaty principles finding that the NZPHD did not give effect to the Treaty principles, particularly the principle of partnership (Waitangi Tribunal, 2023, p. 139). In addition, concerns were raised regarding institutional racism, the failure to provide accessible culturally appropriate services and the lack of data collection or if collected, the ineffective use of that data to measure and report on Māori health outcomes (pp. 122). Dr Rawiri Jansen, a renowned Māori health advocate and former Chief Medical Officer for Te Aka Whai Ora acknowledged that "…*publishing data showing insufficient progress was uncomfortable, but necessary*" adding "…*we have to use data to tell uncomfortable truths*" (Waitangi Tribunal, 2023, p. 133).

The report is littered with "uncomfortable truths" – for example; out of date attempts at an articulation of Treaty principles (partnership, participation, protection, - the 3 Ps); underfunding of Māori primary health organisations and providers; a decade of failures in funding; a lack of effective accountability, institutional racism, and a lack of cultural awareness and cultural safety training across the whole health system (Waitangi Tribunal, 2023). As well as recommending legislative changes to the NZPHD Act to give greater effect to the principles of the Treaty and to ensure the Crown commit to achieving equitable health

outcomes, the Tribunal called for the establishment of a stand-alone Māori primary health authority to address persistent inequities (Waitangi Tribunal, 2023, p. 165). In response, the Crown and claimants signed a Heads of Agreement in 2020, leading to the creation of Te Aka Whai Ora (Māori Health Authority) under the *Pae Ora (Healthy Futures) Act 2022* (Pae Ora Act), the Act that replaced the NZPHD Act from 1 July 2022. Widely regarded as a vehicle for advancing tino rangatiratanga and Māori-led governance in health (Came, et al., 2024), the Tribunal considered Te Aka Whai Ora to be an innovative and necessary response to structural inequities (Waitangi Tribunal, 2023).

1.3 Health Reforms – 2023-2025

Following the 2023 general elections, the new Coalition Government (National-ACT-New Zealand First) moved quickly to disestablish Te Aka Whai Ora. In response, Māori leaders in health filed an urgent claim to the Waitangi Tribunal. The Waitangi Tribunal's *Hautupua Report* found this decision breached Tiriti principles, noting a lack of consultation and regulatory oversight (Waitangi Tribunal, 2024, pp. 69-70). Without input from its Tiriti/Treaty partner to disestablish Te Aka Whai Ora and without a viable alternative to meet Māori health needs, the Tribunal said that "…*the Crown showed 'reckless disregard for the Crown-Māaori relationship*'" (Waitangi Tribunal, 2024, p. 70). The repeal process also bypassed standard accountability mechanisms, further eroding trust and undermining the Crown's Treaty obligations (Waitangi Tribunal, 2024). Despite these findings, the Government proceeded with introducing the *Healthy Futures (Pae Ora) Amendment Bill* (HFA Bill) in July 2025 with minimal consultation raising further concerns.

According to the *Regulatory Impact Statement: Amendments to the Pae Ora (Healthy Futures) Act 2022* (Ministry for Regulation, 2025), the policy objective of the proposed amendments is "…*to streamline and simplify the regulatory settings for the health system*

and ensure that Health New Zealand at all levels has the responsibilities and mechanisms to make its decisions informed by Māori views" (p. 1). The Ministry for Regulation (2025) frames the 'policy problem' as the need to "…*facilitate meaningful Māori involvement in decisions*…" and "…*streamline and clarify legislative provisions supporting a meaningful Māori voice in health decisions*" (p. 1). Among the stated "benefits" is the claim that the proposals "*will improve the ability for Māori to have their voices heard at various levels of the health system*" (p. 2). However, the Ministry for Regulation also concedes that any such improvement will likely be "*marginal and will depend on how changes are given effect by Health New Zealand*" (p. 2).

When the effectiveness of the changes is contingent on Health New Zealand's willingness and capacity to give effect to Māori voices, the prospect of these reforms delivering meaningful benefits or amplifying Māori participation remains doubtful. The Quality Assurance Statement (Ministry for Regulation, 2025) notes that "…*only limited consultation has been undertaken and engagement with Māori representatives has been limited to the Hauora Māori Advisory Committee*" (p. 3). While the Hauora Māori Advisory Committee (HMAC) is tasked under section 89(1) of the *Pae Ora Act 2022* with advising the Minister on Hauora Māori matters, it is the Iwi-Māori Partnership Boards (IMPBs) that are legislatively charged with representing local Māori perspectives on needs and aspirations for Hauora Māori outcomes. The Ministry for Regulation provides no details of the consultation process, whether the HMAC had sought input from the IMPBs, or if the views of those boards were considered. Ironically, the HFA Bill itself envisions a process in which advice flows from IMPBs to the HMAC and then to the Minister. Had the Minister followed this process during the amendments' development, it would have lent greater legitimacy, voice, and weight to the consultation and engagement process.

In his *Health Delivery Plan: Policy and Legislative Changes*, lodged by Hon Simeon Brown, Minister of Health, and considered by Cabinet in June 2025, the Minister stated that he had "…*engaged with the Hauora Māori Advisory Committee on proposed legislative changes to clarify the role of Iwi-Māori partnership boards and the Hauora Māori Advisory Committee*" (Brown, 2025, para. 44, p. 8). He further claimed that "*Committee members are supportive of the direction of the changes proposed. It was claimed that Committee members supported an expansion and elevation of their role… and the proposal to rationalise and co-ordinate the New Zealand Health Strategy*" (para. 44–45, p. 8). Yet, when viewed within the broader scope of the HFA Bill, these changes appear less as an "elevation" of roles and more as a relegation and narrowing of functions and responsibilities, raising concerns about whether the amendments strengthen or diminish Māori participation in health governance.

The Minister of Health claims the amended Bill will improve outcomes by creating a more connected, transparent, and effective system, yet critics argue it deliberately sidelines Māori voices and returns them to a system that has failed them for generations (Paewai, 2025). Crucially the Bill seeks to significantly amend Treaty-related provisions of the Act by removing requirements for Māori expertise and cultural competency among board members and decision-makers and Health New Zealand, effectively erasing the commitments to equity, Kaupapa Māori and te Tiriti o Waitangi. Given this significant amendment, it is difficult to see how the Crown can argue that these changes will give effect to the principles of te Tiriti o Waitangi, let alone to the authoritative text of te Tiriti itself. It is even more concerning if the support given by the Hauora Māori Advisory Committee included support of these legislative changes.

This chain of events illustrates a deepening tension between government reform and Tiriti obligations. In a climate of uncertainty and ongoing challenge to te Tiriti commitments

the need to examine how te Tiriti o Waitangi is being understood, honoured, and embedded in health practice intensifies. The struggle to halt the governments "*escalated discrimination against Māori*" (Paewai, 2025, para. 1) continues with Lady Moxon presenting an urgent claim to the United Nations in Geneva claiming the coalition government has breached te Tiriti o Waitangi since it took office in late 2023 through "*discriminatory laws, political exclusion, dismantling of oversight bodies, inflammatory rhetoric, encroachment on Indigenous lands and waters, and environmental deregulation that harms Māori communities*" (Paewai, 2025). For me, as both a researcher and someone deeply committed to equity for Māori, this is not simply an academic inquiry; instead, it is a *kaupapa* grounded in lived experience, community responsibility, and a vision for change. As such, this backdrop powerfully informs this thesis's inquiry into the effectiveness, and future, of te Tiriti training within public health.

At the time of conducting this study, the Healthy Futures (Pae Ora) Amendment Bill was being considered (see earlier discussions). On July 10th, 2026, the Healthy Futures (Pae Ora) Amendment Act 2026 was passed into statute, following Royal assent. This amended the Pae Ora (Healthy Futures) Act 2022; the primary Act is now the Healthy Futures (Pae Ora) Act 2022. It is beyond this study to discuss these latest health reforms as preparations are being made to submit this thesis. Nevertheless, the writer acknowledges the efforts of Lady Moxon and others in raising awareness and seeking changes through the United Nations and through the Waitangi Tribunal.

1.4 Positioning My Research

In Kaupapa Māori research, positionality is not simply a declaration of identity. It is an acknowledgement of the relationships such as those set out in my *pepehā,* responsibilities,

and experiences that shape how knowledge is sought, interpreted, and shared. As a Māori researcher, Tiriti educator, and descendant of *whānau* whose lives have been shaped by the ongoing effects of colonisation and the enduring significance of te Tiriti o Waitangi, I do not approach this research as a detached observer. My interest in Tiriti education has been informed by decades of professional, governance, and community experience, alongside a longstanding commitment to improving outcomes for Māori. This research reflects not only an academic endeavour, but also a responsibility to contribute to the realisation of equitable futures for current and future generations.

The release of the *Hauora Report* was timely. I was privileged and honoured to be co-teaching the Treaty of Waitangi paper as a Teaching Fellow alongside Distinguished Professor, Linda Tuhiwai Smith at Te Pua Wānanga ki te Ao: Faculty of Māori and Indigenous Studies, University of Waikato. Professor Smith suggested that as a Tiriti o Waitangi educator and trainer, I should consider doing my doctoral study in this area as issues of cultural safety and culturally appropriate delivery of services were identified as points of concern by the Waitangi Tribunal Hauora Tribunal. Professor Smith and another working colleague, Professor Tom Roa were members of the Waitangi Tribunal Hauora Panel. In January 2025, however, the Minister of Māori Development, Minister Tama Potaka replaced both Professors' Roa and Smith on the Waitangi Tribunal along with Professor Rawinia Higgins, following this up with an announcement of plans to launch a review into the Waitangi Tribunal to "…*ensure the Waitangi Tribunal remains focused, relevant, effective and fit for purpose…*" (Radio New Zealand, 2025 January 23). The Act leader, David Seymour welcomed the review claiming that the Waitangi Tribunal had gone well beyond its brief and had become increasingly activist (Radio New Zealand, 2025 May 9). But while the coalition government looked to change the tribunal's scope and jurisdiction, the group reviewing the Waitangi Tribunal's strategic direction and performance called for

greater resourcing of the Tribunal to cope with the burgeoning urgent inquiries in response to policy and legislative changes affecting Māori implemented by the coalition government (Walters, 2025).

My interest in this research is both personal and professional, shaped by lived experience, decades of work in the public sector, and a sustained commitment to te Tiriti o Waitangi. My Tiriti journey began in 1975, during the Māori Land March. At the time I was at Turakina Māori Girls' College (TMGC) and Rangitikei College, the latter to complete my sixth form as TMGC did not cater for sixth and seventh formers. My journey began as a curiosity. In the 1970s, the education system offered no teaching about te Tiriti, colonisation, or their impacts on Māori. Banners proclaiming, 'NOT ONE MORE ACRE OF MĀORI LAND' had no meaning to us without knowledge or context. On a class trip to Wellington, we observed protesters outside Parliament but despite our curiosity, we were prevented from enquiring into their presence or reasons for being there. Although the classroom remained silent, the reality outside was one of racism, stereotyping, and being marked as "other".

My first significant engagement with Tiriti issues came outside formal education—through protest movements, activisms, and community *kōrero*. After the 1975 Land March, a group of the protestors left Wellington and decided to take their protest to the Eastern part of the North Island. The late Dr Ranginui Walker (2004) made mention of a split into factions of participants at the end of the land march. One faction established a tent embassy on the steps of Parliament (clearly the group we saw on our school visit to Parliament), while the other group went on its own march around the East Coast. According to Te Ringa Mangu Mihaka (Dun Mihaka), there was only ever one group; the group left in Wellington was still an integral part of the group marching around the East Coast. One of the key responsibilities of the group left in Wellington was to finance the efforts of the group who were marching around the East Coast (personal communication, Dun Mihaka, December 1975). Whether or

not the group in Wellington understood that to be their role is another matter and given that little to no funds were being received, would confirm Walker's statement.

Led by Dun Mihaka, the group arrived in Te Kaha where I had returned home to prepare for my entry into nursing due to commence after the New Year break. Implored by my sister to attend the rally at the Te Kaha marae, I went and listened and by the time the group left Te Kaha, both my sister and I had joined the crusade.

It was not long before my newfound learning and time spent with Mihaka, Whakataka Brightwell and others, spoilt any plans for nursing as I threw myself into further informal Tiriti education, later regurgitating what I had learnt to all and sundry within the surroundings of Parliament and the Wellington Railway vicinity. These encounters ignited a passion for justice and sparked a lifelong commitment to learning and sharing knowledge about te Tiriti and *He Whakaputanga o te Rangatiratanga o Niu Tireni (The Declaration of Independence of New Zealand, 1835)* – (He Whakaputanga). The Paparahi o te Raki tribunal report noted earlier specifically refers to He Whakaputanga as our founding document that set Māori as an independent country governed by a confederation of chiefs.

My time as an activist[3] was short-lived. I needed to find work and those I had aligned myself with during our days of activism had left for one reason or another. After some time spent aimlessly going from one job to another, I moved to the Waikato with my partner, later to become my husband and sought employment through the Department of Labour. My educational qualifications gained me employment with the Department of Social Welfare. It seems ironic that I should find myself employed by one of the very bureaucratic institutions I was railing against during my brief stint as an activist. It is so much more extraordinary that I

[3] The use of the word, 'activist' is deliberate. Although synonymous with the word, 'protestor' I use the former to separate my 1970s activities from those later activities in my life. In this respect, I contend that I have always remained and continue to be involved in protest.

now find myself researching in an area that I am confident I would have contributed to had I taken up the offer of employment in nursing. Even though my days as a full-time activist are behind me, I still stand up against injustice alongside my *mokopuna*. I continue to do this through formal select committee submissions on discriminatory government legislation, as Figure 1 shows. While at the Te Kaha RSA holding a workshop with members of the local community on the Regulatory Standards Bill, I took the opportunity to ask my mokopuna tuarua, Te Kūraeora Tapae Te Ara Mōwaikura Savage, if she would like to make a submission. She agreed and beneath the photos of her tīpuna, Moana-Nui-a-Kiwa Ngarimu VC 28th Māori Battalion and, Papera Wharepapa (my dad), also 28th Māori Battalion who fought alongside Ngarimu in the Tunisian campaign of World War II, I helped my *mokopuna tuarua* complete her submission. We have also joined protests in the streets, just as so many did during the nationwide mobilisation against the Principles of the Treaty of Waitangi Bill 2024 (94-1), more commonly referred to as the Treaty Principles Bill.

Figure 1

Author and great granddaughter completing submission on the Regulatory Standards Bill.

Note. Personal photo taken by Devena Moengaroa Ruwhiu-Edmonds, authors granddaughter and mother of child. (Ruwhiu-Edmonds, 2025 June 21). Te Kaha RSA.

Professionally, my early career in the Department of Social Welfare placed me at the frontline of systemic inequities. I saw how "politically neutral" institutional policies often failed to reflect Māori realities, values, and aspirations. The 1988 *Puao-te-Ata-tū* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988), experienced both as an employee and as a Māori woman, named the racism I had witnessed daily – the same racism witnessed in my days attending schools in Marton. While its recommendations offered hope for transformation, the Crown's commitment was inconsistent, and structural inequities persisted.

Over time, these experiences deepened my resolve to contribute to meaningful change. My academic pathway, from completing law degrees to working in Treaty education, has been driven by the conviction that te Tiriti provides a principled framework for equity, partnership, and improved Māori health outcomes. My role as a Treaty/Tiriti educator has reinforced the need for research that examines whether current training genuinely shifts understanding, behaviour, and institutional practice, or whether, like previous reforms, it risks becoming another unfulfilled promise.

This research is therefore grounded in both lived experience and scholarly inquiry. It reflects a life shaped by the absence of early Treaty education, a chance encounter with Mihaka and other activists who taught me about the differences between the Treaty and te Tiriti and an introduction to 'He Whakaputanga', a career challenging systemic racism, and a commitment to ensuring te Tiriti is realised in practice. It seeks to critically evaluate the effectiveness of Treaty-based training in the health sector as a tool for addressing health inequities, and to contribute to the broader kaupapa of improving Māori health through systems that honour the Tiriti partnership.

The perspectives I bring to this work are informed by decades of observing the persistent gap between Treaty commitments and the lived realities of Māori. This gap underscores why te Tiriti o Waitangi training within the health sector matters. Training offers one of the few structured opportunities for health professionals to engage with the history and obligations of te Tiriti, and to reflect on how these apply in their practice. Yet, as past reforms have shown, education alone is not enough, it must be embedded in systems that uphold equity and accountability. Against this backdrop, this thesis considers the place of te Tiriti in the health sector, the role of cultural safety and competence, and the ways in which training is currently conceptualised, delivered, and evaluated.

My interest in te Tiriti as a framework arises from its potential to reshape relationships between the Crown and Māori in ways that restore balance, uphold tino rangatiratanga, and address the systemic causes of inequity. Rather than viewing te Tiriti as a historical artefact or compliance tool, I understand it as a living relational covenant (Mikaere, 2011) that has continued to guide ethical, political, and institutional practices in Aotearoa. As Jackson (2019) reminds us, te Tiriti is not a static legal document, but an ongoing relationship grounded in mutual obligation and moral responsibility. In this way then, te Tiriti endures as a living agreement, one that, as Dr Veronica Tawhai (Radio New Zealand, 2025 Feb 3) describes, offers a humanising and healing framework for rebuilding just relationships.

Within the health sector, Came and colleagues (2021) emphasised that a Tiriti-compliant system requires every layer of legislation, policy, and professional practice to explicitly uphold its intent. This thesis, therefore, is shaped by a dual purpose: to critically examine how te Tiriti is taken up within public health training, and to explore whether that training equips staff to understand and act on their Tiriti-based responsibilities in ways that truly support equity. My aim is not only to evaluate the content and delivery of training, but also to interrogate its deeper assumptions, its transformative potential, and its alignment with

the aspirations of Māori. From this foundation, I now turn to the research questions that guide this study, before reviewing the literature on te Tiriti training, equity frameworks, and the role of health professionals in honouring their Tiriti obligations.

1.5 Research Aim

The aim of this study is to explore how te Tiriti o Waitangi and Treaty of Waitangi training equips health professionals to understand, reflect on, and apply Tiriti/Treaty based frameworks in health settings. I also focus on how the training advances health professionals' knowledge and praxis on their Tiriti responsibilities including improving equity and health outcomes for Māori. The following research objectives guide this thesis.

1.6 Research Objectives

1. To examine the theoretical underpinnings and intentions of te Tiriti o Waitangi training programmes delivered within public health.
2. To assess how training content and delivery reflect te Tiriti o Waitangi articles, including tino rangatiratanga, *kāwanatanga, ōritetanga, and wairuatanga.*
3. To explore participants' perceptions of the training's impact on their knowledge, attitudes, and professional practice.
4. To identify barriers and enablers to embedding te Tiriti into everyday health practice.
5. To consider the implications of te Tiriti training for future policy, practice, and relationship-building between Māori and the Crown.

1.7 Research Questions

1. How do te Tiriti o Waitangi training programmes in public health sector prepare health professionals to honour their Tiriti responsibilities in ways that contribute to improved health equity for Māori?

2. What theoretical and historical foundations underpin these training programmes?
3. How do training design, content, and delivery reflect Māori values, knowledge systems, and aspirations?
4. In what ways do participants apply their learning to their roles, and what challenges do they encounter?
5. What factors enhance or limit the effectiveness of training in advancing equity for Māori?
6. How might te Tiriti training be strengthened to support enduring, equitable Crown–Māori relationships in the health sector?
7. What is the future of Tiriti training in Public Health?

1.8 Thesis Outline

Chapter One introduces the study by situating it within the historical and contemporary context of Māori health inequities and the role of te Tiriti o Waitangi in health policy and legislation. The Waitangi Tribunal Reports, *Hauora* and *Hautupua* provide the background and contextual overview of health reforms and their impact on te Tiriti commitments. The latest health reform announcements by the Minister of Health, Hon. Simeon Brown introduces a new level of reforms that, if adopted, will impact the future of Tiriti training in public health, and the broader equity challenges that frame this study. This chapter also sets out the rationale for the research, highlighting the lack of comprehensive evaluation of te Tiriti training and the need to understand its effectiveness in supporting equity outcomes and meaningful Crown–Māori partnerships. My positionality is discussed to acknowledge the perspectives and values that underpin this work. The chapter concludes with the research aims and questions and provides an overview of the thesis structure.

Chapter 2 forms the literature review, providing both an international and local context for the study. It begins by examining why training is considered a vital tool for addressing racism and inequities in health care. Drawing on evidence from overseas, this section explores key anti-racism and Indigenous health training programmes in settler-colonial nations such as Australia, Canada, and the United States. These countries have implemented, reviewed or evaluated training initiatives aimed at addressing systemic racism, strengthening cultural safety, and improving health outcomes for Indigenous populations. My review summarises the aims, delivery methods, and evaluation approaches used in these contexts, identifying the outcomes achieved and the critical lessons learned. These international examples are not presented as models to be replicated wholesale, but as valuable sources of transnational insight into what has worked, what has failed, and why.

The chapter also reviews evaluations and studies of te Tiriti training. While there is some research in community, education, and public sector contexts, there remains a notable lack of systematic, robust evaluation in health. Where evaluations have been undertaken, they suggest that training can raise awareness, shift attitudes, and prompt reflection — but without sustained reinforcement and organisational change, these gains may not translate into practice. This gap in the evidence base highlights the importance of the present research, which seeks to evaluate te Tiriti-based training in the health sector through a Kaupapa Māori lens, applying CTA to understand both strengths and limitations, and to identify pathways for strengthening practice.

Chapter 3 provides the methodology and methods for this research and outlines the theoretical and philosophical foundations of the study. I explain why Kaupapa Māori research was selected as the overarching approach, and how it ensures that Māori worldviews, priorities, and values are central to the research process. The chapter describes how the Critical Tiriti Analysis framework was applied, enabling a structured focus on Tiriti articles to

analyse training programmes. As the researcher, I position myself in this research and include personal and professional motivations for undertaking this study to ensure transparency and reflexivity. I also detail the methods used to carry out the research describing the research design, data sources, and processes for data collection and analysis. This study used a mixed-methods approach, drawing on:

1. Online training evaluation data from participants across the health system (Waikato DHB/Te Whatu Ora).
2. Semi-structured interviews with staff who had undertaken training.
3. Interviews with training providers and facilitators.

Recruitment strategies, ethical considerations and data analysis methods are detailed. The results are presented across three chapters – Chapters 4, 5 and 6 which are as follows:

Chapter 4 Presents findings from; (a) the online eLearning Tikanga Best Practice with its module on te Tiriti o Waitangi; (b) Te Ara Tōtika and; (c) the Public Health and Rautaki's CTA workshop evaluations, highlighting how participants perceived the usefulness of different training components, such as content and delivery: perceived relevance to their work and any self-reported changes in knowledge, attitudes, or practice. It also identifies gaps, challenges, and areas where participants felt needed improvement.

Chapter 5 Presents interview findings from staff participants, structured around the CTA framework. I explore how participants understood and applied the responsibilities against the articles and principles of te Tiriti as described in the *Preamble* (good governance, peace and good order and Māori authority), *Kāwanatanga* (governance and Crown obligations), *Tino Rangatiratanga* (Māori authority and self-determination), *Ōritetanga* (equity and fairness) and *Wairuatanga* (spiritual well-being in practice). The chapter

highlights perceived strengths and weaknesses of training, provides examples of how learning was applied in practice, and discusses barriers to embedding te Tiriti in daily work.

Chapter 6 Presents the perspectives of those involved in the design and delivery of training. It discusses how training was developed, the extent of Māori leadership and co-design, the pedagogical approaches used, and the challenges of delivering meaningful Tiriti-based training in a shifting political and organisational environment.

Chapter 7 provides the discussion, weaving together the findings from all data sources and connecting them to the literature reviewed in Chapter 2. It assesses where current practice aligns with or diverges from both international best practice and te Tiriti obligations. The chapter also addresses broader questions about the role of Tiriti training in advancing equity, the limitations of training without systemic change, and the need for robust evaluation frameworks. I propose recommendations for design, delivery, and evaluation of future training programmes. Finally, the chapter concludes the thesis, summarising the key findings, highlighting the study's contribution to knowledge and practice. It also reflects on the implications for the future of Tiriti-based training in the health sector and the role of such training in fulfilling the obligations of te Tiriti. Limitations of the study will be acknowledged, and directions for future research will be proposed.

Chapter 2: Literature Review

To give a broader context to this study an integrative review of international and local literature where the role of training as a strategy for addressing racism, inequities, and structural barriers within health systems is examined in this chapter. It begins with a discussion outlining the methodology used for this review. This is followed with an exploration of international scholarship and practice relating to cultural safety, anti-racism, and Indigenous health training. Attention is given to initiatives implemented in settler-colonial contexts including Australia, Canada, and the United States, where training programmes have been developed, evaluated, and critiqued as mechanisms for promoting systemic change. These experiences provide a comparative context for understanding developments in Aotearoa New Zealand.

The chapter then considers the Aotearoa context, focusing on Te Tiriti o Waitangi training as a key strategy for strengthening cultural safety, health equity, and organisational accountability within the health sector. Through synthesising the literature across these contexts, the review identifies areas of consensus, ongoing debates, and gaps in current knowledge, thereby establishing the rationale for the research undertaken in this thesis.

2.1 An Integrative Review Methodology

The integrative literature review methodology is a form of research that reviews, critiques, and synthesises literature on a topic in an integrated way from which new frameworks and perspectives on the topic are generated (Torraco, 2005). The integrative review is characterised by Torraco as a distinct research method rather than a basic summary. In his framing of the methodology the primary intention is to synthesise prior knowledge, that is, what is known about the topic, to generate new conceptual understandings. Snyder (2019)

offered some guidelines for how to conduct and evaluate the literature using a four-phased approach. This study followed the strategies outlined to evaluate literature that illustrated why training is widely considered a vital tool for addressing racism and inequities in health care.

A comparative summary of international approaches to Indigenous health and anti-racism training was created which included the country (Australia, Canada and the United States), training focus, strengths of the research, limitations and or risks and key lessons for Aotearoa. The comparative summary of international approaches aided immensely the writing up of the review. It helped synthesise the research focus with existing literature throughout the chapter, rather than treating the literature review as something separate; which is the aim of integrative literature review.

2.2 The International Context

Training has become a key strategy for addressing inequities and racism in health systems worldwide (Browne et al., 2021, MacLean et al., 2023; Wang et al., 2024; Mohamed et al., 2024). Internationally, research has established that health inequities for Indigenous peoples are sustained by systemic racism and colonialism, and that workforce training is one pathway to addressing these inequities (Paradies, 2016; Curtis et al., 2019; MacLean et al., 2023). Across different contexts, education aimed at improving cultural safety, confronting institutional racism, and strengthening equity-oriented practice has been used to shift both individual attitudes and systemic behaviours (Downing et al., 2011; Curtis et al., 2019; Mohamed et al., 2024). While training alone cannot dismantle entrenched inequities, existing literature demonstrates its potential to spark critical reflection (Curtis et al., 2019; Cormack et al., 2020), increase cultural responsiveness (Mohamed et al., 2024; Gray et al., 2020; Browne et al., 2016; Downing et al., 2011, Durey, 2010), and lay the groundwork for broader

organisational and systemic change (Paradies et al., 2014; Cox and Best, 2022; Curtis et al., 2022; Wang et al., 2024).

Internationally, countries such as Australia, Canada, and the United States (US) have introduced targeted anti-racism and Indigenous health training to address persistent inequities in health outcomes for Indigenous populations (Curtis et al., 2019; Browne et al., 2021; Mohamed et al., 2024). These initiatives share common aims: to challenge discriminatory attitudes (Paradies et al., 2008; Downing et al., 2011); address the legacies of colonisation (Curtis et al., 2019; Mohamed et al., 2024); and strengthen health professionals' ability to work in partnership with Indigenous communities and to deliver culturally safe care (Browne et al., 2016; MacLean et al., 2023).

While evaluations show improvements in awareness, empathy, and cultural capability (Browne et al., 2011; Gray et al., 2020; Kowal et al., 2012; Curtis et al., 2019; Mohamed et al., 2024; Wang et al., 2024; Downing et al., 2011), enduring change requires sustained learning (Gray et al., 2020; Curtis et al., 2022; MacLean et al., 2023, Wang et al, 2024), Indigenous leadership (Browne et al., 2021; Mohamed et al., 2024), and system level alignment (Paradies et al., 2014; Wang et al., 2024; Curtis et al., 2022). Mohamed et al. (2024) highlighted that some evaluated programmes conflate cultural awareness, cultural competence, and cultural safety, which limits the transformative potential of such training. They argued that only training grounded in cultural safety with its explicit focus on racism, power and white privilege and health practitioner's accountability, shows greater potential to shift practice and improve relationships with Indigenous patients. It is a stance that is strongly supported in this study. A core part of cultural safety training in Aotearoa is responding to te Tiriti o Waitangi obligations with some using te Tiriti to structure the development of culturally safe health interventions (Hikaka et al., 2021) or to address racism and achieve cultural safety in practice (Oda & Rameka, 2012).

In many countries with Indigenous populations, communities continue to call for treaties as a means of formally establishing a relationship with the Crown (Wellauer & Boltje, 2025). Australia, for example, did not enter a national treaty with First Nations peoples, and only recently, on 30 October 2025, did Victoria sign the first state-level Treaty. Because there are no international equivalents of te Tiriti o Waitangi training, this review turns instead to overseas scholarship and evaluations of Indigenous health, cultural safety, anti-racism, and diversity, equity, and inclusion initiatives (DEI). While the contexts differ, these initiatives share a common purpose: to disrupt systemic racism in health care and to promote equity for Indigenous peoples and other marginalised groups. Reviewing this literature provides valuable insights into effective pedagogies, challenges, and evaluation approaches that can inform the Aotearoa context. At the same time, it is important to note that te Tiriti training is not limited to teaching the historical or political foundations of te Tiriti alone. Rather, it integrates elements of cultural competency, cultural safety, and anti-racism, approaches also present in international training programmes, while grounding them in the specific obligations of te Tiriti and the Māori–Crown relationship. In this way, te Tiriti training both aligns with global efforts to address health inequities and remains distinct in its Tiriti-centric focus. The international evidence is therefore not a substitute, but a complementary body of knowledge that helps illustrate the importance of training as a vehicle for equity and accountability in Aotearoa.

2.3 International training initiatives

The next sections examine training initiatives in each of the countries previously identified; Australia, Canada, and the United States, highlighting lessons that may be relevant to Aotearoa. These international experiences help illuminate what works, what does not, and what might be adapted or avoided. From there, the focus turns back to Aotearoa to trace the development of te Tiriti-based training within the health sector at Te Whatu Ora, Waikato. I

describe its common components and assess what is known, and unknown, about its effectiveness. By situating te Tiriti training within both an international and local evidence base, this chapter positions it as a key, though not standalone, mechanism for achieving equitable health outcomes for Māori.

2.3.1 Australian Context: Cultural Safety and Indigenous Health

In Australia, a substantial body of work has examined the role of training in addressing racism and inequities in Indigenous health care. Early contributions, such as Durey's (2010) analysis, highlighted how racism remains deeply embedded in health systems resulting in disparities in health care between Aboriginal and non-Aboriginal Australians. In her critique of cultural awareness programmes, Durey observed that such programmes could lead to short-term improvements, however, improving Aboriginal health required a sustained political will and a systemic commitment to dismantling racism in health care (Durey, 2010). Central to this is embedding cultural education and reflective practice within health services and higher education, as part of a broader anti-racist framework. Success, however, would depend on evaluating the long-term effectiveness of these initiatives and fostering genuine collaboration between policymakers, health providers, academia, and Aboriginal stakeholders (Durey, 2010).

Building on these critiques, Downing, Kowal and Paradies (2011) undertook a review of Indigenous cultural training programmes for health workers across Australia and selected settler-colonial countries. They reported that the international literature provided some confidence that such training could effectively improve knowledge, attitudes and skills of health professionals (Downing, et al., 2011). However, the evidence also showed a paucity of studies in this field (Stanhope, et al., 2008; Beach, et al., 2005; Chipps, Simpson & Brysiewicz, 2008) to determine the overall effectiveness of such training. Moreover, there

was insufficient evidence to determine that cultural training improved health outcomes and equity of service (Downing, et al. 2011).

There was a similar lack of evidence for the effectiveness of Indigenous cultural training in Australia (Downing, et al. 2011). Studies assessed showed inconsistency in training quality and delivery with critiques reliant on cultural awareness that stopped short of systemic change. They argued that Indigenous cultural training informed by a cultural awareness model had limited potential to create a culturally safe health care system. On the other hand, a cultural safety framework offered more potential because this type of training shifts the focus away from trying to teach about 'Indigenous culture' and instead looks to examine processes of power imbalance, identity and social inequality (Downing et al., 2011).

An integral aspect of training for cultural safety focuses on exposing the way in which power relations play a part in shaping health care relationships (Downing et al., 2011; Curtis, et al., 2019, 2025). As Downing et al. (2011) argue:

> *Training advocated by a cultural safety model does not focus on learning a culture but rather focuses on assisting health workers to practice the reflexivity needed to examine their own identity and cultural beliefs, and the way in which these might manifest in their interactions with those they are caring for.* (p. 254)

Gray et al. (2020) conducted a study of cultural safety training for allied health students in Australia to ascertain whether the implementation of an Indigenous cultural safety workshop increased students self-rated cultural safety knowledge and attitudes. While students reported increased awareness of their own cultural values and the role of their own cultural identity in client interactions, evidence of consistent knowledge or attitudinal change across all areas; for example, political and historical knowledge to understand the power imbalance that can lead to inappropriate treatment (Gray et al., 2020) varied. Although these

authors concluded that this type of intervention showed promise for preparing students to become culturally safe health practitioners, they also recommended embedding cultural safety education throughout the curricula and scaffolding different content across the undergraduates training. Noting the lack of evidence that educational gains translated into clinical practice, Gray et al. (2020) recommended longitudinal research to assess whether such workshops have lasting impact once graduates enter the workforce.

Partly in response to sustained advocacy by Aboriginal and Torres Strait Islander leaders, cultural safety training has increasingly been embedded in health education and professional standards in Australia (Australian Medical Council Limited, 2022). In noting the inclusion of cultural safety in various Codes of Conduct and Accreditation standards, Cox and Best (2022) expressed concern at the apparent confusion and misunderstandings about the differences between cultural safety and cultural competence. They argued that a consequence of this misunderstanding is that "…*privilege, power and racism remain unaddressed and unacknowledged"* (Cox & Best, 2022, p. 75).

This discussion on mixed definitions and understandings of cultural safety was further advanced by authors Mohamed, et al. (2024) in a Lowitja Institute paper, after conducting a literature review of cultural safety training and standards evaluating their effectiveness. They found that while some training was labelled as cultural safety, terms such as cultural awareness, cultural competence, cultural responsiveness and cultural safety were often used interchangeably leading to confusion. Furthermore, different cultural training terms have distinct focuses and implications for practice. For example, cultural safety is a First Nations-led approach aimed at systemic change, focusing on racism, power imbalances, the impact of colonisation and white privilege; cultural competence training is not specific to First Nations peoples and suggests non-Indigenous competence in diverse cultures; cultural responsiveness is common in allied health and education but lacks a focus on power dynamics and cultural

awareness, rather the primary focus is on knowledge about Aboriginal and Torres Strait Islander peoples (Mohamed et al. 2024). Promoting clear distinctions between these terms was therefore critically important (Mohamed et al. 2024).

Nationally consistent standards and accreditation for cultural safety training across health, human services and educational institutions, standards that would require health organisations to commit to tracking and reporting on cultural safety experiences and outcomes, was proposed by Mohamed et al. (2024). It was acknowledged that cultural safety education occurring through tertiary education included standards set by the national health professional accreditation councils, supported by the National Aboriginal and Torres Strait Islander Health Curriculum Framework (Mohamed et al. 2024; National Aboriginal and Torres Strait Health Plan 2021-2031). However, gaps remain in work-based cultural safety training and its evaluation. For example, workplace training often relied on organisational initiatives or individual efforts to seek training with no formal standards in place outside of tertiary education. To create a consistent, impactful approach to cultural safety across Australia it is recommended that an accreditation body to assess cultural safety training against revised standards be set up. Mohamed et al. (2024) argued that a variety of resources were emerging to support the implementation and evaluation of cultural safety initiatives and called on these to be made widely available.

Training by itself "*cannot address racism and strengthen and embed cultural safety in policy and practice*" (Mohamed et al. 2024, p. 48). To achieve sustained change and improve the health outcomes of Aboriginal and Torres Strait Islander peoples' health, experiences and outcomes, systemic support and change need to be "…*embedded as the 'business as usual approach' in health, human services, and educational institutions"* (Mohamed et al. 2024, p. 48).

2.3.2 Canadian Context: Cultural Safety and Anti-Racism Training

In Canada, cultural safety and anti-racism training has been promoted as a key strategy for addressing inequities experienced by Indigenous peoples in health systems (MacLean et al., 2023; Hardy et al., 2023). Indeed, systematic reviews of Indigenous cultural safety training interventions (MacLean et al., 2023; Hardy et al., 2023) report that in the past ten years, there has been significant growth in such training for healthcare professionals to eliminate anti-Indigenous racism and inequities. Despite this, the authors concluded that:

> *There is limited evidence regarding the effectiveness of specific content and approaches to cultural safety training on improving non-Indigenous health professionals' knowledge of and skills to deliver quality, non-discriminatory care to Indigenous patients. (Hardy et al., 2023, p. 1)*

Studies show that while training has potential to shift attitudes and awareness, evidence of its long-term impact on clinical practice and health outcomes remains limited. Hardy et al. (2023) and MacLean et al. (2023) both note that definitions of cultural safety and anti-racism vary widely, and that evaluation methods utilised to assess training efficiency often lack rigour. This makes it difficult to compare findings across studies or to establish a strong evidence base for effectiveness.

Research also stresses that training cannot achieve meaningful change in isolation. Browne et al. (2018) and others highlight that cultural safety, and anti-racism programmes need to be supported by organisational policies, leadership commitment, and accountability mechanisms. Without this broader system-level alignment, training risks being reduced to a compliance exercise rather than a catalyst for transformation.

Canadian evaluations also highlight the challenges with implementing cultural safety and antiracism training and emphasise the need for strong support structures in

implementation. Studies report that participants sometimes experience emotional discomfort, distress, defensiveness, or backlash when engaging with content about colonialism and racism, reinforcing the need for skilled and trauma-informed facilitation (Browne et al., 2016; Thiessen et al., 2020; Goodman et al., 2017). These evaluations also stress the importance of structured follow-up support such as reflective practice, ongoing supervision, and organisational policy alignment in order that learning is not isolated from everyday clinical work (Browne et al., 2021; Thiessen et al., 2020). Other challenges include the absence of locally tailored guidelines, inconsistent leadership commitment, and limited integration of learning into day-to-day clinical practice (Allan & Smylie, 2015; McGibbon et al., 2014; Paradies et al., 2014). Canadian scholarship also highlights the prevalence of "checkbox training"; interventions that satisfy institutional requirements without transforming organisational cultures or addressing systemic racism (Wylie et al., 2021).

The San'yas case study.

A consistent theme across the Canadian literature is the need for genuine Indigenous involvement at every stage of training. MacLean et al. (2019) argue that success depends on Indigenous peoples not only contributing to training content but also shaping governance, delivery, and evaluation. Symbolic actions, such as acknowledgements or brief modules, are not enough without structural changes that embed Indigenous voices and priorities in health systems.

The San'yas Indigenous Cultural Safety Training programme, developed in British Columbia, illustrates both the potential and the complexity of system-wide training. Delivered online and supported at the provincial level, San'yas has reached thousands of health professionals and helped embed cultural safety principles into health policies (Browne et al., 2021). Participants report increased awareness of colonial histories and systemic racism, but evaluations also note variability in impact and the need for ongoing reinforcement

through workplace culture, leadership, and policy change. San'yas demonstrates that training can be scaled successfully, but also that sustainability depends on being embedded in wider structures of accountability and equity.

2.4 Diversity, Equity, and Inclusion (DEI) Training

In the United States (US), health workforce initiatives have largely been framed through the lens of diversity, equity, and inclusion (DEI). Unlike Canada, where cultural safety is explicitly linked to native American and American Indian rights, DEI efforts in the US tend to emerge from broader civil rights and social justice movements rather than from Indigenous sovereignty frameworks (Blackstock, Isom & Legha, 2024). Training programmes typically focus on addressing unconscious bias, structural racism, and inequitable access to care; yet consistent national training standards and clinical guidelines mandating DEI-related practices remain absent (Blackstock, Isom & Legha, 2024).

Systematic reviews indicate that DEI training can increase awareness and self-reported confidence among health professionals (Wang et al. (2023). However, as with Canadian evaluations, evidence of sustained behavioural change or measurable improvement in health outcomes remains limited (Hardy, et al.,2023). Many programmes are delivered as short, one-off sessions, lack theoretical coherence, and are rarely embedded within wider structural reform (Hardy, et al., 2023).

Recent political shifts in the US further reveal fragility of DEI-based approaches. Following the 2024 Federal election, numerous states have initiated legal, policy, and funding rollbacks targeting DEI programmes, including research supporting Native American and other marginalised communities (Ng et al., 2025). These developments illustrate how initiatives not grounded in rights-based or sovereignty-based frameworks can be easily rescinded in volatile political climates. This instability provides an important caution for

Aotearoa; while training is valuable, approaches that rely solely on DEI language without Tiriti-anchored commitments, Indigenous authority, and structural accountability, are vulnerable to shifting political agendas.

2.5 Key Lessons from International Experience

Taken together, the international literature provides a clear message: training matters, but it must be Indigenous led, embedded, and accountable, to move beyond symbolic gestures. Canada demonstrates the potential of large-scale, system-supported training like San'yas, but also the fragility of outcomes without sustained organisational and governmental backing. Canada also highlights the risks of "checkbox" approaches and the importance of linking training to measurable structural reform. The USA illustrates how initiatives not grounded in rights-based or sovereignty-based frameworks and Indigenous authority, are vulnerable to shifting political agendas, providing caution for Aotearoa. Australia reinforces the centrality of Indigenous leadership, experiential learning, and institutional responsibility. These lessons set the stage for Aotearoa, where te Tiriti training is not simply another form of a cultural competence initiative, but a Tiriti/Treaty-based responsibility grounded in partnership and obligations.

2.6 The Aotearoa Context: Te Tiriti Health Equity, and the role of training

The following sections consider the New Zealand context, asking how te Tiriti training is currently delivered, what it includes, and how it might address the gaps that persist in international approaches.

2.6.1 Te Tiriti equity, and health reform

Aotearoa's health system is shaped by the enduring impacts of colonisation which have produced persistent inequities in health outcomes between Māori and non-Māori. These inequities have been repeatedly affirmed through independent reviews and Tribunal findings,

most notably the Waitangi Tribunal's Hauora Report (2023), which concluded that inequitable outcomes for Māori are evidence of systemic breaches of te Tiriti o Waitangi. Central to these findings is the recognition that meaningful improvements require structural change, supported by a health workforce capable of enacting Tiriti-consistent practice.

In recent decades, health sector responses have included the development of cultural safety, cultural competence, and later te Tiriti-focused training for health professionals. However, despite their prevalence, evaluations of such training remain limited. Early studies suggested modest gains in knowledge and awareness (Waitoki, 2012), and anti-racism workshops demonstrated potential for attitudinal shifts (Came et al., 2017). Yet these evaluations also highlight a common limitation: training alone rarely produces lasting behavioural change or structural transformation without alignment to broader system-level reforms (Curtis et al., 2019; Came & Tudor, 2020b). This finding mirrors international evidence, reinforcing the need to situate training within a wider equity strategy rather than treating it as an isolated intervention.

2.6.2 Cultural safety, competency, and conflation issues

A recurring challenge in the Aotearoa context is the conflation of cultural awareness, cultural competence, and cultural safety within training design and delivery. In their review of the literature on cultural safety and cultural competency, Curtis et al. (2019) highlighted the increasing importance of cultural competency and cultural safety to achieve equitable health care, observing that some authorities included cultural competency in health professional licensing legislation and accreditation standards as well as in pre-service and in-service training programmes. However, noting the mixed definitions and understandings of cultural competency and cultural safety and how best to achieve both, it was contended that health practitioners, healthcare organisations and health systems need to work more towards cultural safety, with an understanding of how power works, rather than prioritise

"…*becoming 'competent' in the culture of others"* (Curtis, et al., 2019, p. 1). The authors further contended that "*the objective of cultural safety activities also needs to be clearly linked to achieving health equity*" (Curtis, et al., 2019, p. 1). In recommending a direct focus on the transformative aspects of cultural safety, alongside the more individual orientation of cultural competency, they proposed a definition of cultural safety designed to achieve health equity in systems and practice. This 2019 definition has been adopted by several professional bodies, although a conflation of cultural safety and competency has been noted. A 2025 paper by Curtis et al., provides a refinement of their 2019 definition of cultural safety in line with the need for ongoing critique and continuous improvement in the collective understanding of how cultural safety is practiced.

Cultural safety, according to the definition provided by Curtis et al. (2025) requires health professionals to examine themselves and the potential impact of their own identities and culture on their practice. This requires health professionals to "*acknowledge and address their own*, *biases*, *attitudes*, *assumptions*, *stereotypes*, *prejudices*, *structures and characteristics that may affect the quality of care provided"* (p. 2). Cultural safety *encompasses a critical consciousness where health professionals engage in ongoing self-reflection and self-awareness hold themselves accountable for providing culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity"* (p. 2). Furthermore, culturally safe health professionals "*influence healthcare to reduce bias and achieve equity within the workforce and working environment"* (p. 2*).* Cultural safety benefits all patients and communities. As Curtis et al. (2025) argue: "*This may include communities based on Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability*" (p.4).

Applications of cultural safety in Aotearoa are embedded in an understanding of te Tiriti o Waitangi and the power relationships between Māori and the Crown and in particular, Crown agencies such as the Waikato District Health Board/Te Whatu Ora.

2.6.3 Evidence base for te Tiriti training

Unlike Canada's rights-based cultural safety models or Australia's jurisdiction-specific reforms, Aotearoa has a constitutionally foundational treaty that establishes Māori-Crown relationships. The absence of training internationally that is equivalent to te Tiriti o Waitangi training, reflects both the uniqueness of this context and the critical responsibility placed on the Aotearoa health workforce. While international scholarship provides valuable insights into anti-racism, Indigenous health, and DEI training, the Tiriti context requires approaches that centre tino rangatiratanga, uphold Māori worldviews, and respond to local histories of colonisation and resistance.

Taken together, the Aotearoa context is characterised by both opportunity and challenge. There is a clear mandate for equity and Tiriti-consistent practice and growing awareness of the need for system-level change. Yet the evidence base on existing training remains thin, uneven, and often decontextualised from structural accountability mechanisms. These gaps make the present study particularly timely: by examining how te Tiriti training is delivered, experienced, and understood within Te Whatu Ora Waikato, the research contributes to a critical area where limited evaluation currently exists and where policy and practice urgently intersect.

2.7 Key Lessons from International Experience

Across Australia, Canada, and the United States, several consistent themes emerge regarding the implementation, evaluation, and limitations of Native, First Nations, Indigenous

health, cultural safety, antiracism, and DEI training initiatives. These themes offer important insights for Aotearoa while also highlighting the distinctiveness of the Tiriti context.

Firstly, training is most effective when grounded in Indigenous rights and sovereignty. Canadian models, particularly San'yas, demonstrate the value of embedding cultural safety within statutory or policy frameworks that recognise Indigenous self-determination. This aligns closely with te Tiriti o Waitangi, which affirms Māori tino rangatiratanga and provides a constitutional foundation for equity. In contrast, US DEI training lacks a sovereignty-based anchor and is therefore more vulnerable to political reversal, as seen in the recent dismantling of DEI infrastructure (Ng et al., 2025). This underscores the importance of protecting Tiriti-based training from political volatility by rooting it in constitutional obligations rather than discretionary policy.

Secondly, short, one-off training sessions rarely produce sustained change. Evaluations across all three countries show improvements in awareness, confidence, and empathy (Browne et al., 2016; Gray et al., 2020; Wang et al., 2024), but limited evidence of long-term behavioural transformation or improved health outcomes. Meaningful change requires ongoing learning, reinforcement, and integration into organisational systems, findings echoed within Aotearoa's own limited evaluation literature.

Thirdly, the clarity and coherence of training frameworks matter. Australian scholarship highlights the need to distinguish clearly between cultural awareness, cultural competence, and cultural safety (Downing et al., 2011; Mohamed et al., 2024). Where these concepts are conflated, training risks becoming superficial or personalised. This finding is directly relevant to Aotearoa, where similar confusion persists despite authoritative local scholarship (Curtis et al., 2019; 2025).

Fourthly, Indigenous leadership is essential to effectiveness and legitimacy. Across countries, programmes with strong Indigenous governance, authorship, and facilitation show greater acceptance, relevance, and impact (Browne et al., 2021; Mohamed et al., 2024). This principle is foundational to Kaupapa Māori and aligns with te Tiriti provisions for shared authority and partnership.

Finally, training must be embedded within structural change. International evidence consistently warns against "checkbox" or compliance-based training, particularly within institutions unwilling or unable to address structural racism. Without organisational commitment, accountability mechanisms, or alignment to equity-focused policy, training can reinforce rather than disrupt inequity.

For Aotearoa, these lessons support a Tiriti-centric approach to training – one that moves beyond interpersonal cultural competence to engage with power, structure, and the obligations of partnership consistent with cultural safety approaches. They also highlight the importance of robust evaluation, an area where this study provides a direct contribution.

2.8 Why Training Matters and Why it cannot stand alone

International and Aotearoa-based scholarship consistently affirms the value of Indigenous health, cultural safety, and anti-racism training in increasing awareness, confidence, and critical reflexivity among health professionals (Curtis et al., 2019, 2025; Browne et al., 2021; Mohamed et al., 2024). Across contexts, well-designed training can disrupt deficit-based narratives (Durey, 2010), strengthen understanding of colonisation and racism, and support practitioners to reflect more critically on their roles within health systems (Downing et al., 2011). Findings from this study align with this evidence, with participants reporting increased understanding of te Tiriti o Waitangi, Māori worldviews, and the structural nature of inequity within the health sector.

However, both international and Aotearoa literature caution against overstating the transformative capacity of training when it is not embedded within broader systems of accountability and change. Training alone cannot dismantle institutional racism, reconfigure power relations, or ensure equitable outcomes if organisational structures, policies, and leadership practices remain unchanged (Paradies et al., 2014; Reid et al., 2019; Curtis et al., 2022). From a Critical Tiriti Analysis perspective, an exclusive focus on individual learning risks locating responsibility for equity with health workers, while leaving intact the Crown and institutional arrangements that continue to produce inequitable outcomes.

This study contributes to this body of work by addressing a notable gap in the empirical evaluation of Tiriti o Waitangi training within the public health sector. While much of the existing literature examines cultural safety or Indigenous health training more broadly, there is limited research examining how Tiriti training is experienced, interpreted, and enacted in practice, and how its effectiveness is evaluated (Huygens, 2016). By integrating survey data, interviews with trainees and training providers, and CTA-informed analysis, this research demonstrates both the value of Tiriti training and its limits when not supported by sustained organisational commitment, resourcing, and structural reform. In doing so, the study reinforces a key conclusion emerging across international and Indigenous scholarship: training is necessary but insufficient. Its effectiveness depends not only on pedagogical quality, but on whether learning is scaffolded over time, reinforced through organisational practice, and aligned with institutional obligations to honour Indigenous rights, partnership, and tino rangatiratanga.

Having considered the broader International and Aotearoa wide approaches to health inequities through cultural competency, cultural safety, and Tiriti/Treaty training the next section traces the development of Tiriti training at Waikato DHB, subsequently, Te Whatu Ora Waikato. Attention will be paid to how these programmes have been informed by

theoretical underpinnings in cultural safety, cultural competence, anti-racism, Te Ao Māori, *tikanga Māori*, *te reo Māori* and Critical Tiriti Analysis (CTA). While common elements are found across programmes, such as the inclusion of Māori histories and local knowledge, the impacts of colonisation, and the principles and articles of te Tiriti, there is considerable variation in depth, delivery, and alignment with te Tiriti obligations.

Summary

This chapter has situated te Tiriti o Waitangi training within both international and Aotearoa-based scholarship on Indigenous health, cultural safety, and equity-oriented workforce development. International literature demonstrates that while training alone cannot dismantle entrenched inequities, well-designed Indigenous-led and anti-racist education can foster critical reflection, increase confidence, and support health professionals to recognise the structural determinants of inequity (Curtis et al., 2019; 2025; Cormack et al., 2018). However, these effects are rarely sustained when training is delivered as a one-off intervention, lacks Indigenous leadership, or is disconnected from organisational accountability mechanisms.

Within this broader context, te Tiriti training in Aotearoa remains distinct. Unlike generic cultural competence or diversity initiatives, Tiriti-based training is grounded in constitutional relationships, Indigenous rights, and obligations of partnership, protection, and equity. The enduring impacts of colonisation on Māori health outcomes have been repeatedly affirmed through independent reviews and Waitangi Tribunal findings, most notably the *Hauora Report* (Waitangi Tribunal, 2023), establishing a clear mandate for Tiriti-consistent practice within the health sector. In response, cultural safety, cultural competence, and Tiriti-focused training have become increasingly prevalent. Yet, despite their widespread

implementation, robust empirical evaluations of such training, particularly within public health settings, remain limited.

International scholarship offers important, though not substitutive, insights. Studies from Australia, Canada, and the United States highlight several recurring lessons: training is most effective when grounded in Indigenous sovereignty and rights; clarity of conceptual frameworks matters, particularly in distinguishing cultural awareness from cultural safety; Indigenous leadership is essential for legitimacy and impact; and training must be embedded within broader systems of structural change to avoid becoming symbolic or performative. Collectively, this literature reinforces that training matters, but only insofar as it is Indigenous led, sustained, and accountable.

For Aotearoa, these lessons underscore the need for a Tiriti-centric approach to workforce development, one that moves beyond interpersonal competence to engage with power, governance, and institutional responsibility. At the same time, both international and local literature caution against overstating the transformative capacity of training when organisational structures, policies, and leadership practices remain unchanged. Training alone cannot dismantle institutional racism or reconfigure Crown-Māori power relations without parallel system-level reform.

This review highlights a significant gap in the literature: the lack of empirically grounded evaluations of te Tiriti o Waitangi training that examine not only learning outcomes, but how such training is designed, experienced, interpreted, and enacted within real-world health systems. By focusing on multiple forms of Tiriti training within Te Whatu Ora, Waikato, this study responds directly to this gap. It contributes to a growing body of scholarship that understands training as necessary but insufficient, and positions its effectiveness as contingent upon pedagogical quality, scaffolding over time, organisational

support, and alignment with institutional obligations to uphold Māori rights, partnership, and tino rangatiratanga.

Chapter 3: Methodology and Method

This chapter explains the methodological foundations of the research and the rationale for the methods employed. Kaupapa Māori philosophy and te Tiriti o Waitangi guide every stage of the research from ethical considerations, survey design, interviews, and qualitative and quantitative analyses including Critical Tiriti Analysis (CTA). The research design draws on a mixed-methods approach with an emphasis on transformation and critique.

3.1 Introduction to the Methodological Foundations

Kaupapa Māori philosophy provides the conceptual, ethical, and relational grounding for this research. Decisions about the purpose of the study, design of survey and interview questions, recruitment, consent and ethical requirements, data interpretation, engagement with participants, and the orientation toward transformation within the health system were informed and shaped by Kaupapa Māori theory.

3.2 Kaupapa Māori Research Approach

Kaupapa Māori is both a methodology and a method, a concept articulated by Graham Smith (1997, 2017) and Linda Smith (1999, 2012) and elaborated on by many other Māori scholars (Pihama, 2001; Hiha, 2015; Cram, 2017; & Cram & Adcock, 2022). In their studies these scholars see Kaupapa Māori as a framework and a tool of analysis that determines the theoretical positioning (methodology) and provides the culturally safe, practical guidelines for how research and engagement should be conducted (method). Leonie Pihama et al. (2026) reminded us that fundamentally Kaupapa Māori is “a model that is grounded upon Māori

ways of being and knowing" (p. 2). In her article, *Kaupapa Māori health research,* Fiona Cram (2017) explored Kaupapa Māori health research as a decolonising paradigm that promotes Indigenous perspectives and addresses systemic health disparities faced by Māori. Cram (2017), like the scholars mentioned above, informed us that Kaupapa Māori research methods align with a Māori worldview that centres on core principles of Māori ontology (philosophical assumptions about the nature of reality), Māori epistemology (theory of knowledge) and culturally appropriate methodologies. Research methods should therefore align with Māori values such as *whakapapa*, *whakawhanaungatanga*, and *whakaae (*agreement) to ensure cultural relevance and credibility.

3.2.1 Kaupapa Māori principles and relevance to the study

The principles of tino rangatiratanga, taonga tuku iho, ako Māori, whānau, kaupapa, āta, and te Tiriti o Waitangi (G. Smith, 1997; L. Smith, 1999, 2012, 2021; Pihama, 2001; Hiha, 2015; Cram & Adcock, 2022) helped shape every stage of the study. While often presented as a list, these Kaupapa Māori principles work relationally. They also operate alongside the transformative elements described by G. Smith (1997), positioning Kaupapa Māori not only as a methodological approach but as a political and relational project of Māori advancement, a form of resistance to the domination of Western epistemologies seeking to reassert Māori ways of knowing, being, and doing.

Table 1 below has been adopted and adapted in part, from the work of G. Smith in his doctoral thesis (1997); Cram & Adcock (2022) and Hiha (2015). Table 1 also draws on some of the guidelines adapted in Hiha's work, as well as the work of L. Smith (1999). It also draws on the work presented by Cram and Adcock (2022). These guidelines and the overarching principles informed my research methods, relationships with the research participants and the thesis structure. To highlight the importance of Kaupapa Māori

principles, occasionally, I provide an example of the findings. While this is not standard practice, Kaupapa Māori provides for broader conversation and the pushing of boundaries.

Table 1

Kaupapa Māori Principles

Kaupapa Māori principle	Description
Tino rangatiratanga – upholding autonomy self-determination	Participants control over participation. Māori leadership in training.
He taonga tuku iho – cultural aspirations	Valuing Māori knowledge passed down to mokopuna (descendants)
Ako – culturally preferred pedagogy	Reciprocal, relational learning where everyone shares and learns from each other
Whānau – extended family structure	Relationality, responsibility and collective support.
Kaupapa – Collective vision	Maintaining focus on Māori aspirations for tino rangatiratanga and equitable health outcomes
Āta – Growing respectful relationships	Careful, deliberate engagement; nurturing respectful relationships.

Note: The Kaupapa Māori principles have been drawn from several sources including Smith (1997); Hiha (2015) and, Cram and Adcock (2022).

The principles outlined in Table. 1 and how they informed research relationships, decision-making, ethics, and analytical direction in this research are now discussed in more detail.

Tino rangatiratanga: The principle of upholding autonomy and self-determination.

Tino rangatiratanga is central to Kaupapa Māori research and informed the study's approach to participant autonomy and control over participation. In practical terms, this meant designing consent processes that protected participants' freedom to choose whether to engage (for example in the use of their feedback forms for Te Ara Tōtika and the PHR CTA workshop, and in interviews), reinforcing that participation (or non-participation) would have no implications for their employment, and ensuring anonymity, especially given the

hierarchical nature of the health system. This protection extended to enabling participants to tell their own stories in their own voices with the knowledge that in sharing their stories, not only Māori, but non-Māori might benefit from the experience. Fiona Cram and Anna Adcock (2023) highlighted Māori ways of relating (axiology) to Māori, asking among other things, "What have we got to share with one another so that we will all be both learners and teachers?" (p. 68). Although the discussion giving rise to this question related to being Māori, both Māori and non-Māori raised these same concerns with me during the telling of their stories.

Cram and Adcock (2023) asserted that Kaupapa Māori guide inquiry and provided some examples. Drawing on those examples, the interview questions for the PHR workshops and the PHR training provider were adapted to elicit information about Māori leadership in training. For example, whether the training:

- supported Māori leadership and decision-making autonomy;
- was grounded in Māori knowledge systems (*mātauranga Māori*), values, and belief systems;
- addressed tino rangatiratanga as a critical aspect of te Tiriti partnerships;
- centralised Māori voices in the design and content, and
- embedded Māori aspirations.

The interview questions were also designed to explore training effectiveness to enable health system staff to deliver culturally appropriate and safe services for Māori. Further questions explored whether training programmes addressed colonisation, examined structural and systemic barriers to Māori tino rangatiratanga, and moved beyond deficit framings of Māori health to foreground cultural strengths and Indigenous ways of knowing. I sought to find out how te Tiriti o Waitangi training may contribute to transforming health practices and

what support staff needed to understand and enact their Tiriti obligations. The CTA framework, discussed later in this chapter, informed the examination of how these obligations were articulated and operationalised within the training.

Tino rangatiratanga, understood alongside the cultural values articulated by L. Smith (1999), including *aroha ki te tangata* (respect and care for people), *he kanohi kitea* (being a known and present researcher), *titiro, whakarongo…kōrero* (observing and listening before speaking), *manaaki ki te tangata* (showing generosity and care), *kia tūpato* (acting with caution), *kaua e takahia te mana o te tangata* (not undermining dignity), and *kia māhaki* (humility), informed the ethical and relational conduct of this research. Together, these values give practical expression to what Hiha (2015) described as the balance "…*between the right to focus on and strive for one's own goals and the responsibilities one always has to others*" (p. 134).

Guided by this understanding, I sought to maintain clarity of research purpose while prioritising respectful and reciprocal relationships with participants. Participants were encouraged to determine where interviews took place, what they wished to share, and how their experiences were articulated. These practices, grounded in generosity and respect, were central to building trust and honouring participant authority over their contributions and data. In this thesis, tino rangatiratanga functions not only as an ethical principle but as an analytic guide, informing the interpretation of findings and the recommendations advanced in Chapter Seven.

Taonga Tuku Iho: Valuing Māori knowledge and ways of being

Taonga tuku iho is a central principle within Kaupapa Māori theory, foregrounding the intergenerational transmission and legitimacy of Māori language, knowledge, values, and cultural practices (Smith, 2017). Professor Graham Smith describes this as "*[t]he principle*

of validating and legitimating cultural aspirations and identity," positioning mātauranga Māori as "*a given and a taken-for-granted base in Kaupapa Māori educational settings"* rather than something requiring justification within dominant frameworks (Smith, 2017, p. 86).

As a Māori researcher conducting research within a mainstream institutional context, taonga tuku iho shaped a commitment to treat participants' experiences and mātauranga not as data to be extracted, but as taonga to be handled with care, respect, and accountability. This principle informed both the ethical stance and the analytic orientation of the study.

In practice, taonga tuku iho guided:

- the secure storage and protection of data,
- an interpretive approach that centres Māori conceptualisations of equity, racism, and Tiriti obligations, and
- the selection of analytic frameworks, including CTA, that prioritise Māori rights and Māori interpretations of te Tiriti o Waitangi.

More broadly, this principle reinforced the study's position that te Tiriti-based training must be grounded in Māori knowledge systems, rather than framed through Crown-imposed or compliance-driven interpretations of the Treaty.

Ako Māori: Reciprocal, relational learning

Ako Māori recognises learning as reciprocal and relational, which shaped the design of interview questions, the design of the CTA feedback survey and the conduct of interviews. Interviews were treated as shared spaces of learning rather than data-extraction encounters, allowing participants to lead conversations, define what was important, and guide the depth and direction of the kōrero. The survey design, although a positivist tool, was also

approached through ako Māori by emphasising opportunities for participants to reflect critically on their own learning and experiences.

Ako also guided reflexivity throughout the research process, requiring continual examination of my own assumptions and positioning, consistent with Kaupapa Māori expectations of researcher accountability. Cram & Adcock (2022) described this principle as everyone being a learner with something to learn and everyone being a teacher with something to share, which was evident during the interviews and workshops for both participants and researcher.

Whānau: Relationality, responsibility, and collective support

Whānau, within Kaupapa Māori research, is both a methodological and ethical principle that emphasises relationships, collective responsibility, and participant care. This principle shaped:

- the way participants were approached through whakawhanaungatanga;
- the emphasis on creating safe, respectful interview environments' and,
- the offer of follow-up processes to ensure participants felt heard and valued.
- Whānau also influenced the decision to include both workshop participants and trainers as participants, recognising the interdependence of learning.

Kaupapa: Maintaining focus on Māori aspirations

The principle of kaupapa ensured research remained anchored to a Māori-defined purpose. For this study, the kaupapa is the evaluation of te Tiriti training as a mechanism for addressing inequity, enhancing cultural safety, and strengthening Māori–Crown relations in health. This principle shaped the choice to investigate not just participant satisfaction but the structural and relational dimensions of training, including whether the training aligns with Māori aspirations for tino rangatiratanga and equitable health outcomes. It also required that

the research maintain a transformative intent, consistent with Kaupapa Māori expectations that research should contribute to positive social change.

Āta: Careful, deliberate engagement in growing respectful relationships.

Āta, as articulated by Taina Pohatu (2013), emphasises the need for deliberate, respectful, and thoughtful engagement with a focus on preferred ways of engaging with others. Āta guides how to enter, engage and exit relationships. This principle informed all interactions with participants, from consent processes to interviews. Āta shaped the tempo and tone of interviews, ensuring participants had time to think, reflect, and speak without pressure. It also guided the way feedback from survey and interview participants was handled, to ensure their kōrero was interpreted carefully, contextualised appropriately, and represented with integrity. Āta was particularly important given the sensitive nature of discussing racism, cultural safety, and organisational power dynamics. In her research, Hiha (2015) refers to the principle of manaakitanga as "*the principle of nurturing the connections and relationships through action*" (p. 131). Like 'āta', manaakitanga is a principled approach to healthy relationships - how to behave and conduct oneself (Pohatu, 2013).

3.3 Alignment of key principles with Te Tiriti o Waitangi

Drawing on Pihama's (2001) articulation of te Tiriti within Kaupapa Māori theory, and its subsequent elaboration by Cram and Adcock (2022), this study treats te Tiriti o Waitangi as the foundational framework from which all other Kaupapa Māori principles are derived. Te Tiriti therefore shaped both the ethical orientation and analytical intent of the research.

In practice, te Tiriti o Waitangi functioned as a foundational guide rather than an outcome of analysis. It informed, from the outset, the expectation that the research would uphold Māori authority, challenge inequitable institutional structures, critically examine

Crown actions and omissions, and contribute to the restoration of balanced Māori-Crown relationships. These commitments shaped the formulation of the PHR and trainer interview questions, the criteria by which evidence was interpreted, and the stance taken towards assessing training effectiveness (see further discussion at 3.4).

Te Tiriti also informed the primary interpretive framework through which survey and interview data were analysed. Rather than treating Tiriti responsiveness as an emerging theme, the analysis was oriented toward examining how participants engaged with pre-existing Tiriti obligations, including governance authority (Articles 1 and 2) equity as a Treaty guarantee (Article 3), and the relational and ethical responsibilities of partnership reflected in Articles 4. This approach enabled the analysis to move beyond individual learning outcomes to consider how training supported (or failed to support) engagement with the broader structural and relational responsibilities of the Crown.

Consistent with Kaupapa Māori principles, this Tiriti-informed orientation also shaped how knowledge was generated through the research process. Interviews with trainees and trainers were approached as relational encounters rather than extractive data gathering exercises, privileging participants' authority over their own narratives and allowing them to define what mattered within their experiences of training. This approach points to further possibilities for embedding Kaupapa Māori approaches in the evaluation of Tiriti training, including the use of *wānanga-based* methods, *kanohi ki te kanohi* engagement, and learning situated within *marae* contexts where *tikanga* and *pōhiri* processes can be experienced rather than abstractly described. Such approaches align evaluation more closely with Māori ways of knowing and disrupt models that assess effectiveness solely through individual awareness or self-reporting measures.

Together, the principles of Kaupapa Māori philosophy outlined above establish the ethical, epistemological, and relational foundations of this research. Kaupapa Māori affirms Māori authority over knowledge production, positions research as a site of resistance and transformation, and prioritises tino rangatiratanga, relational accountability, and collective wellbeing (L. T. Smith, 1999; G. Smith, 1997; Pihama, 2001; Cram, 2014). These principles guide not only how research is conducted, but also how knowledge is interpreted, ensuring that Māori experiences, values, and aspirations are not subordinated to dominant institutional frameworks.

3.4 Critical Tiriti Analysis – analytical framework.

Critical Tiriti Analysis (CTA) was initially developed as a retrospective policy evaluation tool for compliance with te Tiriti (Came et al. 2020a). Due to significant interest in CTA, this led to the development of the tool as a prospective guide to making policy that is consistent with te Tiriti (Came et al. 2024b). A distinctive feature of CTA is its attention to the colonial dynamics of Aotearoa that places te Tiriti and the well-being of Māori at the heart of policy analysis (Came et al., 2020a). Furthermore, the relevance of CTA as a critical policy tool has also been explored overseas. For example, Australian Indigenous scholar Natalie Bryant (2024) adapted CTA to evaluate policy and policy processes for alignment with Indigenous Peoples' needs.

In this study, CTA was adapted as an evaluative tool to examine the ways in which te Tiriti and/or its principles were reflected (or absent) in participants experiences of training and subsequent workplace practice. The use of CTA as an analytical framework was appropriate for several reasons. First, it ensures that te Tiriti o Waitangi forms the foundation of evaluation, not merely a point of reference. By positioning te Tiriti articles as the analytical lens, the approach resists the dilution of Māori rights through Treaty principles and/or generic notions of partnership or cultural competency that do not centre Indigenous

aspirations (Came et al., 2020a). Second, CTA exposes and interrogates power relations within institutions, drawing attention to how organisational structures and training systems either enable or obstruct the fulfilment of Tiriti obligations. Third, it provides a critical mechanism for accountability, asking not only whether training improves awareness but whether it transforms relationships between Māori and the Crown-aligned health system in meaningful and measurable ways.

3.5 Ethical Considerations

This study was guided by ethical principles that extend beyond procedural compliance to encompass cultural, relational, and institutional responsibilities. Consistent with Kaupapa Māori approaches, within this study, ethics were understood as an ongoing practice grounded in *manaakitanga,* whanaungatanga, respect, reciprocity, and accountability to participants and their contexts, rather than a one-off approval process. Ethical considerations informed the study's design, data collection, analysis, and interpretation. In addition to meeting institutional ethics requirements and locality approvals, the research was conducted in ways that upheld mana, protected relationships, and honoured the knowledge participants entrusted to me.

3.5.1 Institutional ethics and locality approval

Ethical approval for the study was obtained on 13 April 2021 (Appendix 1) from Te Kāhui Manu Tāiko, the Human Research Ethics Committee for Te Pua Wānanga ki te Ao: Faculty of Māori and Indigenous Studies at the University of Waikato. The approval process ensured that the study met the ethical standards for research involving human participants, particularly concerning informed consent, confidentiality, and data storage. During this research, my supervisory panel changed when both original supervisors relocated to other

tertiary institutions. Notwithstanding this change, my new supervisory panel, maintained oversight of the ethical standards required as approved by Te Kāhui Manu Tāiko.

I also sought locality approval from the Waikato District Health Board (WDHB) as required for research involving its staff and internal data systems (Appendix 2). Because my study proposed to explore how te Tiriti o Waitangi training could contribute to reducing health inequities between Māori and non-Māori, my application was referred to Te Puna Oranga, WDHB's Māori Research Review Committee. Following review, the committee endorsed the study, stipulating that any staff-related research must include the statement: *"Your decision to participate or not to participate will not affect your employment at Waikato DHB"* (WDHB, 2021). This condition affirmed the organisation's support for the research while safeguarding the autonomy and wellbeing of staff participants. The ethical and locality approval process established a robust foundation for the subsequent stages of the research, including the collection and analysis of survey data, however, ethical practice continued throughout the research and did not end with ethics approval.

3.5.2 Protection of participants

A decolonial interviewing style to address subtle and structural forms of racism in qualitative research was discussed by Istiko (2025), in his article, *Race-conscious conversations: A decolonial interviewing style,* Istiko (2025) argued that traditional interviews often fail to capture the complexities of racism, especially its systemic and intersectional aspects. He developed an interviewing style based on five principles to generate deeper, more actionable insights. Of these, the principle of an ethics of care is most relevant to this study. The ethics of care principle prioritises the well-being of both participants and researchers, addressing power imbalances, and being mindful of potential harm or trauma during sensitive discussions.

Istiko's central argument is that race-conscious conversations are not a new method but a decolonial interviewing style that enriches existing qualitative approaches, especially in applied sciences and contexts where race is often silenced. This style is compatible with participatory action research (Eruera, 2010, Wadsworth, 1998) aiming to produce more nuanced, actionable knowledge to help eliminate racism. A cautionary note is that this interviewing style "…*does not aim to substitute established qualitative methodologies from Indigenous communities around the world*" (Ponto, 2018; L. Smith, 2021 [1999], as cited in Istiko, 2025, p. 835) because as emphasised by Mignolo (2021, as cited in Istiko, 2025), "…*universalism is not the key to decolonial thinking*" (p. 835). A limitation of this interviewing style highlighted by the author, includes the need for interviewers to be already race-conscious, and have the time and resources required for in-depth engagement.

As I discuss in Chapter 7, racism is a determinant of health. Because participants were invited to discuss experiences of inequity and by extension, racism and institutional barriers, interviews were conducted with particular attention to relational safety and participant wellbeing. Participants were given opportunities to pause, decline to answer questions, or discontinue interviews at any stage. Interviews were approached as respectful conversations rather than data extraction, recognising the potential emotional weight of reflecting on experiences of institutional racism and Tiriti practice.

As an experienced Tiriti educator, I was aware that conversations concerning racism would potentially evoke discomfort, defensiveness, or emotional responses. Equally, while some Māori and non-Māori participants revisited experiences of institutional racism, other non-Māori participants experienced discomfort as they reflected on privilege, responsibility, or uncertainty. I had anticipated that discussing racism may (and did) evoke some emotional distress. Interviews were therefore conducted with care, allowing participants to determine the pace and depth of discussion while maintaining a respectful and culturally safe

environment. Discussing organisational experiences, power relationships and cultural safety, did not create any professional vulnerability for trainers and participants who were guaranteed confidentiality of information. All data across each of the studies was stored securely and analysed collectively, with no identifying information attached to individual responses.

3.5.3 Identity

How a researcher's identity and positionality can influence all aspects of research, including the research question(s), study design, data collection and data analysis is outlined by Wilson et al. (2022) in their article, *Identity, positionality and reflexivity: relevance and application to research paramedics.* Guided by their insights and to ensure comprehensive transparency and trustworthiness, I share reflections of my identity and positionality acknowledging how those experiences influenced all stages of the research, from the decision to embark on this research study to question formulation, data analysis and dissemination.

I am a Māori woman, descended from my Te Whānau a Apanui *tīpuna* - Te Ahiwaru, Te Aopururangi, Te Aomarama and Te Wharau - who signed Te Tiriti o Waitangi on the 14th of June 1840. Like most rangatira who signed Te Tiriti, they signed this document with the expectation that it would protect their authority, guarantee their rights, and forge a mutually beneficial relationship with the British (Orange, 1987; Mutu, 2010). Since then and for more than 15 generations, Te Whānau a Apanui have sustained themselves in their own *rohe* according to their *tikanga* enduring sustained socio-economic deprivation and inequity (Te Whānau a Apanui, 2023). The services provided by the Crown as partner to te Tiriti have not met Te Whānau-a-Apanui needs. Institutional racism continues to be a feature of my *iwi* engagement with the Crown. Nevertheless, Te Whānau-a-Apanui while remaining resilient, have actively sought to uphold their *rangatiratanga,* and have pressed the Crown to honour its obligations under Te Tiriti o Waitangi (Te Whānau-a-Apanui, 2023). In 2023, Te Whānau

a Apanui *hapū* and previous Treaty Negotiations Minister, the Right Honourable Andrew Little, initialled the Deed of Settlement which included a Crown apology, an agreed historical account and financial and cultural redress for historical breaches of te Tiriti that caused harm to Te Whānau a Apanui. It also included a "sovereignty clause" (Office of Treaty Settlements and Takutai Moana, 2023). This clause acknowledged that the Crown and the hapū of Te Whānau a Apanui agreed that they had different positions on sovereignty – widely accepted by both parties as an 'agree to disagree' clause about Crown and Te Whānau a Apanui sovereignty (Office of Treaty Settlements and Takutai Moana, 2023). Commenting at the occasion of initialling the Deed, on the length of time it took to reach this stage, Dayle Takitimu, Te Whānau a Apanui *uri* and negotiator said:

> *It's been frustrating at times as the government sees the Treaty as negotiable. We've tried to hold the line as an iwi to say that the rights negotiated by our tipuna have been set in stone since the 14th of June 1840 when our four tipuna, Te Aopururangi, Te Wharau, Te Aomārama and Te Ahiwaru signed Te Tiriti o Waitangi at Te Kaha…That was the crystallisation of pre-existing rights for our iwi. Those were not up for negotiation again…We're not going to get all the way there because this is a system that is entrenched in anything but honourable Treaty implementation and we've got to cut our iwi free from the oppression.* (Perry, 2023).

In 2025, the Treaty Negotiations Minister, Paul Goldsmith refused to finalise the Treaty Settlement because of the 'sovereignty clause' (Te Ao Māori News, 2025). However, despite this set back, Te Whānau a Apanui remain committed to ensuring that the Crown understands that Te Whānau a Apanui did not cede sovereignty. Speaking on the sovereignty clause, Rawiri Waititi, Te Pāti Māori co-leader and uri of Te Whānau a Apanui said the sovereignty clause "*is probably one of the most important parts of that particular settlement*

and we will not be moving from that" (1News Reporters, 2025, para. 4). In this research and in life, I have remained committed to that endeavour.

Growing up in a small Māori community, but in a large whānau being one of 14 children, our parents instilled in us the values of sharing and caring for one another and for others, '*aroha ki te tangata*' '*manaaki ki te tangata*'. This value was and remains our whānau responsibility. Our home was an open home to many other children despite our own large whānau. While we did not have material wealth, we had loving parents. From my parents, I learned that leadership was measured not by personal gain, but by service, responsibility and care for others. These values continue to shape how I approach research and my responsibilities to participants, communities and the knowledge entrusted to me.

My mother was of the generation who was punished at school for speaking te reo. Denied her right to speak *te reo* at school, when she stood on the marae to *karanga* and *waiata*, no one could, or dared to, deny her the right of first voice on the marae. Ironically, it was while she was performing her duty to her whānau and community, giving voice to years of dedication to her lifelong partner, our dad, that her voice went silent. Just six weeks later, my dad followed her. While it was an agonizing loss, it is also a true reflection of how they lived their lives—always together. They were never meant to be apart, even in death. Witnessing both the silencing and the reclaiming of Māori voice profoundly shaped my understanding of justice, responsibility and the importance of creating spaces in which Māori knowledge and experience are heard. The sharing of this story is not to generate sympathy but to honour their legacy; a lifelong legacy of stewardship, obligations and responsibilities. A legacy of ensuring our voice is not silenced, no matter what the circumstances.

My positionality is important as I am not a neutral researcher; I am a Māori researcher situated within and accountable to Māori communities. I have been delivering Tiriti

education at the University of Waikato and to other sectors including community, local government and with a professional connection to the health sector. I also have a lived personal connection to the health sector. Like many, my whānau and I have high health needs, physically, mentally and spiritually, and where racism has been at the forefront of many decisions made about and for my whānau.

As discussed in Chapter One, I have experienced personal, cultural and institutional forms of racism. Professionally my early career working in the then Department of Social Welfare placed me at the frontline of systemic inequities. I found the voice to speak up about those during a hui with the Ministerial Advisory Committee who reported on racism within the department, acknowledging racism was equally rife in other departments (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1986).

My parents' legacy continues to shape not only my personal values but also the ethical commitments that underpin this research. These experiences shaped a lifelong commitment for justice, for effective change that could meaningfully contribute to the elimination of racism and equitable outcomes for Māori. My professional and academic pathway, from completing law degrees to working in Treaty education, has been driven by the conviction that Te Tiriti provides a principled framework for equity, partnership, and improved Māori health outcomes. The sharing of these experiences aims to make transparent the values, responsibilities, and lived experiences that shaped the conduct and interpretation of this research.

3.5.4 Researcher Reflexivity

Researcher reflexivity is the process of critically examining and questioning one's own assumptions and positionality throughout the research process, aiming for transparency in and trustworthiness of the research. The researcher must reflect upon the way research is

carried out and explain to the reader how they moved through the research processes to reach certain conclusions (Wilson et al., 2022). To help the researcher give an honest account of how they conducted their research, Wilson et al. (2022) provide practical reflexivity strategies used in different research phases (systematic review, qualitative interviews, quantitative studies and the overall PhD). Reflecting on my own strategies to address challenges beyond the methodological concern, I see similarities between the strategies suggested and my own. For example, my own review included utilising a journal (manual and online) noting down decisions made during interviews with participants and trainers, and discussions and decisions made with my supervision and supporting research team. I also noted decisions made during and about data extraction and analysis. Alongside journalling my experiences and thoughts, reaching out to peers and my supervisors to validate and or guide decisions, provided sources of support and emotional safe spaces.

Writing on *Critical Reflexivity of the Researcher as an Exploratory Vehicle in Sensitive Research,* Banerjee and Dasgupta (2024) discussed researcher vulnerability in their sensitive and challenging research arguing that "…*researcher reflexivity can be used as a strategy to look behind the curtain of the research project*…" (p. 1). Through practicing critical reflexive experiential analysis, documenting and analysing their emotional journey through each stage of the research project, these researchers were able to address what they describe as, "…*the silence of researcher vulnerability*" to resolve each dilemma at both personal and professional levels (Banerjee & Dasgupta, 2024, p. 1).

Given the centrality of Te Tiriti implementation and institutional racism in the research, it was anticipated that participants might recount experiences involving discrimination, inequity, organisational tension, or emotionally challenging situations – and they did. On more than one occasion, participants shared experiences of personal and cultural racism in the workplace and in training. A study by Hamed et al. (2022) found that

"*…healthcare staff's reflections on racism and antiracist training show that healthcare staff tend to construct healthcare as impartial and that healthcare staff do not readily discuss racism in their workplace*" (p. 1). While some research participants may not have wanted to discuss or acknowledge that racism exists, others were wanting to make it known that it did exist. By and large, the latter group were those from ethnic minorities. Because of my own identity and positionality, navigating these discussions required diplomacy and empathy. Kaupapa Māori values and principles were key guides to interview strategies throughout the research process.

At the beginning of each participant interview, I shared my pepehā, gave a brief *mihi* and introduced myself as a Tiriti educator and one of a team of facilitators of the Te Ara Tōtika workshops, i.e. an insider. I also invited my participants to share their pepehā and/or whakapapa maintaining the *kawa* and respect of *mihi whakatau.* I did not keep records of ethnicity as I had indicated in my ethics application that I would not be detailing this as a requirement for my study. Nevertheless, once a participant shared their pepehā or whakapapa, it became clear who were of Māori ethnicity and who were of *tauiwi* ethnicities as shared by each individual.

The research topic guide was shaped by legal and professional experience, existing literature (for example, in the works of several researchers such as Dame Irihapeti Ramsden's 1988 doctoral thesis, Professors' Graham and Linda Tuhiwai Smith's work on Kaupapa Māori theory and principles). With input from my multidisciplinary research team, I used existing theory to make sense of data analysis. Divergent findings during analysis write-up were highlighted and discussed with members of my multidisciplinary and supervision team.

Quantitative data was provided by WDHB following locality ethics approval and consent from participants (specifically from participants of the Te Ara Tōtika cohort).

Quantitative studies were presented at events and conferences (University of Waikato Kiingitanga Day event, 2023; Te Kupenga o MAI (Māori and Indigenous national postgraduate student network and programme in Aotearoa) Conference, 2023; WERO Conference, 2025 and more recently, Te Puku Kōrero, 2026 (University of Waikato Research Seminar). All of these were opportunities to share my research and invite enquiries relating to all facets of my research including methodological choices.

The values that shaped my upbringing including service, collective responsibility, stewardship and the protection of Māori voice, moved beyond personal values; to become methodological commitments that informed every stage of this research. As discussed in 3.2, Kaupapa Māori helped shape decisions about the design, data collection methods, and procedural choices shaped the findings.

My insider knowledge was both a strength and a potential source of bias. As a trainer of one of the training programmes, I had developed a relationship with the WDHB Learning and Development Unit and had insights into the training programmes. Even without participant consent, I was privy to participants evaluations of the Te Ara Tōtika programme. Those provided our training team with opportunities to review our training programme and delivery and even though I only used the data consented to, my insider knowledge placed me in a position of potential bias. To manage the risks, I remained reflexive throughout interpretation of data, discussing my data analysis with my supervisors and the trainer from the Public Health and Rautaki team as well as one of the trainers from Te Ara Tōtika.

Having established the philosophical and methodological foundations that underpinned this study, Kaupapa Māori philosophy, te Tiriti o Waitangi, CTA, and relational and cultural ethics, the chapter now turns to the specific methods used to operationalise these commitments in practice.

3.6 Data Collection methods

This study adopted a mixed-methods approach that enabled both breadth and depth: quantitative survey data provide a descriptive picture of how training was experienced, while semi-structured interviews and open-ended responses offered insight into the meaning's participants attributed to those experiences. The data analysis process involved multiple layers, as set out in the datasets (Appendix 3). This provides the information pertaining to the the three programmes and analytic methods use. Each method was selected and adapted to ensure consistency with Kaupapa Māori principles, and with the study's broader aim of examining whether te Tiriti training can contribute to transformative, system-level change. Data were drawn from multiple sources, including existing organisational surveys (Tikanga Best Practice study), a researcher-designed evaluation tool, and semi-structured interviews with both training participants (participants) and training providers/facilitators. Together, these methods enabled analysis of how Tiriti training was designed, experienced, evaluated, and constrained within contemporary health system contexts.

3.7 Online Training and Survey Evaluations

To support analytic clarity, the methods are presented by *data type* rather than in chronological order. This section outlines the rationale, design, and analytic approach for each data source, including survey data from three training contexts and semi-structured interviews with participants and training providers. Each method was selected to capture different dimensions of training effectiveness and limitation, and together they form a triangulated mixed-methods design aligned with Kaupapa Māori and CTA principles.

Three different data sets were drawn on for this research. **The first data set was survey data** provided by Learning and Development and related to the Tikanga Best Practice

e-learning module (TBP) with its Te Tiriti o Waitangi section, and Te Ara Tōtika (TAT) workshops. Anonymised completed surveys pertaining to Tiriti o Waitangi training were emailed to me along with excel spreadsheets of participants responses to the survey questions, both open and closed.

The **second data set** comprised a survey that I designed (Primary researcher-generated data) that was completed by participants following the Public Health and Rautaki (PHR) teams' Critical Tiriti Analysis (CTA) workshop. I also designed the **third data set** that comprised semi-structured interviews with trainers and participants who had completed at least one of the programmes analysed.

The following provides an overview of those programmes.

3.7.1 Three programmes surveyed

Tikanga Best Practice (TBP) e-Learning Module with its Tiriti o Waitangi section

The Tikanga Best Practice (TBP) e-learning module is a course within the Ko Awatea LEARN website at Te Whatu Ora, Waikato (and across Te Whatu Ora, nationally), as one of several 'Mandatory Training' modules (Waikato District Health Board/Te Whatu Ora, n.d). TBP is comprised of two learning modules: What is Tikanga and Te Tiriti o Waitangi. At the time of this study, the aim of the course was to help enhance participants workplace performance by aligning their daily work with the Tiriti/Treaty Relationship Framework (Waikato District Health Board/Te Whatu Ora, n.d), noting that: "*This relationship is underpinned by a set of Māori values and concepts which have stemmed from key principles founded in Māori tradition*" (Waikato District Health Board, n.d.). The Tiriti o Waitangi module was developed to help increase participants understanding of the influence and impact of a Māori worldview (pre and post Treaty of Waitangi) and to learn about the purpose, principles, and relevance of te Tiriti, presumably in contemporary times (Waikato

District Health Board/Te Whatu Ora, n.d). The modules are available to all WDHB/Te Whatu Ora site users (not available to the public unless, like me, they are given user and password access). Users are then able to complete these modules at their leisure. While staff are expected to complete this online module, the responsibility for monitoring whether staff do, apparently rests with each Manager (see Chapters 4 and 6 for further discussion). Once completed, the staff member receives a certificate of completion which is recorded in their e-Learning record in the portal. The portal therefore records all staff who have completed the module and those who have not. This module continues to be available on the Ministry of Health's Ko Awatea LEARN portal.

Te Ara Tōtika (TAT)

Te Ara Tōtika was a kanohi-ki-te-kanohi cultural awareness programme. The programme catered for a cohort of up to 40 participants; its focus was on upskilling staff in terms of cultural competency; pronunciation, identify and describe key Māori values and beliefs, gain an awareness of the importance of Māori health to te Tiriti o Waitangi/the Treaty of Waitangi, identify key markers in the health history of Tainui, practise applying Tikanga Best Practice to case examples and gain an awareness of the role of Waikato DHB to Māori health gain. Te Ara Tōtika was to have been part of a participants scaffolded learning, a follow on from TBP (see Chapter 6 for further insights into this). The programme was contracted to the University of Waikato to deliver. More recently it was a one-day programme but in its earlier iterations, it was run over 2 separate days: Te Ara Tika Tuatahi and Te Ara Tika Tuarua (see Chapter 6 for more details about the restructuring of this programme). In the main, clinical and health service administrators from the WDHB/Te Whatu Ora participated in this programme. Unlike Tikanga Best Practice, the course was optional, although in its earlier iteration, Te Ara Tika Tuatahi was compulsory. At the end of

2023, Te Whatu Ora ended the contract with the University of Waikato as the organisation moved into restructuring its training programme.

Public Health and Rautaki (PHR) Training

In 2022, the Public Health Rautaki (PHR) team set themselves up to deliver a series of five two-hour workshops to public health service staff and separately to Strategy and Funding staff at Te Whatu Ora, Waikato, with a focus on te Tiriti o Waitangi and Crown responsibility for achieving equitable health outcomes to and for Māori. The PHR training programme was an initiative that was created following the Equity Report '*Rapua Te Ara Mātua*' (Waikato District Health Board, 2021). That report highlighted persistent gaps in equity and health outcomes between Māori and non-Māori. While the Report omits any reference to the Waitangi Tribunal Hauora Report, *Rapua te Ara Mātua* clearly builds upon its foundations. The establishment of the PHR training programme was one initiative to address the persistent gaps through a scaffolded kanohi-ki-te-kanohi education programme aimed at bringing awareness to staff in order that staff could contribute to a changing culture in healthcare. The PHR team was made up of staff from the Māori Policy and Strategy team (Rautaki) of the WDHB and the Public Health Research group. This team began delivering the scaffolded training to staff in the Public Health Service and to the Strategy and Funding group in February 2023. Prior to this, they were delivering various workshops to many other health service groups, for example, the Breast Cancer Foundation, among others. In the main, the programme catered to public health services staff and other groups on request. By the end of 2023, the PHR team had disbanded due to the Te Whatu Ora-Te Aka Whai Ora restructure and with changing management, the programme ceased to be supported.

3.7.2 Access, consent and locality approval processes

As noted in the ethical considerations section, following research approval, the Learning and Development Unit at WDHB sent me excel spreadsheets of the e-learning survey data for July 2021 and August 2022 to August 2023 for analysis – a total of 1007 completed responses. The survey data provided a summary of participants responses to questions asked in their evaluation of the TBP module. None of the data contain identifying information of any participants who completed the module.

Participants were invited to complete a course feedback form, after which a Certificate of Achievement was issued. As I needed knowledge of the module content so that I could analyse the data effectively, I was granted access to the Ko Awatea portal (see discussion at Chapter 4). This gave me a full knowledge of the portal's contents and knowledge of the modules as part of this research. At the time of writing, this course was being redesigned.

The Learning and Development Unit also sent me copies of evaluation sheets completed by participants who attended the Te Ara Tōtika (TAT) workshops and who had consented to the use of their evaluations for my research (see Chapter Four for further discussion). Although the evaluations were anonymous, the Learning and Development Unit required that I obtain consent from the participants as the reason for their initial completion differed to my purpose. Therefore, at each of the TAT sessions I facilitated, I began the workshop with a karakia and mihi before introducing myself and outlining the topic and purpose of my research. An information sheet (Appendix 4) was made available to each of the participants explaining the study's aim, the voluntary nature of participation, and their right to withdraw. I explained that I was requesting consent to use the information from their evaluation forms for my research. Although the forms were anonymous, I invited them to provide written consent for their completed surveys to be used in this research by inserting a

statement granting consent for my use of the information completed. Without putting their name to the document, anonymity was maintained. All completed evaluation forms were left for collection by the Learning and Development Unit, who then scanned and emailed the consented course feedback forms to me.

Consent to analyse the Public Health and Rautaki (PHR) teams CTA workshop followed another process. I first learned of the Public Health Rautaki (PHR) workshops midway through 2023. As one of the objectives of my research was to examine all workshops that provided training to staff in health services about te Tiriti o Waitangi and the Treaty of Waitangi, I was very keen to include the training provided by the PHR team in my research, particularly as the teams list of workshops included: Te Tiriti o Waitangi 101, Te Tiriti o Waitangi 102, Te Tiriti o Waitangi – Equity in health context, Critical Tiriti Analysis and Recognising Pākehā culture and privilege.

To aid access to information for my research Dr Rose Black (permission to name Dr Black provided), a Senior Policy Researcher with Te Whatu Ora and one of a group of facilitators of the PHR team, presented a 'Memorandum of Understanding' (MOU) for consideration. The MOU was agreed to and signed on the 17th of August 2023. The parties to the MOU included my Supervision team, myself and Te Whatu Ora's National Public Health Service Waikato representative (Appendix 5). This added another layer of approval allowing for the sharing of resources and access to data of the PHR workshops for the purposes of evaluation to contribute to my research. However, by the time I became aware of this suite of programmes, many of the workshops had already been held. Furthermore, efforts to obtain evaluation data were unsuccessful. It appears that either no evaluations of any of the workshops already held had been carried out or if carried out, were unavailable for analysis, apparently largely due to restructuring. Staff who had been involved in this area or who may have had knowledge of any surveys/evaluations had left the organisation.

After the MOU was signed, I learned about the CTA workshop through conversations with my supervision team. I contacted one of the facilitators of the workshop who extended an invitation to a CTA workshop the PHR was hosting. My role was to observe (not evaluate) the training. Following this observation, in the absence of any questionnaire or survey to evaluate the workshop and in collaboration with my supervisor and one of PHR's training provider's, a survey questionnaire was designed for an upcoming CTA workshop (Appendix 6). Prior to attending the workshop, I emailed a copy of the survey questionnaire, information of my research and ethics documentation to the training provider to make available at the workshop. At the CTA workshop, during the whakawhanaungatanga session, I introduced myself and explained the purpose of my research. I made available the information sheet of my research and ethics documentation to anyone who had not received this information, gave further explanation of the ethics requirements and invited participants to provide consent (Appendix 7) to take part in my research and complete the survey questionnaire. I pointed out that the questionnaire guaranteed anonymity; I was not seeking any information that would identify them or where they worked. There were several participants who had joined the workshop on-line and despite my making the questionnaire available to those participants via the Programme convenor, no consent forms or completed questionnaires were received from those online participants.

3.7.3 Differences between surveys

The differences between the surveys for each of the programmes centred largely around content, learning experience and analysis. This section addresses the first two differences, while Section 3.10 where I discuss data analysis, addresses the second. The surveys for Tikanga Best Practice and Te Ara Tōtika, created by or for WDHB/Te Whatu Ora formed the first phase of data collection and were designed to capture participant perceptions of their learning experience across three dimensions: content relevance, learning experience,

and perceived application to practice. The survey questions included a mix of Likert-scale items (e.g., 5-point “Strongly Disagree” to “Strongly Agree”) and open-ended questions to provide both quantitative summaries and qualitative insights into the Training delivery.

The PHR survey drew on established approaches to ensure the questions were comprehensible and meaningful to participants with diverse professional and cultural backgrounds. While the questions being asked were different to the two previous programmes discussed above, overall, the focus was similar (i.e., to capture participants perceptions of their learning experience across content learning and perceived application to practice). The questions were non-leading and aligned with the study’s broader Kaupapa Māori and Critical Tiriti Analysis (CTA) framework (see more detailed discussion of the framework in this Chapter and Appendix 6 for the survey). The survey questions for this workshop also included a mix of Likert-scale items and open-ended questions to provide for quantitative summaries and qualitative insights into training content and delivery style of teaching.

3.8 Semi-structured Interviews with Trainees

Semi-structured interviews were designed and carried out firstly with workshop participants and secondly with workshop trainers. The aim of interviews was to investigate ways in which the workshops informed any Tiriti related practice changes at personal and structural levels within health. The interview questions developed over time and that evolution became part of the research process.

At the beginning of my research journey, the interview questions for the participants who had completed te Tiriti o Waitangi training through the DHB/Te Whatu Ora (Waikato) were designed as broad guides for the ethics approval stage. Their purpose was to surface

participants understandings of the training programmes and their experiences within them. At that early stage the intention was not to create a fixed or prescriptive interview schedule but to allow space for participants to speak to what was meaningful in their contexts.

This aligns with a Kaupapa Māori approach, where flexibility and responsiveness are important. As the research progressed, with the discovery of the PHR's CTA workshop and with the guidance of my supervisors, the questions were refined to better align with the focus of the inquiry. This included sharpening the emphasis on how te Tiriti was understood and enacted within training. A further development was the integration of Critical Tiriti Analysis. CTA-aligned questions were introduced (Appendix 8) to more directly explore issues of presence, absence, and interpretation of Tiriti within the programmes.

Semi-structured interviews were selected for their flexibility and capacity to elicit detailed, reflective narratives. This approach aligns with Kaupapa Māori and qualitative methodologies that privilege participants' voices, relational engagement, and co-construction of knowledge. Interviews followed a conversational style and were guided by open-ended questions structured around the study's objectives, exploring participants' understanding of te Tiriti o Waitangi, the perceived relevance of training content, and how that learning translated into professional practice and organisational change.

Interviews were conducted either face-to-face or via online, depending on participant preference, and each interview lasted between 35 to 60 minutes. With participants' consent, all interviews were audio-recorded and subsequently transcribed verbatim. This process ensured accuracy and supported an iterative and reflexive analysis. During each kōrero, space was given for participants to determine the direction of discussion, reflecting the principles of manaakitanga and *whakawhanaungatanga* (establishing relationships) by recognising the relational nature of the research encounter.

3.9 Semi-Structured interviews with trainers

The interview process closely mirrored that used with workshop participants but was adapted to reflect the trainers' perspectives and responsibilities (Appendix 9 for interview questions for management and training providers). Interview questions for the PHR training provider were adapted to reflect the broader scope of the PHR training programme, i.e. a suite of scaffolded learning, including a workshop on Critical Tiriti Analysis (Appendix 10). Interview questions were designed to explore the intentions, challenges, and perceived impact of the training, as well as reflections on participants' engagement and learning processes. Questions also probed how the trainers interpreted and embedded te Tiriti principles within their curriculum design and facilitation practices (see Chapter 6 for further discussion).

Interviews with all trainers were conducted with 3 trainers kanohi-ki-te-kanohi and with one trainer online. Each interview lasted between 45 and 75 minutes. Conversations were recorded with consent and later transcribed for analysis. A key difference from the trainee interviews was the emphasis on exploring how trainers balanced organisational expectations, cultural integrity, and pedagogical effectiveness. This provided valuable insight into the relational and systemic dimensions of te Tiriti training within health services.

3.10 Sampling and Recruitment

Sampling and recruitment applied to two groups: participants and trainers. Participants for the interviews were drawn from staff who had completed te Tiriti o Waitangi training through DHB/Te Whatu Ora (Waikato). The purpose of this stage, particularly as it related to the trainers, was to understand the pedagogical intentions underpinning the training, how the trainers approached the teaching of te Tiriti, and their reflections on participant

engagement and learning outcomes. As I already knew the TAT facilitators and Training Provider personally through prior professional relationships, invitations to participate (Appendix 11) were made directly, ensuring that ethical protocols were strictly followed. When the questions were put together to meet ethics approval, the interview questions in Appendix 9 were a combination of questions for management and training providers. Efforts to interview management were unsuccessful. For this reason, the interview questions used for the TAT providers were separated out from the original list to be used specifically for TAT training providers (Appendix 12).

An invitation was also extended to the PHR trainers who I also knew through prior professional relationships or had come to know through attending the CTA workshop. Key relationships had been established between me and Waikato Public Health Services through the MOU. Formal invitations were sent via email to trainers and facilitators; however, only trainer from the PHR sector responded and accepted the invitation to be interviewed. I later became aware that the others had either left the organisation or had relocated to other areas within Te Whatu Ora/Te Aka Whai Ora.

To use a purposive sampling technique, I enlisted the help of Dr Black and the Learning and Development Unit to recruit participants for my research. Firstly, I asked Dr Black if I could attend any or all the PHR workshops. Included in the information provided to Dr Black was my letter of introduction, the information sheet about my research, and ethics documents (refer to section 3.5.1). I also included a list of research questions including a set of questions specifically for those who had completed the CTA workshop, the survey designed precisely for this purpose or any other CTA workshop (see Appendix 8). As a trainer of the PHR workshop series at that time, Dr Black was perfectly positioned to know the staff who had attended their workshops.

Next, I forwarded the same documentation to the Learning and Development Unit to enlist their help in extending invitations to individuals who had completed the online survey and/or expressed interest in participating in follow-up interviews including those who may have completed TAT and PHR training. The aim was to reach a large, diverse, or unknown population (Braun et al., 2021) across professional roles and departments, thereby reflecting the varied contexts in which staff encounter and apply te Tiriti.

In total, 19 participants responded to the invitation to take part in semi-structured interviews, representing clinical, public health, and administrative roles but of these, three later withdrew or became unavailable. Of the remaining 16, four of those were training providers/facilitators with three from the TAT programme and the one PHR trainer. During the interviews, one participant advised she had had no Tiriti training since medical school. She had been encouraged by a colleague to participate as the colleague believed that she could offer something to my research given her experience of working in the hospital setting. However, I advised her that as my research was about gauging participants experiences of te Tiriti training in health services, unfortunately she did not meet that brief. For this reason, I explained that I could not use any information she may have shared or would share with me and she was excused from further participation leaving eleven participants and four training providers/facilitators.

Each of those who agreed to participate in this study were sent or given the information sheet outlining the study's aims, the voluntary nature of participation, and confidentiality procedures. Written consent was obtained before each interview.

3.11 Data analysis

Interview data for participants were analysed using CTA (Kidd, Came, Doole & Rae, 2022). CTA was applied by Kidd et al. (2022) to examine whether responses from interviews on the extent of Primary Health Organisations were Tiriti compliant. They found poor to fair compliance with most elements of te Tiriti but good engagement with equity. Suggestions were made to strengthen practice. It was suggested by the authors that CTA was a useful methodology for reviewing Tiriti compliancy and could be used in other contexts. I decided to adapt the CTA approach taken by Kidd et al. (2022) to analyse interviews with participants in my own research. In this respect, CTA became an evaluative tool to examine the ways in which te Tiriti and/or its principles were reflected (or absent) in participants' experiences of training and subsequent workplace practice.

Critical Tiriti analysis (CTA) comprises a five-stage process (see Table 3.2) to assess the extent to which policies adhere to the Preamble and the Articles of te Tiriti o Waitangi (Came et al., 2020a; Rae et al., 2022, 2023; Hamley et al., 2024), I adapted and employed this framework to ascertain the degree of alignment of the training programmes with te Tiriti o Waitangi (the Māori text). CTA is appropriate for this analysis because it centres te Tiriti o Waitangi and Māori well-being at the heart of [policy] analysis (Came et al., 2020a).

Table 2

Five stages of Critical Tiriti Analysis

Critical Tiriti Analysis Stages 1-5	
Stage 1: Orientation	Assessment of the representation of Te Tiriti in the training programmes by examining the feedback from workshop participants.
Stage 2: Close reading	Scrutiny of the training programmes based on the five elements of Te Tiriti; preamble, kāwanatanga (governance); tino rangatiratanga (Māori self-determination); ōritetanga (equity) and wairuatanga (spirituality).
Stage 3: Determination	Exploration of how the training programmes respond to each Te Tiriti element based on five points (silent, poor, fair, good or excellent).
Stage 4: Strengthening practices (Discussion)	Consideration for practical suggestions to strengthen Te Whatu Ora's commitment to its ongoing Tiriti training programmes.
Stage 5: Māori final words (Conclusion)	Critical engagement of the training programmes outlining Māori aspirations.

Note. Adapted from information provided in Came et al., 2020a. (p. 440) where the various phases are discussed.

The primary objectives of the interviews were to:

1. Assess whether te Tiriti o Waitangi, the Māori text (te Tiriti or Tiriti) is central in the training.
2. Assess whether te Tiriti training promotes understanding or competency in Hauora Māori and supports Te Whatu Ora staff to carry out their Tiriti obligations.
3. Investigate the barriers and enablers to participants' learning and the application of knowledge gained.
4. Evaluate whether the training supports ongoing learning about te Tiriti and the Treaty of Waitangi (the English version), hereafter referred to as the Treaty.

5. Identify the actions needed for current and future Tiriti o Waitangi training to achieve Tiriti compliance.

When applied to training, CTA provides plenty of scope to address how te Tiriti o Waitangi training might facilitate transformation of public health practices and service delivery to Māori. This innovative analysis considers whether a Tiriti focused training programme can offer the greatest opportunity for strengthening Tiriti commitments and contributing to more equitable and improved health outcomes for Māori. The analysis includes examples of the questions asked and the responses provided by the workshop participants. To protect confidentiality, all participant names and any references to their specific roles within the public health sector or external organisations have been anonymised in accordance with ethical guidelines.

This analytical process involved reading and re-reading the transcripts to identify key patterns and tensions in participants' accounts, coding data in relation to both CTA dimensions and emergent themes. Through this approach, participants' narratives were interpreted in connection with wider systemic conditions, aligning with the study's goal of understanding how individual learning is shaped by institutional practice and policy. Each phase of the analysis was undertaken in consultation with my supervisors.

While CTA provided an analytical framework through which participant learning experiences and training programmes could be examined in relation to Tiriti obligations, the trainer interviews generated a different form of knowledge. Rather than evaluating programme content alone, trainers reflected on the relational, organisational and historical processes involved in designing, adapting and sustaining Tiriti education. These narratives

required an analytical approach capable of preserving complexity and context. Thematic analysis was selected because it better honoured trainers' narratives, it enabled patterns of meaning to emerge inductively while understanding how individuals make sense of experiences through identifying patterns, constructing meaningful themes, and ensuring a richer, more nuanced analysis (Braun & Clarke, 2006).

3.12 Thematic Analysis.

Thematic analysis is a useful and flexible method for identifying, analysing and reporting patterns or themes within data (Braun & Clarke, 2006). Not only does it offer an accessible and theoretically flexible approach to analysing data, as argued by Braun and Clarke (2006), it is a useful research tool for capturing rich and detailed data. While the participants' interviews explored lived experiences of learning and enactment, the trainers' interviews explored the design, evolution, relational work, and organisational realities of delivering Tiriti education. In sharing those lived experiences, the trainers were not simply talking about principles; they were talking about relationships, programme evolution, organisational constraints, aspirations, decision-making, values, leadership, emotion, experience, practice, adaptation, complexity, wairua and institutional history and tensions. Importantly too, they were describing the relational work required to sustain Tiriti training. These are stories of practice; stories that are not dependent on quantifiable measures and do not necessarily sit comfortably inside predefined analytical categories. CTA was never designed to privilege that kind of narrative richness.

In addition to outlining what thematic analysis is, Braun & Clarke (2006) provided a 6-phase guide to performing thematic analysis, among other things. This step-by-step process was "…applied flexibly to fit the research questions and data" (Patton, 1990, as cited in Braun & Clarke, 2006, p. 86). The phases of thematic analysis are set out in Table 3.

Table 3

Phases of thematic analysis

Phase	Description of the process
1. Familiarising myself with my data:	Transcribing data, reading and re-reading the data and noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic way across the entire data set and collating relevant data to each code.
3. Searching for themes:	Collating the codes into potential themes and gathering all data relevant to each potential theme.
4. Reviewing themes:	Generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme.
6. Producing the report:	Selection of extracted examples that relate back to the research questions and literature to produce a scholarly report of the analysis.

Note: Adapted from *Using thematic analysis* (p. 87), by Braun & Clarke, 2006, p. 87)

3.13 Quantitative analysis

Although quantitative surveys are typically associated with positivist research traditions, they can be meaningfully incorporated within a Kaupapa Māori methodology when analysis is guided by Māori values, aspirations, and critical intent (Henry & Crothers, 2019; G. Smith, 1997; L.T. Smith, 1999). The quantitative datasets used in this study (i.e., the e-learning feedback surveys and Te Ara Tōtika (TAT) course evaluations) were clearly not developed as Kaupapa Māori instruments, and respondents were anonymous and of mixed ethnicity. For this reason, the quantitative phase does not attempt to infer Māori-specific outcomes. Instead, the data are used to examine organisational practices, institutional responsiveness, and system-level factors that shape how te Tiriti o Waitangi training is experienced within Te Whatu Ora.

However, within this research design, quantitative data serve several Kaupapa Māori-aligned functions. They provide an overview of how training is received across a broad workforce, highlighting patterns that may reflect areas of promise or structural constraint.

They also reveal potential sites of transformation, anywhere from learning environments, processes, to organisational arrangements that are supporting or limiting Tiriti-informed practice. Importantly, the quantitative findings act as a platform for deeper qualitative exploration through interviews, allowing for a more critical and relational analysis consistent with Kaupapa Māori philosophy.

This approach aligns with Henry and Crothers' (2019) argument that quantitative methods can be reclaimed for Indigenous research when guided by tikanga-based ethics, collective benefit, and interpretive frameworks grounded in Māori ways of knowing. Interpreted through the principles of tino rangatiratanga, *taonga tuku iho*, whānau, āta, kaupapa, and te Tiriti o Waitangi, the surveys operate not as neutral measures of impact but as one component of a wider, transformative evaluation. In this way, quantitative evidence is used to illuminate institutional patterns, challenge structural norms, and support the development of Tiriti-compliant health education.

3.14 Qualitative analysis

Open-ended survey responses were analysed using inductive content analysis following the guidance of Vears and Gillam (2022). This approach is suited to exploratory qualitative research of my study as it enables themes to emerge directly from the data rather than being constrained by pre-existing theoretical frameworks. The process involved multiple readings of the data to achieve familiarity, open coding to identify key ideas, and the grouping of similar codes into broader thematic categories. These categories were then reviewed to ensure coherence and alignment with the overall research aims.

Inductive content analysis was chosen because it aligns with the study's Kaupapa Māori orientation, privileging participants' voices and allowing meaning to arise from their

lived experiences within the organisational context. As noted by Elo and Kyngäs (2008), the strength of inductive analysis lies in its capacity to produce authentic, participant-driven insights while maintaining systematic transparency in the research process.

Survey methods are more commonly associated with positivist approaches to research that are designed to produce measurable, generalisable data, privileging objectivity and in this research were used for the PHR's CTA workshop. The use of the survey was not to quantify or objectify participants experiences, but rather to create a space where reflection and awareness could emerge, which is an important step in what Graham Smith (1997) terms conscientisation or the process of developing critical consciousness that can lead to transformation. Within a Kaupapa Māori framework, methods are judged by their capacity to uphold relationships, affirm *mana,* and contribute to positive transformation for Māori. In this context therefore, the survey became a tool, serving not as a neutral instrument of measurement, but as a vehicle through which participants' voices could be heard, their experiences recognised, and potential sites of transformation identified.

The open-ended questions in surveys are a recognised tool for collecting rich, reflective, and participant-led data and fall within qualitative research frameworks. Open-ended questions are designed to elicit participants' own words, perspectives, and experiences around a central topic (Braun et al., 2021). They are self-administered, meaning that all participants receive the same set of questions in a standard order, yet they allow the respondents considerable freedom to express what they perceive as most significant. In this way, qualitative surveys balance structure with flexibility, providing both consistency of question framing and openness to the diversity of participant voices.

Open-ended data captures what is important to participants within the framework set by the researcher (Braun et al., 2021). These data are useful when exploring unexamined or

under-researched areas and, where hearing a broad range of perspectives matter. For example, when examining health professionals' reflections on te Tiriti o Waitangi training across different disciplines and roles. This "wide-angle lens" enables researchers to explore how people make sense of a topic across contexts, capturing varied sense-making practices, discourses, and professional identities (Braun et al., 2021).

Surveys have sometimes been viewed as limited in depth compared with interviews, however, recent methodological work challenges that *whakaaro* (viewpoint). Virgina Braun and colleagues (2021) demonstrate that qualitative surveys can produce data that are both rich and complex, often densely packed with focused and relevant information. Indeed, participants who prefer to remain anonymous may disclose more in a survey setting than in a kanohi-ki-te-kanohi interview. The perceived anonymity of online participation can encourage honesty and openness, allowing respondents to share reflections they might otherwise withhold in person.

The use of online qualitative surveys also offered several practical advantages in this study. Online delivery made it possible to engage a large and geographically dispersed group of health professionals while minimising costs, travel, and scheduling barriers. Participants were able to or had already completed the online surveys of Tiriti o Waitangi modules or were able to complete the survey at a time and place of their choosing, providing flexibility and control over their engagement. These features align with qualitative research's commitment to accessibility and participant-centred design. Braun et al. (2021) argued that while there are obvious disadvantages, for example a risk of excluding participants with limited literacy skills or least privileged or vulnerable groups with little or no access to digital resources, these factors need to be considered during the design of the survey. Another criticism is that the depth of data in surveys is lost through thin or perfunctory responses compared to interviews. However, Braun et al. (2021) dismiss this critique as in their studies

they found that qualitative survey data "…*provided valuable accounts of their experiences and perspectives, and some were long and richly detailed*" (p. 644). These insights highlight how question wording and structure is crucial for surveys. To address this issue, the CTA workshop survey was specifically designed to ensure clarity, inclusiveness, and accessibility. Questions were intentionally open, concise, and unambiguous to allow participants from diverse professional and cultural backgrounds to interpret them comfortably.

Overall, the use of an online qualitative survey in this study aligns with the methodological guidance of Braun et al. (2021), offering an unobtrusive, inclusive, and contextually appropriate means to capture the breadth of experiences and reflections on te Tiriti o Waitangi training within Te Whatu Ora. While the method does not aim for statistical generalisability (Braun et al., 2021), it enables a deep and wide-ranging understanding of how participants interpret and enact their Tiriti-related responsibilities in practice. For these reasons, qualitative surveys were an efficient evaluation tool for my study.

3.15 Integration of Quantitative and Qualitative strands

The mixed-methods approach (integrating quantitative and qualitative methods) was selected to capture patterns of learning and confidence across large groups, and the contextual, relational and interpretive dimensions of how Tiriti Training is understood and enacted in practice. The use of multiple methods in qualitative research to develop a comprehensive understanding of phenomena is called, triangulation (Carter et al., 2014; Patton, 1999; Denzin, 1970/1978). Caillaud & Flick (2021) define triangulation as "looking at one research object from different perspectives" (p. 2). Carter, et al (2014) credit Denzin (1978) and Patton (1999) with identifying four core types of triangulation – data source (the use of multiple data sources within a single study) used for checking for consistency; methodological (using multiple methods to gather data for example mixing qualitative (interviews) and quantitative (surveys) to collect and analyse data; investigator (utilising

multiple researchers to collect and analyse data) and theoretical (applying multiple theoretical framework or lenses to analyse and interpret the same dataset).

In this study, triangulation occurred through integrating quantitative and qualitative strands, for example, utilising semi-structured interviews and surveys to collect and analyse data. Arguably, **investigator triangulation** occurred through multi researchers collecting and analysing data. I refer specifically to the fact that the e-Learning Tikanga Best Practice surveys were collected and analysed for 2 separate periods in the first instance, by the Learning and Development Unit (Waikato District Health Board). I received this data in a charted excel spreadsheet with descriptive statistics including participants responses to open and closed questions. I then began my own process of investigation by checking that all data fell within the research period recorded and eliminating any that did not. While the charted information did not make any observations, the charting of the responses made it easier for me to code the data using data filtering and inductive content analysis (Elo & Kyngas, 2008). This same process was repeated with the Te Ara Tōtika evaluations except this time; the Learning and Development Unit sent me both a Summary of the data in an excel spreadsheet and copies of the participants consented surveys. Furthermore, the excel spreadsheet presented the data responses to closed questions in graph, plotted as bars comparing categories. I followed the same process as I did with the e-Learning data ensuring that numerical data matched the number of consented surveys received. Once I was able to confirm that all information matched, I proceeded with coding and data analysis using inductive content analysis.

Methodological triangulation occurred through conducting semi-structured interviews, gathering and analysing the data from those interviews integrating quantitative and qualitative strands. Triangulation is described as "…*a method used to increase the credibility and validity of research findings*" (Noble, H., & Heale, R., 2019, p. 67). Pihama

(2001) and Cram & Adcock (2022) argue that Tiriti commitments are frequently abstracted or symbolically referenced within institutional practice, requiring analytic tools that can critically examine how power, accountability and responsibility are enacted in practice. To address this analytic need, this study drew on Critical Tiriti Analysis (CTA) as a complementary framework to analyse participants' data from the semi-structured interviews and thematic analysis from the trainers semi-structured interviews.

3.16 Trustworthiness and Rigour

Noble & Heale (2019) assert that credibility is about trustworthiness and believability of a study. It is concerned with "…*the extent to which a study accurately reflects or evaluates the concept or ideas being investigated*" (p. 67). Furthermore, triangulation overcomes the any biases arising from the use of a single method or observation by combining theories, methods or observations in a research study (Noble & Heale, 2019). Other advantages of triangulation include its ability to offer a more balanced explanation to readers enabling validation of data, assisting explanation in the results of a study and importantly, giving more confidence in the research findings particularly if methods used lead to the same results (Noble & Heale, 2019).

In their paper discussing ways to avoid common problems in research to become "*knowing* researchers", Braun & Clarke (2023) encouraged researchers to link their personal positioning to their analytic process, provide more detailed discussions of how they engaged in reflexivity, and demonstrate through their research "…*how this shaped the analysis they produced…*" (p. 3). In other words, researchers were being encouraged to own their perspectives. Others highlighted elements such as credibility, reliability, trustworthiness (Ahmed, 2024) and rigour (Vears & Gillam, 2022). Those new to qualitative research are advised to be 'explicit' and 'transparent' in their research to "*ensure that they are analysing*

their data appropriately and increase the methodological rigor of their research" (Vears & Gillam, 2022, p. 125). This is especially important when there is little in the way of existing research in the topic area, or where an approach that does not depend solely on the existing literature is desired.

This research has endeavoured to address these concerns by employing triangulation integrating quantitative and qualitative strands. The endeavour has not been without its challenges. However, reflexive practices, embracing Kaupapa Māori with its specific measures such as tikanga, mana and relational accountability located within the context of a Māori worldview (Hiha, 2015) has guided the process of this research to ensure trustworthiness of data interpretations and rigour of research.

Summary

The methodological foundations of the research, and the rationale for the methods employed are explained in this chapter. Kaupapa Māori provided the grounding for the research helping to shape the decisions, design and data collection methods. This positioning also informed the use of Critical Tiriti Analysis as a methodological tool. CTA is typically used to analyse policy and formal documents, providing a structured way to assess the presence, absence and quality of Tiriti engagement. Outlined is the way this study extended the CTA method to include semi-structured interviews and training evaluations. A mixed-method approach which included quantitative survey data to provide a picture of how training was experienced, and semi-structured interviews to offer insight into the meaning's participants attributed to those, are described in this chapter.

Chapter 4: Results of three programmes

This chapter covers in detail the results of each of the three programmes I examined at Waikato DHB/Te Whatu Ora Waikato. Each programme is reported on in the following sections: 4.1 - Tikanga Best Practice e-Learning; 4.2 - Te Ara Tōtika; and 4.3 - Public Health Rautaki: Critical Tiriti Analysis Workshop.

4.1 Tikanga Best Practice e-Learning

The purpose of this study is to explore the effectiveness of te Tiriti o Waitangi Treaty of Waitangi online training in assisting staff at the Waikato District Health Board (WDHB) to understand and meet their Tiriti o Waitangi obligations to Māori. The data for this study came from the questionnaires participants completed online immediately following the completion of the module. Feedback was collected from two periods: July 2021 (2021) and August 2022-August 2023 (2022-2023) representing 1007 participants who had completed the modules, each responding to the same three Tikanga Best Practice questions about what worked well for them from the course, what improvements to the course they would like to see, and whether or not participants believed they were likely to apply the learning to their job within the next 3 months of completing the course. The responses were analysed using inductive content analysis (see 3.14) (Vears & Gillam, 2022).

While the surveys provided valuable insights into participants' experiences and perceptions of te Tiriti o Waitangi training, it also revealed areas that warranted deeper exploration. Specifically, participants' comments often pointed to contextual or systemic factors that could not be fully explored within the limits of a survey format. These findings informed the design of the second phase of data collection—semi-structured interviews—

which sought to build on the survey data by exploring these themes in greater depth (see Chapters 5 and 6).

Participants were also asked if they would recommend the course to ***other Waikato DHB employees*** (2021) or ***to others***[4] (2022-2023). In 2022-2023, a fifth question seeking views around the training was added to the 2022-2023 cohort but was not asked of the 2021 cohort. Although the two cohorts participated at different times, their feedback to questions one to four reflected similar themes, enabling a combined analysis. Even though the fifth question was not put to the 2021 cohort, an analysis is provided as to whether this and other differences between cohorts provide additional or comparable insight.

What worked well?

Across both periods (2021 and 2022-2023), participants consistently identified **four core strengths** of the Tikanga Best Practice, *Tiriti o Waitangi* module (see 3.7.1): the quality of the online presentation in terms of navigation, ease of use and flexibility; the design, format, content and structure; the clarity and cultural relevance of content; and, the variety of teaching mechanisms to cater for different learning needs and to engage and reinforce learning.

Navigation, ease of use and flexibility

Participants found the module easy to navigate, visually clear, and well structured. The majority credited the layout as being beneficial to learning. As one participant said, "*The layout [of training] was beneficial – information was evenly distributed and easy to follow so as not to be overwhelming"* (anonymous, 2022-2023) and another said, "*The way the information was given kept me interested*" (anonymous, 2022-2023).

[4] Note the change in wording from the July 2021 question

Participants also appreciated that as an online module, this allowed for learning in one's own time and space where being able to choose when and where they completed the module allowed for flexibility in completing to:

"...go at own pace to allow for better learning."

"The option to do it when I had time to and was able to leave it and come back to it".

"Being able to do it in mini modules with progress saved as we only get small chunks of time to do it in between patients."

However, some participants found navigating the module slow; as one participant said, "*I understand it is a difficult topic to summarise - some information was very long to read [and] the videos were very difficult to comprehend coming from a Māori perspective*" (anonymous, 2022-2023). Like many others, this participant expressed a desire for some kanohi-ki-te-kanohi (in person) opportunities or blended delivery to deepen learning.

Design, format, content and structure

Both cohorts revealed a high level of satisfaction with the course design, format, and its relevance to participants' job. The structure, layout or format was widely commented on with many crediting that feature of the course as being the reason why participants felt the course worked well for them with one participant saying:

The structure was simple to follow. I liked knowing the timeline of how improvements to healthcare have been made and how inequity has been recognised with plans implemented to improve the health care services. (anonymous, 2022-2023).

This comment reflects a moment of major structural change in Aotearoa's health sector. As discussed in Chapter One, the Labour-led government introduced the Pae Ora (Healthy) Futures Act 2022, which abolished District Health Boards and put equity and

system reform at the forefront of the new health system. For some staff, understanding this reform narrative – including timelines, drivers of change, and the explicit focus on Māori health equity – helped situate the Tikanga Best Practice programme with its '*Tiriti o Waitangi'* section, within a wider national effort to correct long-standing inequities. Further, participants appreciated learning about the impacts of colonisation on Māori with several identifying colonisation and legislation that breached the Treaty as causes of inequity in healthcare. Many credited the module for providing understanding or in some cases, increased knowledge of te Tiriti and the Treaty, tikanga and Māori culture. As one participant said: *"This course was full of valued information from which I learnt and understand a lot more about NZ history and its peoples' cultural protocols"* (anonymous, 2022-2023). Another lamented:

> *It helped me understand better the Māori world view and the clear disparities between Māori and non-Māori which I am ashamed to admit, I didn't fully understand why. I am 47% Māori myself but know nothing about my culture. That's pretty shameful. (anonymous, 2023)*

This comment highlights an issue that surfaced at times across the data, not just this data but across all data (see further discussion under Study Two - Te Ara Tōtika and Study Three and Four - the interviews). While participants often valued the cultural content, many expressed feelings of disconnection from their own Māori identity. This response reflects a wider social pattern – colonisation, schooling, education, employment, and in this case health-sector norms have produced generations of Māori health workers who may be ethnically Māori yet culturally distanced (Hamley & Stanley, 2025). Training in this context, becomes more than professional development, it becomes a site of cultural recovery, identity work, and (for some) emotionally discomforting.

Such reflections illustrate how the learning prompted participants to confront gaps in knowledge or identity. For others, the emphasis moved from awareness to practical application. As one participant noted, the module was:

"...reinforcing important concepts and helping me understand how to make healthcare more effective and for me to be culturally understanding and also to focus on models which may work" (anonymous, 2022-2023).

Increased confidence in learning and cultural understanding

Many participants saw benefits in the module in terms of providing a better understanding of Māori culture, Māori history and the Treaty of Waitangi. Most participants in both cohorts felt confident in identifying the differences between te Tiriti and the Treaty, explaining the implications of these differences, and recognising the health impacts of legislation on Māori health. Participants also valued the way tikanga concepts were explained, simply and clearly, making them easy to understand and apply. Gaining a better understanding of Māori culture, Tikanga Māori, New Zealand history, the Treaty of Waitangi and the impacts of colonisation helped participants gain valuable insights into Māori practices, values, and cultural norms. Some participants felt better equipped to apply this knowledge in their professional practice.

Findings also suggest that the module was effective in enhancing participants' knowledge of te Tiriti and the Treaty and awareness of its health impacts on Māori. However, the close-ended questions limit the extent to which real-life learning can be captured. For instance, participants were asked to rate their acquired knowledge in terms of being able to identify the necessary protocols required for a pōwhiri during a marae visit. Most participants from both cohorts reported that they believed they had acquired the knowledge to identify the necessary protocols required for a pōwhiri. In reviewing the content of the course there was no marae visit or any learning on the pōwhiri process. A review of the training supports this

with one participant commenting that the modules *"Had nothing to do with pōwhiri" while another stated that "Actual protocol for individuals with a pōwhiri not covered"* (anonymous, 2022-2023). Another commented:

> *Unless I missed it, the review question: "On completion of this course, I can identify the necessary protocols required for a pōwhiri during a marae visit" does not actually correspond to the material presented, which must be pretty challenging to overseas nurses in particular... (anonymous, 2022-2023)*

Another participant commented that they would have liked to have seen *"more information on the pōwhiri process*" (anonymous, 2021), while another speculated about some missing components. One participant pondered about having *"A face-to-face course on a marae with an actual pōwhiri, including karakia, waiata and kai. The content would then be more memorable" (anonymous, 2021).* Perhaps the fact that there were a higher percentage of participants who agreed or strongly agreed with the statement in 2022-2023 - may in part be due to how participants perceived the question, rather than what was being asked. As one participant said:

> *With the feedback section perhaps re-word some of the questions as I am Maaori*[5] *and understood the poowhiri process prior to this course so it is not due to this course that I know the process of poowhiri but I did end up deciding to select "Strongly agree" after deliberating between neutral, agree and disagree as I can identify the process. (anonymous, post-q, 2022-2023).*

The responses reflect the limitations of the evaluation questions which, as I understand it, were designed by an external team[6] and appear not to be specifically tailored to

[5] The use of double vowel is a reo variant of the Waikato people.

[6] Waikato District Health Board. (2023). Personal communication with a staff member from the Learning and Development Unit. I later discovered the course was designed through Catalyst (see Chapter 6).

the course that was run. This matter is discussed in Chapter 3. It is also noted that none of the evaluation questions addressed prior knowledge. This is important as training courses should be designed to build on knowledge. Both issues are deliberated in the Discussion chapter.

Despite the limitations identified here, many participants reported greater confidence in applying tikanga in their roles. This pattern remains consistent across both datasets, although the 2022–23 cohort more strongly emphasised the need for localised content (e.g., Waikato histories, local kawa, references to Kingitanga), suggesting growing expectations for place-based mātauranga.

Multimedia and Interactivity

Participants appreciated the variety of teaching mediums – video's, audio clips, and written content. Visual components such as graphics, animations, and pictures were particularly enjoyable and helpful, especially for those who found reading long scripts of information challenging (see discussion under Theme 1). The use of video or multimedia to convey the information was the second-most commented feature of the course that participants felt worked well for them. Video summaries and presentations were appreciated for making content more accessible or helping to cater for special learning needs as attested to by the following comments about what worked well for them in this course (anonymous responses, 2022-2023):

"…I am a kinesthetic learner, I can listen to slides, not very good at reading long novels."

"…the short [video] clips as it helps with the understanding more especially as English is my second language."

The responses make it clear that multimedia and interactivity significantly contributed with aiding the learning overall, but equally, there were many suggestions for improved

quality of these teaching mediums with calls for classroom discussions to enhance engagement and learning.

What could be improved?

While many participants felt that no improvements were necessary and expressed satisfaction with the course content and structure, several suggestions were made for potential improvements and to enhance the overall learning experience for participants.

Content-Related Improvements and Localised Māori Content

There were numerous calls for more basic examples, practical experiences, and culturally relevant content. In the main, suggestions included adding more detailed information about Māori culture and more practical examples and real-life scenarios related to health and health practices to better align with culturally competent care:

"More practical use of how to respect [the] culture of Māori patients, i.e. taonga, food spaces, toilets, privacy, etc" (anonymous, 2021).

How to approach a Māori family and how to deal with them effectively" (anonymous, 2021).

Participants also wanted to see more content covering te Tiriti and the Treaty, Māori culture and values, more Hauora Māori learning and the inclusion of the impact of current and relevant legislation on Māori health and cultural safety. These requests highlight competency gaps where participants lack the necessary skills, knowledge, or behaviours required to respond to Māori patients and whānau more effectively and with greater confidence. For many, this course was their first introduction to te ao Māori, te Tiriti and the Treaty. Some participants commented that there were many new staff from overseas now employed in all areas of the health sector who may have little to no knowledge of Māori culture. While participants believed that the course was a good introduction to te ao Māori, tikanga, te Tiriti and the Treaty, it was also suggested that staff should be encouraged to go

back to the course to prompt their learning. The module was available to all staff on the Ko Awatea platform and staff could revisit the information at any time, something that one participant in the 2022-2023 cohort suggested. Another called for the provision of live instructions during online learning while several wanted:

"...kanohi ki te kanohi course tailored for those already knowledgeable about te Tiriti, beyond the basic principles" (anonymous, 2022-2023).

"...follow-up training and support especially for those who see from an 'ao māori lens" (anonymous, 2022-2023); or

"...for complex topics like Tikanga and te Tiriti o Waitangi" (anonymous, 2022-2023).

Several participants favoured classroom type sessions with one participant saying:

I think a class session on te Tiriti would also benefit ALL employees/employers at some stage as there WILL be staff with questions particularly around some of the Māori kupu (words) featured in the module. It is important to be clear and specific around the Māori interpretation of "Kāwanatanga" and "Tino Rangatiratanga" and how these terms are viewed from a truly Māori perspective. (anonymous, 2022-2023)

These comments, among others, provide insight into the way the feedback form was designed. There are no questions that take account of prior knowledge. Participants' accounts suggest that in the main, confidence and cultural understandings increased or were gained, however new knowledge is more effectively acquired when it is connected to what learners already know and can do (National Research Council[i], 2000; Ausubel, 1968), without which content is just discrete or standalone. Perhaps the suggestion made by one participant for a "pre-course test and a post-course test to assess for changes in knowledge after engaging with the course matter" (anonymous, 2022-2023) deserves some consideration.

While some participants from the 2021 cohort felt that ***all*** (my emphasis) WDHB staff should complete the eLearning course to introduce them to the Treaty and tikanga best practices, the choice between online and in-person formats was a recurring theme, with a significant number favouring in-person interaction. One participant argued:

> *That the Tikanga & te Tiriti o Waitangi modules be delivered kanohi ki te kanohi not online. Or at least for follow up support to be available for someone like me who has ended up with so many unanswered questions & more confusion. (anonymous, 2022-2023)*

Confusion and perceived bias and accuracy in content, were some of the criticisms of the course. Others commented on the need for cultural sensitivity especially regarding Māori perspectives, historical facts and translation issues. For example, one participant said:

> *For Maaori, not all iwi signed the treaty/tiriti and those that did believe that the only valid document is the maori [sic] text not the english one because of the mistranslation of the English text. So, saying that both are correct is a gross overstatement and needs further reflection on wording that question/statement so as to be culturally aware and responsive. (anonymous, 2022-2023).*

Te Whatu Ora Waikato sits in the heart of the Kiingitanga movement however, the failure to include content pertaining to the Kiingitanga and the Waikato story attracted comments from some participants wanting more localised content, especially around the Kiingitanga. Another participant found the course "offensive", saying:

> *This course is offensive. It has clearly not been proofread. There are words missing from the actual wording (English version, [G]od knows what the Māori version is like) of the articles of te Tiriti, numerous grammatical mistakes, numerous errors of historical fact, and the 'correct' answers to the tests are in several instances*

historically incorrect. The impression given is that Te Whatu Ora is paying lip service to te Tiriti and has no real care for any kind of equity. It's shameful (anonymous, 2022-2023).

Technical and Usability Improvements

Many of the issues identified in this area have previously been highlighted such as addressing issues with content being too text-heavy, improving grammar and adding more practical examples and real-life scenario's related to healthcare. Some participants wanted more quizzes with relevant questions to reinforce learning while others recommended better quiz questions to align more closely with the course material. As one participant said:

...some of the correct options to answer the quiz questions were not explicitly covered in the content of the course which made it hard to answer some of the questions. I think this ambiguity needs to be addressed either by providing clearer information in the course content or by rewording the 'answer' options provided in the quiz so that people doing the course are able to recognise the correct answer without needing to 'guess'. (anonymous, 2022-2023)

Technical and logistical issues included slow search engines and difficulties navigating the course with some participants calling for more accessible and easy-to-navigate content. There were also logistical concerns about the amount of time allocated for training or for more time to fully understand and complete the modules. From some of the responses, it appeared that some staff were trying to complete modules while carrying out normal work as attested to by the following comments:

"...allocated time away from normal duties to complete modules and less in-depth information, i.e. far too much to read through and watch while trying to complete normal admin duties in ED" (anonymous, 2022-2023).

"Having available times to be able to sit and concentrate as being a reliever it is difficult to find the time and also very difficult when in a room full of people talking" (anonymous, 2022-2023).

Transfer of learning to the job

Across both cohorts, the majority of participants indicated that they would apply what they had learned within the 3 months of completing the course to their jobs although 6% of the participants from the 2021 cohort, compared to half that number in the 2022-2023 cohort indicated they were unlikely to do so. This is likely because the period of the 2021 cohort included two major events – the Covid 19 pandemic and the cyber-ware attack at the Waikato DHB in May 2021).

Recommending the course

In 2021, staff who completed the survey were asked if they would recommend the course to other Waikato DHB employee's, what aspects of the course worked well for them and what improvements they would make. After 2021, the survey was updated to include new questions. Participants were asked about their views on the course delivery, the usefulness of the training and the likelihood of recommending the course ***to a friend or colleague*** (my emphasis to distinguish the change from the 2021 question which referred to 'other Waikato DHB employees'). I do not know the reason for the change, who was responsible for making the change and what purpose the change was meant to serve. Participants view on what worked well for them and what improvements they would make is covered in the previous subsections.

The data indicates a generally positive attitude in participant satisfaction with the course, as evidenced by the overall high willingness to recommend it to others, whether they were Waikato DHB employees or friends or colleagues. It is noted that in the 2022-2023 cohort, 1.8% of participants did not respond to the recommendation question. Although a

small percentage, it may reflect a need to ensure all participants are engaged and prompted to complete all survey questions.

Rating Training Delivery

As previously stated, participants completing the course after 2021 were asked to rate their experiences of the delivery and training of the Tikanga Best Practice training. Up until this question, the rating options for all questions in the survey followed a Likert scale – 1 *Strongly Disagree* to 5 *Strongly Agree* with Neutral in the middle. Changes were made in subsequent years where participants ranked their perception of the workshop delivery on their learning engagement with (1) Low and (5) High. I conducted descriptive analyses including frequency counts and average ratings to identify broad patterns in participants feedback, consistent with the exploratory focus of this research.

It is assumed that the intention was for participants to give a rating of 1 if they considered the delivery was not effective (in other words, if they strongly disagreed) or 5 if they believed the delivery engaged them in the learning (that is, they strongly agreed with the statement). A rating between 1 and 5 would sit within the parameters of the rating options given for all questions in the survey. However, this change appears to have confused participants. Instead of indicating their level of agreement by using the numbers, participants rated each statement under the words, “high” or “low” or did not respond at all to the statements.

Table 4:

Experiences of the delivery and training of Tikanga Best Practice, te Tiriti o Waitangi module.

5 August 2022 – Aug 2023 Responses n=827	1 = Low n (%)	2	3	4	5	No response
The delivery engaged me in learning	0.9				39.1	60
The training is useful in my work	0.85				49.3	49.85
I got what I needed from this training	0.6				44.2	55.2

Note: This table represents the collated responses from participants who completed the questions in the survey for Tikanga Best Practice, te Tiriti o Waitangi module (5 August 2022-August 2023) collated by the Waikato District Health Board's Learning and Development Unit.

The data shows a notable trend of high non-response rates across all three questions, with 60% for engagement, 49.85% for usefulness, and 55.2% for meeting needs. This indicates that some participants chose not to provide feedback about the training. This may be due to the changes in the rating scale without instructions as to how to respond. Among those who did respond, a number found the training highly engaging and useful, and felt that it met or exceeded their needs. The low percentages of negative responses suggest that those who engaged with the training generally found it beneficial. However, the high non-response rates point to a need for improvements in engagement strategies, relevance and possibly survey design to ensure more comprehensive feedback that better address participants' needs.

Comparative insights

A comparative synthesis of results across both cohorts (2021 vs 2022 - 2023) shows consistency across the cohorts. The only meaningful shift was increased calls for Waikato-specific content in the 2022-2023 feedback and some key differences in staff 'experiences of

the training module which likely reflects growing organisational conversations about local partnership obligations under te Tiriti and the maturing expectations among staff having navigated several health reforms since 2021. Otherwise, the patterns remained stable across time. These findings are summarised in Table 5 below.

Table 5:

Staff experiences of the Tikanga Best Practice, te Tiriti o Waitangi module

Themes	2021 Feedback	2022–2023 Feedback	Summary of Change Over Time
Content clarity & cultural relevance	Content described as clear, simple, and culturally meaningful. Participants valued learning more about NZ history, tikanga and cultural protocols.	Similar comments. More explicit emphasis on deeper cultural elements such as, Māori cultural needs in healthcare; contextual explanations of impact of colonisation and legislation post Treaty.	Consistent strength across both cohorts. Demand for greater depth emerged more strongly in 2022–23.
Online presentation & design	Participants found the module easy to navigate, visually clear, and well structured.	Continued appreciation for layout and clarity. Recommendations for better alignment of quiz content to course material.	Overall positive, with growing expectations for more engaging, and accurate online content.
Flexibility & accessibility	Strong appreciation for being able to complete training online at own pace and to cater for special needs.	Same benefits noted. Expressed desire for a blended or in-person add-on option, especially to support learning.	Preference shifting toward hybrid delivery (online + face-to-face).
Technical and usability issues	Access difficulties, login issues, and videos not loading were common complaints. Some participants found content too text heavy.	Fewer but still recurring technical and usability issues, e.g., audio/video or portal access.	Some but ongoing issues remain. Stronger dissatisfaction in 2022-2023, reflecting increased expectations.

Local relevance (iwi, rohe, Waikato context)	Some early comments requesting more local tikanga information.	Significantly more feedback calling for content on Kiingitanga, Waikato-Tainui history, local values, kawa, and place-based examples.	A notable shift toward expecting regionally grounded mātauranga.
Practical application / real-life examples	Requests for more applied examples, scenarios, or clinical context.	Participants want specific scripts, case studies, and examples tailored to their work and improving health equity by reflecting the Treaty of Waitangi.	Increased expectation for practice-based learning rather than conceptual overview.
Behavioural change intentions	Not measured.	Participants report plans to use increase reflective practice and build cultural confidence by continuing their learning.	New evidence of behavioural impact — only measurable from 2022–23 additions.

Note: This table synthesises the results across cohorts (2021 vs 2022–2023) for the Tikanga Best Practice, te Tiriti o Waitangi modules (Waikato District Health Board, n.d.).

Summary of Tikanga Best Practice Findings

Across both periods, participants consistently valued the clarity, accessibility, variety of teaching and cultural relevance of the Tikanga Best Practice module, especially for those with specific learning needs or new to learning about the Treaty and te ao Māori. Feedback over time, however, shows a clear shift toward greater expectations with the 2022-2023 cohort calling for deeper learning, regionally grounded content, more applied examples, and supplementary kanohi-ki-te-kanohi opportunities. Technical issues persisted but also reduced. Limitations of the evaluation questions were identified when participants were asked to rate their acquired knowledge about a process that was not in the module. Furthermore, participants were not asked about any prior learning. The 2021 cohort were not asked to rate their experiences about the training while the 2022–23 feedback revealed some behavioural intentions, indicating growing confidence and commitment to applying tikanga in practice.

Together, the datasets reflect both the strengths of the current module and the emerging need for a more context-specific, practice-oriented, and blended learning approach.

4.2 Te Ara Tōtika

In this part, I explore the effectiveness of the 'Te Ara Tōtika' (TAT) workshop in much the same way I reviewed the Tikanga Best Practice eLearning module. The TAT workshop was a one-day workshop held quarterly each year. The data for this study was collected over a twenty-two-month period in the form of an evaluation from staff who had completed the workshops from 19th May 2021 to 15th March 2023 - and who had agreed to my use of their evaluation of the training (see discussion at 3.7.2). In total, 103 participant evaluations were analysed (see Appendix 3 for datasets). TAT was a kanohi-ki-te-kanohi training programme, and I was a co-facilitator of the workshops. I also received evaluation summaries from TAT workshops held on 17 May 2023 and 20 September 2023. To check for any possible bias, I reviewed the findings of these workshops, which were consistent with information from the authorised cohorts. There were no notable variations.

I reviewed the close-ended responses and open-ended responses from the authorised evaluations to gain a general impression of participants ratings and whakaaro on; achievement of the learning outcomes of the workshop; usefulness and application of the learning; workshop process or resources, and; any other comments that would or could make the workshop more useful. The results are presented as an integrated narrative across the cohorts considering: the objectives and expectations of the workshop, what participants found particularly useful, any intended actions participants committed to taking and, participants ratings and commentary on processes and resources. Before turning to consider any changes in thinking over time, I discuss the impact of the May 2021 cyberattack on the workshop held on the 19 May 2021. Like the TBP module, a combined summary of the TAT feedback across all cohorts is presented at Table 5 which identifies consistent findings and any notable variations.

Learning objectives, and expectations of the workshop

Participants were asked to evaluate the workshops for knowledge competencies such as being able to identify and describe key Māori values and beliefs and being able to identify key markers in the health history of Tainui. The evaluations also included the participants awareness of the importance of Māori health to te Tiriti o Waitangi/the Treaty and the role of Waikato DHB to Māori health gain. A total of 150 staff attended the workshops with 103 (68.7%) authorising the use of the completed surveys.

Across all cohorts, participants consistently reported that the workshop objectives and expectations met or exceeded their expectations. There was little variation over time in these ratings, suggesting that the core structure and content of Te Ara Tōtika remained effective and relevant. There was a stable and enduring alignment between the intention of the programme and participant experience, despite changes in delivery context, time constraints or organisational circumstances. Where minor fluctuations were observed, these did not indicate declining satisfaction; instead, they appear to be more reflective of contextual factors influencing delivery rather than content quality. For example, the cyberattack in May 2021 severely limited access to electronics. Following 2021, there was a notable decline in attendance numbers at workshops. Participants were engaging with the training amid significant changes at Waikato DHB (and nationwide) with broader organisational pressures associated with the health sector reforms, restructuring, workforce strain, uncertainty, and workload demands. Importantly, feedback suggests that these conditions influenced the mode and context of delivery rather than participants' assessment of the relevance, clarity, or value of the training itself. In fact, there were many calls to make these workshops compulsory with one participant even suggesting that information about the course "…*should be put up around the wards*…" (anonymous, March 2003). Others suggested that this programme be held more frequently – "…*weekly or monthly, compulsory not voluntary*" (anonymous,

March 2023) suggesting that "*increased knowledge will make change happen*" (anonymous, March 2023).

Benefits of the workshop

Responses across cohorts from a single-item question, reveal remarkably consistent patterns that were summarised in four categories below. Participants commonly highlighted **an increased understanding of tikanga and Māori worldviews**. As one participant said: "*I have a deeper understanding of the Māori world view through an explanation of the stories behind Māori myths*" (anonymous, July 2021).

Included in the content were case study exercises. These had been shared with the training providers to use in learning and were of real situations other staff had experienced with Māori patients and /or their whānau. The practical relevance to everyday practice was widely commented on with participants appreciating the case studies and activities for their relevance to healthcare and helping increase their understanding. One participant credited the case studies with teaching them how to honour and adhere to tikanga best practice in their approach to Hauora Māori. Participants appreciated the opportunity to discuss these relevant scenario's, share their own examples and find solutions to deal with the issues by applying acquired learning from the workshop. As one participant said, "*I found the exercise very useful to give a practical perspective of what we learnt*" (anonymous, 2023).

The reinforcement of values-based approaches to care

Participants viewed this part of the workshop as very useful, especially in assisting staff to engage in a more respectful way with their Māori patients' and whānau and each other.

A greater awareness of inequities and their structural drivers

Across the cohorts, participants appeared to appreciate the role of structural determinants in generating stratification such as class and race and associated hierarchies of

power, prestige, and access to resources that have resulted in inequities in health (Spolum, Young & Schulz, 2025) and in this case, for Māori. As one participant said:

> *Today I was able to learn the importance in advocating for Māori patients. I have learnt basic ways via Māori values to recognise and acknowledge Māori despite a health system that largely does not cater to our Indigenous people. (anonymous, July 2021).*

Over time, there is a subtle shift from comments focused primarily on learning new information toward reflections on application, confidence, and responsibility. This suggests progress in how participants engaged with the material – moving from awareness-building toward praxis.

Intended application of Tikanga Best Practice

Across cohorts' participants consistently identified actions they intended to apply following the workshop. These included changes in communication, greater intentionality in relationships, and more reflective practice. For example, one participant said that in future they would employ cultural safety to "…*protect Māori…working in partnership with and encouraging participation in care*" (anonymous, March 2023). Another said they would be more aware of their own body language when dealing with whānau and would make sure they were available and open to answering questions while another said they would: "B*e more inclusive, communicate effectively, treat Māori with dignity and respect and have respect for Māori culture*" (anonymous, May 2021).

Processes and resources

Participants across cohorts rated facilitation, the workbook, and skills practice highly. These elements were repeatedly identified as mutually reinforcing, rather than discrete components**.** Notwithstanding these positive results and complimentary comments, some participants especially in the earlier cohorts, expressed a wish to include slides in the workbooks or align content being taught with information contained in the course material.

Noting that there was so much content to be covered in one day, participants suggested that the course be taught over two days or split into two sections with the first section covering basic learning of values, tikanga, New Zealand history, He Wakaputanga o te Rangatiratanga o Niu Tireni, 1835 (the Declaration of Independence of New Zealand) and the Treaty/te Tiriti (pre-signing) with a second section covering more in-depth advanced learning. As one participant said:

I felt like there wasn't enough time to focus on indepth knowledge due to covering basics that I already felt confident with (anonymous, July 2021).

This participant was not to know that prior to the online eLearning TBP modules, this is exactly how the programme ran, however the Waikato District Health Board decided to introduce the online eLearning TBP, presumably to reach a greater number of people at less costs. This is discussed by one of the TAT trainers in the interviews (see Chapter 6: Results Section – Training Providers).

Impact of the May 2021 cyberattack

The May 2021 cohort represents a clear contextual outlier. Feedback from this group explicitly references the absence of online or electronic resources due to the cyberattack on the Waikato DHB's systems. Despite this constraint, participants continued to rate the workshop positively, often commenting on the strength of facilitation and discussion-based learning. One participant suggested that it was very important to have completed the TBP online learning prior to attending the course acknowledging that the workshop was "*very compromised by no technology to help the two facilitators who did extremely well to manage using felt-tips and paper*" (anonymous, May 2021). This suggests that the programme's effectiveness was not dependent on digital resources, but on relational, pedagogical, and kaupapa-based delivery.

Later cohorts, where electronic resources were restored, did not demonstrate markedly different satisfaction levels. This further reinforced the conclusion that the programme's core strength may lie with its purpose, facilitation, and experiential learning, rather than in its mode of delivery.

Changes in thinking over time

While the overall ratings remained stable, collective responses indicated a gradual deepening of reflection across cohorts. Earlier feedback tended to emphasise content clarity and usefulness, whereas later feedback more frequently referenced:

- confidence in applying learning,
- responsibility to act,
- awareness of one's own positionality,
- the need for ongoing learning rather than one-off training.

This pattern suggested not a change in programme effectiveness, but a shift in how participants situated themselves in relation to the learning.

Table 6:

Reflections of the Te Ara Tōtika workshops

Domain	Consistent findings across cohorts	Notable variations
Objectives met	High ratings across all cohorts	None of significance
Perceived usefulness	Strong emphasis on relevance and applicability	Slight shift toward praxis over time
Intended actions	Clear intention to apply tikanga-informed practice	Increasing system-awareness in later cohorts
Facilitation	Consistently highly rated	Cyberattack cohort rated facilitation more strongly
Resources	Workbook and skills practice valued	More use of workbook but less critical of content or facilitation skills.

Note: The table synthesises participants reflections of Te Ara Tōtika feedback across the cohorts used in this study (2021; 2022–2023).

Summary

Across the five cohorts analysed, participant feedback demonstrates a high level of consistency in how Te Ara Tōtika was experienced and evaluated over time. Overall, participants across all cohorts reported that the workshop objectives and expectations were largely met, with most ratings in the upper end of the scale. This suggests a stable and enduring alignment between programme intent and participant experience, despite changes in delivery context and organisational circumstances**.** Participants reported increased understanding of tikanga and greater awareness of inequities articulating intentions to be more reflective in practice. Facilitation and skills were highly rated suggesting the effectiveness of the programme lay in relational, pedagogical and kaupapa-based delivery.

4.3 Public Health Rautaki: Critical Tiriti Analysis Workshop

Following on from the previous two studies, I examined and analysed survey data from the Public Health Rautaki (PHR) team's Critical Tiriti Analysis (CTA) workshop held on 5th October 2023. I was invited to attend and evaluate this workshop and in collaboration with my supervisor and one of the workshop's facilitators, we designed a post-training questionnaire and invited participants to complete the questionnaire applying the usual consenting documentation as per the ethics consent process described in Chapter 3. The questionnaire was a mix of closed and open-ended questions (Appendix 10).

The questionnaire was developed to determine not only what the participants thought about the training, but the participants beliefs about the training (Blanchard & Thacker, 2013) and their confidence in applying the learning into their regular practice. Rather than applying CTA as an evaluative rubric, this study captures the data built around CTA to ascertain how CTA is taken up by participants, what kinds of Tiriti reasoning participants develop and what capacities CTA training builds for future application.

Demographics and Prior Tiriti o Waitangi training

Ethnicity information was sought, and whether participants had attended any previous Tiriti training. The ethnicity question was not intended to promote any stereotype but to obtain a better understanding of what background factors could be influencing a respondent's choices. Participants were able to self-identify as they wished. The responses are presented in Table 7.

Table 7.

Quantitative Demographics and Prior Tiriti Training

NZ European Pākehā Tauiwi	Māori European	Chinese	NZer	Prior training	No prior training	No response
7	2	1	1	9	1	1

Note. Data taken from the completed survey questionnaire workshop participants completed 2023, October 5 (see discussion at 4.3).

Likert-scale confidence and understanding

Participants were asked to rate their confidence and understanding to critically design, review and analyse a Tiriti-aligned health policy for addressing health disparities experienced by Māori. A precondition for CTA is assessing the extent to which a policy is consistent with te Tiriti (Came et al., 2023). The responses from the Likert-scale aligns with CTA's capacity-building function. In other words, it provides a basic assessment of participants readiness to engage with power, authority, and obligations. It also assesses participants ability to recognise Crown obligations in policy. These are preconditions for CTA practice. Table 7 presents participants' responses to the CTA workshops.

Table 8.

Close-ended responses to CTA workshop

5 October 2023 Responses n=11	**Strongly agree**, n (%)	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**	**No response**
Understands that writing a Tiriti aligned policy is crucial for addressing health disparities experienced by Māori	91	9				
When designing health policies/interventions will be	91	9				

more conscious of obligations and responsibilities to Māori (including biases, and assumptions) as Tangata Whenua or Tangata Tiriti				
Has more confidence to critically review health policy based on te Tiriti articles	18	82		
Has more confidence to design Tiriti aligned policy, intervention and/or projects	9	73	18	
Feels confident in working collaboratively with colleagues to evaluate a policy using CTA	18	36.4	45.6	
Wishes to further develop skills in CTA	64	18	9	9

Note: Data obtained from the survey questionnaire participants completed for the CTA workshop 2023, October 5.

Post-Workshop Responses

Understanding the importance of Tiriti-aligned policies

Participants reported particularly strong agreement that writing Tiriti-aligned policy is crucial for addressing health disparities experienced by Māori. This indicates that the workshop effectively communicated the importance of this aspect in healthcare.

Consciousness of obligations and responsibilities to Māori

The data shows that the workshop increased participants consciousness of obligations to Māori as *Tangata Whenua* or *Tangata Tiriti* when designing policy or interventions. All the participants strongly agreed/agreed that they would be more conscious of their obligations and responsibilities to Māori when designing health policies or interventions. This reflects a high level of awareness and a commitment to embedding these principles into their work.

Confidence in reviewing and designing policies

Participants felt more confident critically reviewing health policy based on te Tiriti articles. Although 100% agreed/strongly agreed that they felt more confident in critically reviewing health policies based on te Tiriti articles, this number represented only 18% who strongly agreed to the statement, suggesting that while the majority (82%) felt confident, there may still be some who require further support to fully engage with this process.

Similar findings can be seen in participants confidence in designing Tiriti-aligned policy interventions/projects with only 9% strongly agreeing with the statement, 73% agreeing, and 18% remaining neutral. This indicates that while participants gained some confidence, there is still room for growth in this area.

Confidence in collaboratively evaluating policies using CTA

The responses here were more varied, with 18% strongly agreeing, 36.4% agreeing, and 45.6% remaining neutral. The neutral responses suggest a need for more collaborative exercises or confidence-building activities. Tied to a feeling of confidence, some also expressed their desire to further develop their CTA skills, indicating that participants viewed CTA not as a one-off tool but as a practice requiring ongoing learning.

Intended Actions – From Awareness to Application

This section presents participants responses to "new actions" participants would take to apply CTA in their work and aligns most closely with CTA's orientation to action and accountability. Examples such as: *"Using CTA when reading policies"*; Challenging language framing and assumptions for example the use of "*we*" and "*them*" (anonymous, October 2023) and "*Applying CTA to documents already processed*" (anonymous, October 2023) reflect Phase 1-2 sensibilities (language, framing, assumptions). Further comments reflected intentions to apply CTA to project work. For some participants, that involved moving beyond tokenistic inclusion of Māori in the workplace toward engagement with all

three articles of te Tiriti. These responses are evidence of CTA as a practice, not just a framework.

Learning about te Tiriti o Waitangi in the health system reform

Participants were asked to share their learning experience about te Tiriti o Waitangi in the context of health system changes that was particularly useful and/or interesting. Participants found the workshop to be informative, particularly in understanding "…*the discrepancies between te Tiriti and the Treaty*" (anonymous, October 2023) and their implications on the health system. The responses indicated a growing awareness of the lack of recognition and acknowledgement of te Tiriti in healthcare policies and a heightened awareness that Māori involvement in policy development remains inconsistent. Participants were also intrigued by the Māori governance aspects of Te Whatu Ora's health system changes connecting these directly to contemporary health reforms and expressing a desire to learn more. This section aligns with CTA's historical and constitutional grounding, particularly in terms of understanding Pae Ora Act changes, recognising neglect of te Tiriti in system design and awareness of Māori governance gaps. These are not CTA indicators per se – but they are foundational knowledge CTA requires.

Reflections on the Workshop

In this section, participants reflected on their workshop learning experiences. Participants appreciated the interactive nature of the workshop, particularly the group discussions and practical applications of CTA. The relaxed yet informative environment, along with the use of resources and real-time adjustments to the session based on participants' interests, was well-received. The facilitators were praised for their knowledgeable discussions and the balance of information delivery. However, some participants suggested improvements, such as providing more time to review documents used in the training or incorporating longer sessions for a more in-depth exploration of the topics. Overall, the

feedback was positive, with participants valuing the opportunity to engage in meaningful discussions and apply what they learned.

Suggestions for improvement focused primarily on time and depth with one participant expressing a desire for "…*a whole day(s) wānanga*" (anonymous, October 2025) while another would have liked more time to engage with policy documents during the workshop itself. Notably, several participants stated there were no improvements needed with one adding that it was, "*Great to have 'in person' discussions*" (anonymous, October 2025).

While this section sits outside the CTA rubric entirely, I consider that to be appropriate in that I am evaluating pedagogy, facilitation, relational dynamics and *wānanga*-style learning. From a Kaupapa Māori perspective, this is essential, because CTA is not value-neutral; it must be taught in ways that uphold manaakitanga, wairuatanga and collective learning.

Summary of Critical Tiriti Analysis Workshop

The data and feedback reflected a positive reception to the CTA workshop, with participants gaining good insights into the importance of Tiriti-aligned policies and developing a strong commitment to applying CTA principles in their work. While confidence in some areas, such as designing Tiriti-aligned interventions, could have been further strengthened, the overall sentiment is one of progress and desire for continued learning. The responses also underscored the effectiveness of the workshop's interactive and practical approach, which facilitated deeper understanding and engagement with the material. Moving forward, the focus should be on providing more opportunities for participants to refine their CTA skills and collaborate on policy evaluation to further enhance their confidence and capability.

Rather than applying CTA as an evaluative rubric, this study uses CTA as an organising epistemology, examining how Tiriti-centred analytical capacities are developed through training and how participants envisage applying these capacities within health system contexts.

Chapter 5: CTA applied to Interviews with Te Whatu Ora Participants

Critical Tiriti Analysis (CTA) was used in an exploratory way as a guiding framework to report on how I worked with interviews conducted with 11 Te Whatu Ora staff who completed various te Tiriti o Waitangi and Treaty of Waitangi training/workshops with either Te Whatu Ora Waikato, or Waikato District Health Board – WDHB. The exploratory use of CTA is discussed more fully in Chapter 7. Pseudonym's have been applied to each participant to protect their anonymity. In Table 9, I outline the details of participants whom I interviewed, their roles, training completed for programmes examined for this study, and ethnicity.

Table 9.

Workshop Attendance and Participant Demographics

Names	Roles	Training completed	Ethnicity
Brenda	Management, PH	TBP & PHR	Māori
Phoenix	Management, PH	TBP & PHR	Pākehā
Stafford	Clinician, Rural	TAT	Pākehā
Tyler	Admin, Hospital	TAT	Māori
Sophie	Clinician Hospital	TBP & TAT	Pākehā
Katelyn	Clinician, PH	TBP & PHR	Asian
Sacha	Clinician, PH	TAT & PHR	Pākehā
Nora	Clinician Hospital	TBP	Asian
Lisa	Clinician, PH	TBP	Māori
Chelsea	Clinician, PH	TBP & PHR	Pākehā
Marcus	Professional, PH	PHR	Pākehā

Note: This table represents the demographics of the participants who were interviewed for this study between 2023 and 2024.

NB: PH = Public Health; TBP = Tikanga Best Practice; TAT = Te Ara Tōtika and PHR = Public Health and Rautaki

I begin the chapter with a brief reminder of the training programmes/workshops including expectations around attendance, followed by narratives from participants related to the interviews. I then examine their responses within the frame of the Critical Tiriti Analysis (see earlier description at chapter 3.11) following the Five Stages (sometimes referred to as phases in the literature): **Orientation**; **Close Reading**; **Determination; Strengthening practices**; and **Māori final words** (Came et al. 2020a).

5.1 The training programmes/workshops

Three training programmes were examined for this study (see 3.7.1 and Appendix 13 for course aims and descriptors); Tikanga Best Practice (TBP), an eLearning digital programme with a particular focus on its Tiriti o Waitangi module; Te Ara Tōtika (TAT), a kanohi ki te kanohi training, delivered by the University of Waikato Treaty education team (see discussion at Chapter 6) (Waikato District Health Board, n.d.); and a Critical Tiriti Analysis (CTA) workshop delivered by a team consisting of staff from the divisions, Public Health Research and Rautaki (PHR) of the Waikato District Health Board/Te Whatu Ora (WDHB/TWO). The PHR training was only available to those working in Public Health or some other professional health group such as Occupational Therapists or Dietitians. At the time of writing, the online module remained the only available Treaty-related training across Te Whatu Ora Waikato, following organisational restructures. This is notwithstanding any training that may be occurring within the different professional health bodies. Both the PHR and TAT programmes ceased at the end of 2023.

5.2 Perspectives of that training

The training workshops overall were viewed positively. The workshops were acknowledged for content around cultural awareness with participants consistently describing the training as meaningful, affirming and transformative. Participants

acknowledged increased awareness, confidence, and in many cases a stronger sense of responsibility in relation to te Tiriti.

From this point, I turn to the CTA frame to contextualise whether the findings reflect an honourable Tiriti relationship. I use the CTA indicators to analyse the responses from this study. The overall findings are arranged within the Articles listed below (Table 10) with a description of the participants responses.

Table 10:

Critical Tiriti Analysis Indicators

Preamble	Elements showing that te Tiriti is central, and Māori are equal or lead parties in the training
Article 1 - Kāwanatanga	Mechanisms to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing and evaluating training programmes
Article 2 – Tino rangatiratanga	Evidence of Māori values, approaches and authority influencing design, content and delivery of programmes
Article 3 - Ōritetanga	Evidence of Māori exercising their equitable citizenship
Article 4 - Wairuatanga	Acknowledgement of the importance of wairuatanga and wellbeing

Note. Adapted from, A critical review of the Cabinet Circular on Te Tiriti o Waitangi and the Treaty of Waitangi advice to ministers (p. 1099), by D. O'Sullivan, H. Came, T. McCreanor and J. Kidd, 2021, Ethnicities, Sage Publishers. Copyright 2021 by Sage Publishers.

5.3 Training outcomes within a CTA analysis

Stage one: Orientation

The collective data produced mixed results of Tiriti-upholding practice. All the participants recognised they had Treaty responsibilities as health workers, but some were unable to articulate what those were. References were made to the Treaty (the English version), Treaty principles, or concurrently to te Tiriti and the Treaty as though these

documents were the same. Some participants were aware of the differences between the two versions but were unable to answer questions confidently, if at all, about how te Tiriti informed practice or policy development. Participants broadly understood that Māori health should be prioritised, however, many could not explicitly link inequities to te Tiriti. Many expressed a desire to attend a CTA workshop to learn more about the tool.

Stage two: Close Examination

Preamble and kāwanatanga

Many participants were able to meaningfully connect *kāwanatanga* responsibilities to their professional roles. They understood from the training, how colonisation had a devastating impact on Māori health. While most participants were able to link inequities to te Tiriti, only a few could specifically make the link to the intent outlined in the Preamble. Nevertheless, they all agreed that addressing health inequities and practices must be a priority. Some of the participants working in public health were actively engaged in working with Māori community groups, such as working collaboratively on projects or involved in co-designing of programmes and policies. Others were in decision-making positions, such as approving contracts. Within both public health and health services, some senior practitioners and health clinicians were responsible for training staff in their own profession. Regardless of what area of public health or health services staff were working in, they all shared a common *whakaaro;* the skills, knowledge and tools acquired from the training received, were helpful in their roles and in guiding decision-making.

Training programmes associated to one's profession were also credited with providing supplementary and valuable information to help embed the learning. For example, Lisa credited the New Zealand College of Public Health Medicine (NZCPHM) with helping her to more clearly understand her Tiriti obligations through their ongoing compulsory dedicated Tiriti o Waitangi sessions that focused on cultural competency, cultural safety and Māori health inequities, which are core components of the NZCPHM

training programme where participants must demonstrate how they are actively reflecting te Tiriti in their work. Lisa (2023) noted that each year, these topics must be "*ticked off*" to demonstrate active engagement. She described the process as involving *"a very strong reflection on te Tiriti"* (Lisa, 2023), including the requirement to show, in every report, how one is embedding te Tiriti principles in their practice and reflecting on their application.

Lisa credited the NZCPHM training with significantly supporting her in her role. While not directly involved in designing health policy or interventions, she frequently contributed through advisory roles. In situations where she represented her organisation or engaged in decision-making, Lisa said she always strived to ensure that te Tiriti was actively reflected in the processes and ways of working (Lisa, 2023), highlighting that much of public health work involves engaging with Māori or other communities facing disadvantage. For this reason, she stressed the importance of understanding one's obligations under te Tiriti:

"*So, you absolutely need to understand that [obligations and responsibilities to Māori] to be able to drive every intervention that you do. If you're not, then you're not really doing public health*" (Lisa, 2023).

Lisa acknowledged the value of understanding history but felt that training sometimes lacked the ability to convey the deeper significance and emotional resonance of what te Tiriti represents arguing:

"... the traditional workshops just tend to talk through the historical context of where we've been and how we've got to where we are, but they probably sometimes aren't able to convey the essence, the feel… its very prescriptive...You can learn all the historical context and the foundations, but I think people really struggle with the application of that. What does that mean to my work? (Lisa, 2023).

Brenda was very clear about how te Tiriti should be embedded in the workplace. I interviewed Brenda twice: once in 2023 and again in 2024 (the second interview was due to a recording mishap). On both occasions, Brenda shared her sense of being unsupported across emotional, structural, and cultural domains. Brenda developed a departmental training programme to help staff understand their roles and responsibilities under Pae Ora; specifically, how to implement the new legislation and apply te Tiriti principles in their everyday work. Before designing the content, she conducted interviews with both Māori and non-Māori staff to assess their understanding of te Tiriti o Waitangi. She found that most had very little awareness of how to deliver services in line with the legislation. This confirmed her concern: while the Pae Ora Act clearly outlined TWO's obligations in relation to te Tiriti, many staff lacked clarity around how te Tiriti applied to their work. She also noted that the leadership team neither required staff to embed te Tiriti into their roles nor supported them to do so. In her view, most staff and managers did not even see te Tiriti as part of Te Whatu Ora's core business.

To inform the training, Brenda developed a Kaupapa Māori-centred training programme, working alongside and in collaboration with Māori colleagues and a local Hauora Māori provider to incorporate community-based cultural experiences. Brenda had long recognised the value of community-based learning by including the local marae in her training programme wanting to provide staff with an authentic marae-based experience, including pōhiri protocols and exposure to Māori history and *mahi toi*. Brenda believed that a Kaupapa Māori experience would have provided staff with a far deeper understanding of Māori values, history, and aspirations than any classroom or online course could offer. Although another colleague in public health had created Tiriti-focused training before Brenda's programme, Brenda felt her approach was more action-oriented:

"It was one thing to provide a workshop or forum to learn about and discuss te Tiriti, but it is another thing to then look at how we embed that into our practice" (Brenda, 2024).

Invitations were sent out to all staff to attend the training sessions with the proviso that anyone who was unable to attend, needed to discuss that with their line manager. This ensured that the responsibility for staff attendance at training resided with the line manager. Even though there were some staff who were not happy about having to attend the training when they were under pressure in their own work, the sessions were well-attended. Brenda noted that once attendance became optional, participation declined until eventually the programme was "*pushed aside*" (Brenda, 2023). Brenda attributed the discontinuation of her programme to fiscal reprioritisation and lack of leadership support.

In a genuine kāwanatanga relationship, both Māori and Crown agencies share responsibility for ensuring that training leads to measurable improvements in health equity and culturally safe care (Brenda, 2024). Shared accountability requires a commitment not only to collaboration but to transparency, evaluation, and responsiveness, with both Māori and Crown agencies contributing to the design, delivery, and monitoring of outcomes. Brenda's efforts aligned with these commitments and given that many staff (predominantly non-Māori) appeared to have no clear concept of how te Tiriti applied to their duties, and no apparent expectation from leadership that staff should, led Brenda to question Te Whatu Ora's own commitment to health equity.

"The whole commitment to developing equity measures, that should have been something that the executive leadership should have been pushing for. It was quite frustrating…there was no commitment from the leadership team" (Brenda, 2024)

Phoenix acknowledged Brenda's efforts and confirmed the issue with not having the support of the leadership. She noted the team's diversity had significantly declined

since Māori staff were recruited to Te Aka Whaiora. This had a flow-on effect; Māori staff who remained were now expected to be available to answer everyone's questions:

> *"You know they don't want to have to answer everybody's questions all the time" (Phoenix, 2023).*

Marcus also commented about the loss of staff to Te Aka Whaiora and the flow-on effect from this. He had enjoyed working with Māori and calling on them for their expertise or just to provide another perspective because he was aware that his approach was *"very European"* (Marcus, 2023). He shared that he had not had any exposure to anything whatsoever to do with the Treaty, tikanga and inequities, prior to taking up employment in public health. However, reflecting on the recent changes, he said the training had helped shape his learning with tikanga practices being integrated into the team's operations. He described the environment as a space where you didn't just talk about relationships, "*you lived them"*. He felt that the relationships and ways of working in that space were central to his work and development. However, after the departure of Māori staff to Te Aka Whaiora, the culture had shifted. The loss of those relationships meant that collaboration had to be formalised rather than lived.

Several participants recognised the importance and benefits of long-term, enduring relationships, including relationships between the Crown and Māori, between clinicians and communities, and between Māori and non-Māori staff. These relationships were seen as critical for giving life to te Tiriti and enabling culturally safe and equitable practice (Brenda, 2024). Participants offered varying views on whether the organisation was fulfilling this expectation.

During my interview with Brenda, she acknowledged that when Māori staff (leadership in particular) took up positions at Te Aka Whaiora, it did leave a gap in their

work area. She was aware that Māori staff who remained in public health were expected to answer everyone's questions. Brenda responded by saying that unless that was part of Māori staff's responsibility, part of their job description, Māori staff should not be expected to have to carry this responsibility without due recognition, including fiscal recognition, for the extra duties. Unless that happened, the responsibility remained an organisational one.

Māori staff who are asked to lead or support training in these environments often do so without adequate backing, leaving them exposed and unsupported when challenges arise or when advice is undermined. The relational foundation that Brenda was trying to build with staff and the communities (public and private, inside and outside of Te Whatu Ora) was eroded by structural decisions beyond her control. Brenda's experience highlights the emotional burden on Māori staff but also the consequences of treating training as a finite, one-directional exercise rather than part of a shared, ongoing process of growth, reflection, and mutual responsibility.

Collectively, participants reported an increased understanding and awareness of Māori health inequities and Treaty obligations, though concerns remained regarding accountability, organisational commitment, and the sustainability of Tiriti-focused initiatives.

***Tino rangatira*tanga**

Tino rangatiratanga speaks to Māori leadership, authority, and self-determination. Training must meaningfully address tino rangatiratanga as a critical aspect of te Tiriti partnerships. In this section, I examine how training programmes reflect Māori leadership and co-design, the extent of Māori-controlled content, and the roles of non-Māori in supporting tino rangatiratanga in training and practice. Although governance and accountability are generally associated with kāwanatanga responsibilities, these themes are discussed here to consider how they intersect with tino rangatiratanga.

The Te Ara Tōtika (TAT) workshop was co-designed by people with deep mātauranga Māori and tikanga knowledge (see Chapter 6). It was a collaborative effort including senior staff in Te Puna Oranga, the Māori leadership group that sat within the Waikato District Health Board (see Chapter 6 for further elaboration). At the time of interviews, only Māori staff were facilitating TAT workshops although at times, non-Māori were also involved (see Chapter 6). The training content incorporated *whakataukī - whakatauākī* to illustrate concepts, and included a section devoted to the Tainui - Waikato narrative (see Chapter 4: Results Study 1(B) – Te Ara Tōtika Programme). Participants, Sophie, Stafford, and Tyler acknowledged the relevance of this regional story. The TAT programme also centred Māori values including; mana, rangatiratanga, *mauri, wairua*, *taonga,* manaakitanga, and whakawhanaungatanga, through case-based learning (see Chapter 4: Results Study 1(B) – Te Ara Tōtika Programme). Participants engaged in group discussions to explore real-life health scenarios and apply Māori values in their responses:

"I thought some of those case examples are really good because that's very realistic…and particularly for those of us who are in patient care. It's very, very realistic and good to apply" (Stafford, 2023)

Participants consistently expressed appreciation for the training programmes content, particularly its focus on pronunciation, te Tiriti, *te ao Māori* values and tikanga, and how these could be applied in practice within the health system. Participants, like Tyler, shared how they had been able to transfer knowledge to make tangible improvements within their own work areas and encouraged other staff to attend the training to gain the full benefits of learning.

The Public Health Rautaki (PHR) training was co-designed by both Māori and non-Māori staff, including members of the Māori Directorate (see Chapter 6). Brenda, who created her own training programme, audited the PHR content as part of the designing process. It was her intention to call on the PHR team to deliver on some of the training within her own programme. When her own programme was sidelined, she continued to support the PHR workshops, including helping to organise sessions and promote engagement. As with TAT, PHR workshops regularly included contributions from Māori experts and *kaitiaki,* who brought lived experience and mātauranga into the training space. Phoenix shared an example of the value of these contributions, recalling a guest speaker whose story had a strong impact on her. However, she also noted gaps in the training, expressing a desire to explore local history in more depth. A strong advocate for co-design and co-governance, Sacha described the amazing relationships she had formed through working with Māori experts in her field. When Te Aka Whaiora was established, many of the original facilitators transitioned to new roles within the Ministry of Health.

The TAT programme foregrounded Māori knowledge systems including tikanga, Māori values, mātauranga Māori, and Māori health models. Sessions began with *karakia*, *mihimihi,* and whakawhanaungatanga. Participants were encouraged to introduce themselves in te reo Māori, supported by workbook examples and pronunciation exercises. Stafford, Tyler, and Sophie noted the value of this foundation:

"I think probably the main thing is just realising the importance of making those connections for Māori people…that's obviously one thing I got out of the workshop – my big learnings from the day" (Stafford, 2023)

Stafford shared how this learning shifted his understanding of professional boundaries:

"You're the professional and you're not here to disclose personal information, but it is [important] for the Māori person" (Stafford, 2023)

Helping staff to make the connections between the content they were learning and application to their professional roles, was a strong feature of the training programmes. Te Ara Tōtika introduced learners to foundational tools like the waiata "A Haka Mana" to help with pronunciation. They used culturally resonant health campaigns like "Smear Your Mea" and "Legend" to connect Māori values to health priorities. The Public Health Rautaki programmes also integrated *karakia, mihimihi,* and *whakawhanaungatanga*, and drew on local Waikato-Tainui knowledge and speakers to talk about local experiences and how tīpuna dealt with health issues drawing on mātauranga Māori, and tikanga to reflect models of health.

Although aware of some more contemporary Māori models of health, Stafford appreciated learning about others discussed in the TAT workshops, such as the Pūtangitangi model, a framework developed by Davies, Elkington, and Winslade (1993). This framework uses the paradise duck (putangitangi) as a metaphor to understand Māori intra-cultural differences (Davies et al., 1993). Learning about this model, gave Stafford cause to reflect on the experiences of his wife's ancestry and being a product of cultural assimilation. He shared hope that their children would benefit from the increased presence of te reo in schools as a step towards reclaiming that part of their identity.

Sophie, new to Aotearoa, was inspired to begin a te reo journey following the TAT training. Although her employment priorities prevented enrolment in Te Whare Wānanga o Awanuiarangi courses, she pursued online learning and completed cultural safety training through the Royal College of Australian Physicians. Her global experiences had shaped her

understanding of colonisation and her commitment to learning the language and culture of the people she serves:

"Coming from the outside, one had to learn the language…it's hard because we're not completely immersed…so all the things like rangatiratanga…they're around me all the time, but trying to learn what they mean and remember is difficult…" (Sophie, 2023)

Given that much of the health service workforce is non-Māori, their role in supporting tino rangatiratanga is crucial. Although both PHR and TAT provided cultural awareness, their one-day format meant ongoing learning was necessary. Phoenix and Sacha were among those who pursued further te reo learning in the hope that learning the language and culture would help them to better serve the community they worked with. Phoenix had completed a Level 3 Awanuiarangi course that blended te reo, mātauranga Māori, and Tiriti content. Sacha's reo journey began on her return to Aotearoa after ten years of absence. Upon her return to health services, Sacha became curious and interested in learning te reo. She had been to Wales and seen how learning the language helped her to understand the people she worked with. As she explained:

"Going into this space I was really curious and interested and keen and desperately keen to be a help and to be the right fit in terms of work" (Sacha, 2024).

Sacha's te reo journey evolved through a series of tertiary courses. Although COVID-19 disrupted her noho marae experience, she found learning the language transformational. But learning the language also brought with it an internal ethical battle. While wanting to stand in a place of comfort in learning the reo and be an ally for Māori, she was concerned about whether she was taking someone else's opportunity to learn the language, especially Māori who did not know their own language, saying:

You do have this kind of push and pull as to how much and who am I as a person. What do I actually believe in, cause certainly a lot of concepts from te ao Māori really resonated with me. Is that mine to actually take on? (Sacha, 2024)

Eventually Sacha concluded that there was nothing wrong with her trying to learn te reo saying:

"I'm just trying to embrace this world in a way that's really going to help and support and make people feel encouraged and flourish and accepted" (Sacha, 2024)

Sacha is also an advocate for the normalisation of te reo. Critiquing the Coalition Government's decision to prioritise English names, she struggled to understand the logic behind such a move, arguing that by prioritising English names was not going to advance understanding of te reo, let alone change anything.

Through her journey of learning, Sacha had embraced values-based advocacy. She challenged deficit thinking saying that nowadays she was much more inclined to take a strength-based approach that empowers people to become their own agents of change, evident in the workshops she held with this very goal in mind. She credited the PHR training as well as like-minded allies with helping her:

"It gave me a pathway…how to be a Treaty partner…and to know where and how to use my Pākehā privilege" (Sacha, 2024)

Other non-Māori participants like Katelyn and Stafford also supported tino rangatiratanga in practice. Katelyn drew connections between Māori and other Indigenous experiences, advocating for allyship that transcends cultural boundaries:

"What we do for Māori is actually quite applicable for almost all ethnic populations…" (Katelyn, 2023).

Katelyn shared that she had been doing a lot of extensive reading around health reforms, Waitangi Tribunal Reports and the Simpson Report, among others. She pointed out that one needed to do their own homework because, although the workshops were a starting point, they were not going to be enough (Katelyn, 2023). Nevertheless, when thinking about how to engage people and to find out about their health needs and how to investigate or treat those, Stafford said:

> *"You're not trying to be an expert in tikanga Māori…you're trying to be somebody that makes that person feel safe to be who they are while you look after them" (Stafford, 2023)*

Stafford commented that te Tiriti offered a pathway to enhancing ones rangatiratanga.

The workshops encouraged participants to support tino rangatiratanga and help achieve Pae Ora through several ways. This is clearly articulated in the *Public Health Tiriti Series Presentation 3, Health Equity* workshop (Te Whatu Ora, 2023) which asked participants to:

- *Challenge racism as a determinant of health;*
- *Study the local history of the area;*
- *Accept that Māori are partners in and to the health system and therefore resourcing for Māori health is a system responsibility;*
- *Accept that equity work was everyone's responsibility;*
- *Enable Māori to be Māori; and*
- *Get the facts right.* (Public Health and Rautaki Power Point slide, 26, 2023)

Participants offered varying views on whether they were active in applying or operating in a way that supported these goals. Yet, when it came to governance of training, the picture showed that Māori did not have equitable decision-making or resourcing authority. Brenda's efforts to deliver a training programme that would address these aims by bringing awareness to staff about te Tiriti o Waitangi, mātauranga Māori, tikanga, and

equity among other things, required careful navigating. Brenda understood that staff were struggling with the restructure, however she felt that this training was needed more than ever because a major reason for the restructuring of health services was because of the organisation failing to meet its obligations to Māori. Brenda was trying to address that failure by making everyone accountable for equity. Without leadership support and restructure priorities, her training programme was sidelined.

Across both the kanohi ki te kanohi workshops, participants identified and appreciated strong Māori influence in the design, content and facilitation of the workshops although when it came to training, concerns remained on equitable decision-making, accountability and resourcing authority.

Ōritetanga

Ōritetanga engages with the principles of equity, fairness, and equal outcomes for Māori in health. It encompasses Māori leadership including co-design of training programmes with Māori-controlled content. Ōritetanga also considers the role of non-Māori staff in helping advance Māori tino rangatiratanga and considers how the training reflects Māori values and authority and strengthens Māori collective well-being and mutually beneficial outcomes. A key consideration is how Māori would expect the training to support health services to uphold their Tiriti o Waitangi obligations in ways that contribute to improved health equity outcomes and obligations for Māori.

The Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act) introduced a major restructure to better reflect the Crown's te Tiriti obligations. Brenda found its clarity on equity refreshing and built her training programme around its legislative direction. As she explained:

"No one could really pinpoint, like how do we know if we are delivering on equity? What are our measures to tell us whether we are actually meeting the targets? And how do we know that what we are doing is making an impact?" (Brenda, 2024)

Despite her best efforts and the clear equity obligations outlined in the Pae Ora Act, Brenda's training programme had a short life span, ironically because of the restructure and fiscal concerns (Brenda, 2024). Brenda surmised that the executive leadership team lacked commitment to equity and te Tiriti and this had a flow-on effect for staff engagement and service delivery, citing the lack of support received following the side-lining of her programme. Brenda claimed that when she gave advice on several matters, her advice was either challenged, undermined or ignored, rendering her to a position of "invisibility". Regardless, Brenda remained engaged through the PHR workshops, giving her full support to those.

As noted in the previous section, Phoenix acknowledged Brenda's efforts and the lack of support. Phoenix concerns similarly highlighted the limited incorporation of Māori knowledge into key service decisions and practices. She believed that while training sometimes included powerful stories and perspectives, opportunities were lost when staff are oblivious to how these stories can "give some insight into the health issues of Māori in this particular area" (Phoenix, 2023). As she pointed out, TWO is not listening *"to how Māori are telling us what's not working for them" (Phoenix, 2023).*

An area that raised a lot of concern was the hospital. Nora said that a lot of her patients were Māori, but she claimed that staff are not as exposed to any formal Tiriti training within the hospital, other than their own professional training. Nora surmised that one possible and obvious reason why there was no regular training was because people were too busy and any extra training that is not medical training is seen as a waste of time.

She believed that understanding the history and health inequities would help her to understand her patients and their needs more, as she said:

"If you go back to the root causes of that, it is institutional racism" (Nora, 2023).

Katelyn shared Nora's concern. Through the training and through her own research, Katelyn understood the impact of colonisation; on te reo Māori, on Māori knowledge systems, and on Māori way of life. She recognised that the broken promises made by the Crown had transformed Māori society and significantly contributed to the current inequities in the health system. For Katelyn, the hospital was a very unsupportive environment, not a space where one talks about how to bridge equity. As she explained, staff were so caught up in trying to care for people and discharge them because of the backlog, they did not have time to support people to access training adding that this is why they have resorted to online training and getting numbers through instead of focusing on addressing inequities:

"We signed up for the health reforms, to achieve just that, only to rename ourselves into Te Whatu Ora from DHB but just continue the same thing that we did and actually not achieve equity" (Katelyn, 2023).

Katelyn was keen to see more mātauranga Māori incorporated practices and perspectives, greater incorporation of te Tiriti o Waitangi in everything staff do and taking a more holistic Hauora Māori approach. As she explained:

> *I see the hospital and the clinical environment as so far behind. They don't have exposure to te Tiriti, proper te Tiriti training. They don't really understand the historical implications of stuff and that's why we are in the position we are now in New Zealand. What we do for Māori is actually quite applicable for almost all ethnic populations. (Katelyn, 2023)*

Sacha, a strong advocate for co-governance also supported this call for more training for hospital staff, emphasising that while training was extremely helpful in bringing understanding, and awareness, she felt that it was not yet sufficient:

> *I do think that it needs to be more extensive. I do think that it needs to be compulsory or mandatory within the hospital settings as well because they have a long way to go to understand people and culture*. (Sacha, 2024)

The kanohi ki te kanohi training programmes were designed to address the issues raised by participants, especially in relation to a lack of knowledge and understanding about te Tiriti and addressing inequities. Their programmes included historical content, and the delivery reflected Māori values, knowledge systems, and aspirations (see Chapters 4 and 6). The workshops highlighted the social determinants of health and called for a whole-of-system, intersectoral approach led by Māori (PHR, 2023, Slides 26 of training workshop). Participants explored systemic drivers of inequity including racism, colonisation, historical trauma, underrepresentation in leadership, and undervaluing of Māori knowledge systems. Kaupapa Māori approaches, mātauranga Māori, and te reo me ōna tikanga were foregrounded as essential to equitable health responses. The PHR training also introduced texts that participants could use to address systemic inequities, including, He Whakaputanga o te Rangatiratanga o Nū Tīreni, Te Tiriti o Waitangi, He Korowai Oranga strategy, The Hauora Report (Waitangi Tribunal), and Te Pae Tata Interim Health Plan. The Hauora Report served as a catalyst for this research and outlined clear expectations for the Crown to uphold te Tiriti and ensure equity for Māori. Two participants referenced the report directly, noting its confronting statistics and the way Hauora Māori professionals held public health to account for the health of services to Māori *"…in the nicest possible way" (Phoenix, 2023).*

Participants credited the workshops, especially the kanohi-ki-te-kanohi workshops (TAT and PHR) with helping them to understand that inequitable health outcomes for Māori constituted a breach of te Tiriti. Sacha shared how the training had revealed the devastating impact of colonisation for Māori. Gaining understanding and knowledge changed her own perspective to the extent that she is a lot more comfortable having conversations around Māori health, te Tiriti and equity than before the training. She also continues to devote her time to sharing and growing understanding and knowledge about te Tiriti, equity and Māori health and advocating for equitable practices and resourcing. But Sacha's reflections also pointed to gaps in how accountability was being enacted. Despite advocating for co-governance and delivery of services directly in Māori communities supported by local Hauora providers and clinicians to increase accessibility, cultural safety, and uptake, her proposal was declined.

Unlike Brenda and Sacha's experiences, Tyler found that having a manager who supported her learning by encouraging her to attend Te Ara Tōtika (TAT) when she [her manager] could not, and then providing follow-up resources was hugely beneficial. It helped her deepen her knowledge of te Tiriti and tikanga Māori and led to pursuing tertiary study in the field. When Tyler attended the TAT training, she was provided with a cultural safety quick-reference card. Although this was provided by Te Whatu Ora, Tyler said she had never seen these before. Upon her return to work, she requisitioned some and distributed these to staff to help them adopt tikanga best work practices when dealing with Māori patients. This is a clear example of ways participants can apply their learning.

Another critical tool referenced by multiple participants was the Critical Tiriti Analysis (CTA) framework. Several had completed the CTA workshop and described it as an invaluable resource for evaluating policies, service design, and organisational practice. The workshop invited participants to ask rigorous questions at each stage of development:

whose interests were being served, whose knowledge was being prioritised, and whether the outcome upheld te Tiriti intent and Māori tino rangatiratanga.

> *She [anonymised] got everyone to brainstorm how you would have approached the restructure under a CTA framework, which was gold... you could turn this tool into something... for planning and strategy and implementing something in a more appropriate te Tiriti-based way. (Brenda, 2024)*

Within their work environments, participants were aware of other practical tools that can be used to assess existing services and guide decisions for the future such as the Health Equity Assessment Tool (HEAT) which Katelyn referred to in her interview. These are designed to assess the likely impacts of programmes or policies across different populations and identifies how to mitigate inequities. There are also Disaggregated data dashboards. These dashboards allow for the tracking of Māori-specific outcomes, as well as general or total population indicators. They track data such as health status outcomes, access rates, waiting times, and patient experience, alongside general or total population indicators. In doing so, they enable organisations to identify disparities and monitor whether equity strategies are in fact closing gaps (Te Whatu Ora, n.d).

The HEAT and Disaggregated data dashboard tools sit directly within Marcus's area of work. However, even if he was aware of them, he expressed concern that his approach might be too *"European"* to apply in a way that truly aligns with Māori aspirations. Though keen to work with Māori researchers, Marcus found the system burdensome and felt discouraged by what he described as:

> *"...the maize of trying to form a collaboration...the dumb-arse European bureaucratic system that do Māori's head in" (Marcus, 2023).*

Marcus's frustration reflected a deeper critique of structural processes that create barriers to authentic, reciprocal collaboration. As he had previously noted, collaboration now must be "officialised" (Marcus, 2023). To give context to this discussion, it is better understood by providing some background to Marcus' journey. Raised in what he described as a *"very sheltered, middle-class European Pākehā" (Marcus, 2023)* environment, when he joined Public Health during Covid-19, Marcus found himself immersed in a setting where meetings began with karakia and te ao Māori principles were actively lived. He described how these tikanga-based practices shaped his own development:

"It was a bit like being on the inside of the tribe. And when it works, you start thinking, 'Oh, this is kind of nice…" (Marcus, 2023).

Māori experts regularly visited the unit to share knowledge and tikanga and although it was all new to Marcus, he valued these contributions and saw them as grounded in manaakitanga:

"It's trying to get…changes in behaviour in the organisation so that it's not like a Pākehā bureaucratic place – it's like something else. This wasn't training. This was the actual doing and some of how the place feels" (Marcus, 2023).

Feedback from other participants confirmed that many could apply their learning to healthcare practice. They described greater respect for Māori approaches, incorporation of te reo, and reflection on professional responsibilities. Some noted that equity reporting was a requirement of their profession. Others, however, highlighted the need for ongoing support; that training while important, was not enough if it was not accompanied by systems and structures that supported Māori values and relationships (Sacha, Katelyn, Lisa and Phoenix). As Lisa declared:

If the systems aren't in place to actually support you …then it's not going to happen or if the system hasn't got enough cultural support or advisory around you to support you to make safe decisions... and actually there's no structure around you to deliver in that way, then it's not gonna happen. (Lisa, 2023)

Furthermore, despite the availability of tools like CTA, ***cultural safety quick-reference cards and content that reflected Māori values, knowledge systems, and aspirations, participants reported barriers to enacting equity in practice. Once they returned to their workplaces, it was work as usual (Katelyn, 2023) and nothing had changed.***

Collectively, participants described train***ing as useful for understanding Māori health inequities and Treaty obligations, though concerns remained regarding accountability, organisational commitment, and the sustainability of Tiriti-focused initiatives.***

Wairuatanga

"Wairua is fundamental to Māori existence and therefore, important to Māori health and wellbeing" (Valentine et. al., 2017)

In 1985, Sir Mason Durie asserted: *"Without a spiritual awareness, the individual is considered to be lacking in well-being"* (p. 483, as cited by Valentine, et al., 2017, p. 65). Wairuatanga reflects the choice for Māori to practice their own spiritual beliefs (Berghan, et al, 2017).

This section examines how wairuatanga is reflected in te Tiriti training and its impact on participants. It considers whether training respects Māori worldviews of health and whether it equips participants to ensure cultural safety. It also evaluates whether the delivery

style and learning environment embody wairuatanga principles, creating a safe, relational space.

Many participants found the training useful in providing knowledge and understanding and respect for Māori values, such as manaakitanga and whanaungatanga. Wilson et al. (2021) emphasised the importance of building relationships (whakawhanaungatanga) using values such as *aroha*, manaakitanga, mauri and wairua. These cultural values were key components of the TAT workshop (see Chapter 6). Stafford credited the workshop with helping him understand and reflect on more culturally appropriate responses to apply in his work, although he lamented the lack of organisational support and constant structural changes. Reflecting on the complexities of delivering services in rural areas with high Māori and Pacific population, Stafford noted the disconnect between training and real-world contexts:

"...you have to think about those things otherwise, you're gonna chew out the typically brown family ...because of your own bias. (Stafford, 2023).

Stafford also appreciated how the training helped him to make sense of other cultural values such as whakapapa. He explained that his wife was on her own journey of connection to her iwi and having learned more about whakapapa, he felt better equipped to support her and their children, in that endeavour.

As a recent immigrant to Aotearoa, Sophie appreciated the emotionally safe space created in the TAT workshop. Sophie had been drawn to Aotearoa, because of the work done around cultural safety but noted that fear of saying the wrong thing often paralyzed non-Māori colleagues:

They're just scared of asking. They're scared of saying the wrong thing. They're scared of offending, but in that they then don't do anything. (Sophie, 2023).

Participants understood from the training that Māori worldviews of health and Māori models of wellbeing offer holistic tools to guide service delivery that honours Māori spiritual and cultural values. The TAT programme reflected this understanding by introducing some of these models in the training content, for example; Te Whare Tapa Whā; Te Wheke; Te Pūtangitangi, and Te Pae Mahutonga. It also acknowledges other models including Maramataka and Rongoā. The PHR programme also referenced Māori health models. Although few participants discussed these in interviews, there is evidence that Māori models of health and wellbeing were discussed as the PHR team set about addressing this "…*lack of understanding of how to utilise Māori health models and practices…"* (PHR, 2023, slides 24 & 65). I was also aware from discussions with Stafford, who had attended the *Aspiring Leaders* workshop facilitated by the PHR team, that Māori health models were positioned as tools to support equity. Despite this, participants raised doubts about their ability to apply these models because they considered these models were not meaningfully embedded in work practices.

Some participants struggled to articulate the differences between cultural competency and cultural safety. Lisa had read Dame Irihapeti Ramsden's work on cultural safety (2002) and appreciated that cultural safety demands internal reflections:

> *Cultural competencies…tended to focus more on you recognising others' differences…whereas cultural safety is more… 'How am I perceiving this situation? (Lisa, 2023).*

Wairuatanga embraces the concept of cultural safety as an aspect of well-being. Brenda shared that when she tried to implement her training programme to upskill the team around te Tiriti and the legislative obligations under Pae Ora, she experienced moments of feeling unsafe and unsupported. She described being openly racially attacked for championing te Tiriti training. While some staff were receptive to her training, there

were a few who were not and by the time the workshops ended, she was emotionally depleted:

> *There was definitely a desire after the workshops to do some more work. By then I was ready to get the heck out of there because I was exhausted… the way I'd been treated—it was pretty exhausting, unhealthy, bad for me spiritually, mentally, emotionally… And it wasn't a safe environment… and I don't think that non-Māori realised how bad it was. (Brenda, 2023)*

Brenda stressed that the restructure process had been difficult for everyone, but she felt Māori staff bore an additional burden beyond what any other non-Māori staff experienced. Her experience also highlights the emotional, cultural, and professional toll on Māori staff when organisational accountability is weak. Even when Māori staff are employed in advisory roles, if their knowledge is disregarded or their positions are undermined, the organisation is failing to uphold its Tiriti responsibilities (Brenda, 2024). This undermining by others, including senior staff, left Brenda feeling unsupported, alone and questioning her role. She believed that senior staff should have extended their support, emotionally, structurally and financially; the latter in recognition of the cultural labour involved.

Despite her experiences, Brenda acknowledged the value of the final PHR workshop she attended, which focused on Pākehā cultures, commending the facilitators for navigating difficult conversations, though she emphasised how exhausting it can be as a Māori to constantly be in the position of educating others:

> *"It's quite hard to be in that space when you know that people just don't get it and you're having to unpack for them [non-Māori] constantly, not just in that space, but in every other space you go into" (Brenda, 2023)*

Brenda expected that there would be different experiences for different people in those workshops. She noted that some staff found workshops on Pākehā culture confronting and appreciated facilitators setting expectations that discomfort was acceptable and necessary for growth. She described some participants as being openly resistant to being called "Pākehā" and admitted that the conversations *"got a bit heated"* (Brenda, 2023). She recalled when a particular staff member would not accept that she shared similar experiences to other Pākehā people noting:

"…just a complete lack of self-reflection on how she contributes to the racism that is experienced by people around her" (Brenda, 2024).

Chelsea offered a different viewpoint on the delivery of training around Pākehā culture. She claimed some PHR sessions were dismissive and hostile:

"I felt a couple of the sessions were very anti…anti anyone that didn't agree…" (Chelsea, 2023).

She shared concerns about a colleague being silenced and eventually leaving the organisation (although she could not confirm that it was because of that persons encounter in the workshop). Chelsea viewed this as a missed opportunity for respectful dialogue. When I asked Chelsea if anyone else was feeling the same way, she replied that she absolutely knew others were. This was confirmed by others. Katelyn said she had witnessed occasions where staff were 'shut down' and advocated for safer spaces where vulnerable ideas could be explored without fear of judgment. Conversely, Sacha was disturbed by unexamined racism expressed by some workshop participants. Phoenix, offered an alternative explanation, one that highlighted Pākehā vulnerability and the need for validation saying:

"…one of the consequences of targeted training around te Tiriti…you open up a conversation and a dialogue, but you also highlight a vulnerability… "(Phoenix, 2023)

Phoenix also thought that the workshops were perhaps too condensed, leaving little time for deep reflection on issues such as institutional bias and Pākehā privilege. She had suggested carving out space during training for discussion and reflection, something Brenda had hoped to include in her own sidelined programme. However, this suggestion was not taken up, essentially because there was so much material to deliver. She also pondered that:

"Maybe they [trainers] didn't want there to be too many questions... We chewed over it on our own and sometimes it was quite challenging and confronting, you know—as Pākehā" (Phoenix, 2023).

Nevertheless, unlike Chelsea, Phoenix appreciated the care in delivery:

"It was done in a way that didn't make people feel guilty... though there is an inherent consequence, and some people might feel it and others might not" (Phoenix, 2023)

Expressions of wairuatanga can transcend formal settings. Lisa, a public health physician working within a locality prototype, shared her transformative experience attending the Rangiporaruri/Mataora training at a Gisborne marae:

"It was probably the most uncomfortable I have felt but the most eye-opening experience of all the training…" (Lisa, 2023).

This immersive training deepened her understanding of cultural safety by exposing her to an environment where she experienced what it meant to feel culturally unsafe. She contrasted this with more "prescriptive" te Tiriti workshops, arguing that real learning requires emotional engagement and discomfort:

"…you have to actually sit in that space and go, aha, I see now. This is what we're losing and what we've lost" (Lisa, 2023).

Overall, participants experience of training varied with some describing the training as culturally safe while others reported discomfort, conflict and a lack of emotional safety and support.

Stage three: Determination

CTA was extended into this evaluation of Tiriti o Waitangi training programmes in public health and health services between 2021 and 2023 to determine whether participants believed that the training prepared them to understand and assist those working in these areas to honour their Tiriti responsibilities in ways that contribute to improved health outcomes for Māori.

Preamble/Kāwanatanga: Participants generally reported increased understanding of Treaty responsibilities and Māori health inequities. However, only a few participants could specifically make the link between the intent outlined in the Preamble. Many staff lacked clarity around how te Tiriti applied to their work. Concerns were also raised regarding leadership commitment, accountability, and ongoing support for Māori-led initiatives.

Tino Rangatiratanga: Participants identified strong Māori influence in the design and facilitation of kanohi-ki-te-kanohi programmes, TAT and PHR. While workshops encouraged participants to support tino rangatiratanga and help achieve equity, when it came to training, Māori did not have equitable decision-making or resourcing authority leading participants to question Te Whatu Ora's commitment to tino rangatiratanga.

Oritetanga: Participants reported increased awareness of inequities, colonisation, racism, and equity-focused practice. However, many expressed uncertainties about how improvements were measured or how and whether Te Whatu Ora were upholding their Tiriti

o Waitangi obligations in ways that contribute to improved health equity and obligations to Māori.

Wairuatanga: Experiences varied considerably. Some participants described training as culturally safe, relational, and transformational, while others reported discomfort, conflict, and a lack of emotional safety.

Stage four: Strengthening practice

In their review of the Pae Ora (Healthy Futures) Bill, Rae et al. (2022) discussed the problem with using or referring to the Treaty and te Tiriti interchangeably as if they were one and the same document with the Crown privileging the Treaty over te Tiriti. It was argued that in doing so, Māori authority is subservient to Crown authority in ways not envisaged by te Tiriti o Waitangi (Rae et al., 2022). The Preamble of te Tiriti sets out the broader context and the intent behind te Tiriti and can act as a guiding tool for understanding the objectives or the underlying principles of te Tiriti (Waitangi Tribunal, 2023) however most participants were unable to make the link as outlined in the Preamble.

The online training explicitly referenced both te Tiriti and the Treaty although there was little discussion or interrogation of the Preamble. Furthermore, the teachings suggested that both versions (te Tiriti and the Treaty) are "the real ones" (Ko Awatea, 2025) because the government has regard to both. However, outside of the training, the reality was different with staff returning to an environment that privileged kāwanatanga (governance) authority over tino rangatiratanga, Māori authority and aspirations. The kanohi ki te kanohi training programmes, endeavoured to address this issue by delivering training that explicitly referenced te Tiriti and the Preamble. This situation could be remedied by Te Whatu Ora embedding te Tiriti in their policy, practices and training

statements and recognising Māori as sovereign Tiriti partners. Specific attention needs to be given to the Preamble for the reasons discussed above.

The Pae Ora (Healthy Futures) Act 2022 was meant to be the driver to tackle persistent inequities in health outcomes and access for disadvantaged groups, especially Māori (Manning, 2022). Inequitable health outcomes constitute a breach of te Tiriti. Māori-led initiatives including the Kaupapa Māori Training programme introduced by Brenda, were created to help staff at Te Whatu Ora to meet their Tiriti obligations. Indeed, participants credited training with providing them with increased awareness of te Tiriti, colonisation, racism and equity focused practices. These Māori-led initiatives were applying delivered kanohi ki te kanohi, providing greater opportunity for participants to discuss and practice how to apply learning and how to make tangible improvements. However, the decision not to continue funding these initiatives, without clear directives as to how Te Whatu Ora was going to meet its ongoing statutory obligations, raised several issues. These included issues around organisational accountability, monitoring and measurement of improvements in health equity to Māori and lack of support of Māori-led Kaupapa Māori initiatives. As one participant highlighted, Māori voices were not being listened to.

The Crown has a Tiriti obligation to ensure that health services are culturally appropriate (Waitangi Tribunal, 2023). The issue of cultural safety was widely discussed in the Waitangi Tribunal's Hauora Report with references to the concept of cultural safety, obligations to upholding the Treaty and its principles, and guaranteeing freedom from discrimination. They highlighted that actions that contribute to experiences of personal and institutional racism, are breaches of the Treaty. Despite those findings, Brenda

described experiences of personal and institutional racism. A further issue that came to light during the interviews was that Māori staff were expected to carry the responsibilities of providing cultural advice when that is not part of their responsibilities. This becomes even more concerning when they are asked to lead or support training in environments without adequate backing, leaving them exposed or unsupported when challenges arise or when advice is undermined. The Waitangi Tribunal (the Tribunal) offered several solutions to mitigate these issues, which this study fully supports. These include supporting Māori who design and deliver Kaupapa Māori models of care and providing fiscal recognition for extra duties. Unless those happen, the responsibility remains an organisational one. Kaupapa Māori approaches in training addresses cultural safety as well as cultural awareness. Te Whatu Ora must provide leadership support to all its staff but especially Māori and make clear in its policies, practices and training curriculum that all forms of racism must be eliminated.

The importance and benefits of long-term, enduring relationships were considered by several participants to be critical for giving life to te Tiriti, enabling culturally safe and equitable practices. Trainer interviews reflected similar sentiments with the success of the programmes being attributed to those enduring relationships rather than curriculum design. The consensus was that while online training was one way of educating people, it cannot substitute for relational learning.

Participants saw value in scaffolded kanohi ki te kanohi learning but criticised workshops for being too heavy in content to be delivered in one day. Additionally, delivering training on racism, unconscious bias, and Pākehā privileging tended to create discomfort, conflict and a lack of emotional safety. A Kaupapa Māori values-based

training initiative such as that proposed by Brenda, is directly relevant to this discussion and is advanced as an initiative that has the greater potential (than an online module) to address concerns raised by participants. Some, if not all of this should be delivered in a marae style environment where cultural concepts of *tapu* and *noa*, manaakitanga, whanaungatanga and *utu* are strictly observed, offering places where emotional safety is prioritised. Such an initiative would require a collaborating effort with Māori and their communities, including the marae community. It would also require the full support from leadership in Te Whatu Ora.

To address the concerns raised regarding the lack of regular training for hospital staff (clinicians and administrators), the scaffolded learning programme proposed above must be mandatory for all staff working in health services as well as public health. Full auditing of training should be undertaken regularly to measure and monitor improvements in staff's awareness, understanding and commitment to equity. Furthermore, Māori must have equitable decision-making and resourcing authority in training and must be fully supported by management. To strengthen commitment to Tiriti obligations and Maori health inequities te Tiriti must be embedded in policy and training curriculum.

Stage Five: Māori Final Word

When the kanohi ki te kanohi programmes existed, there was a strong Māori influence in the design, content and facilitation of the programmes. Participants acknowledged the relevance of local and regional input sharing historical Tainui Waikato stories relevant to health. Through basic pronunciation te reo sessions, participants were inspired to enrol in te reo classes or enhanced learning. However, the termination of these programmes saw Māori voices silenced, rendered invisible. For Māori voices to be heard,

kanohi ki te kanohi Kaupapa Māori-led training programmes must be reinstated. Māori must be fully controlling the narrative in how they are represented in the training so that structurally they are not the junior partner.

Chapter 6: Results from interviews with Training Providers

This chapter presents findings from semi-structured interviews with four training providers involved in the design and delivery of face-to-face Tiriti training within Waikato District Health Board/Te Whatu Ora. Three participants were associated with Te Ara Tōtika (TAT) programme, including one of the programme's original designers, while the fourth participant contributed to the design and facilitation of the Public Health Rautaki (PHR) programme.

Although a common interview schedule was used across interviews with the TAT training providers (see Appendix 9), questions were adapted for the PHR provider to reflect the broader scope of that programme (see Appendix 10 and discussion at 3.9). To preserve anonymity, training providers are identified using participant codes (TP1 through to TP4) throughout this chapter. The interviews explored four interconnected areas designed to respond to specific questions:

- the origins and development of the training programmes - How did these programmes come into being?
- programme content and pedagogical approaches - What educational philosophy informed the programmes?
- organisational constraints and tensions shaping programme delivery - What constrained transformative Tiriti education?
- reflections on programme effectiveness and the future of Tiriti training - What does transformative Tiriti education require in the future?

Interview data were analysed through a thematic analysis to explore how training providers understood the purpose, design, implementation, and ongoing evolution of Tiriti education within a changing health sector. The findings are presented under four themes that correspond with these areas of inquiry.

6.1 Foundational development: Training as a response to institutional and Tiriti obligations

It could be argued that the 1990s, the sesquicentenary year of te Tiriti o Waitangi (te Tiriti) and the Treaty of Waitangi (the Treaty), provided the ideal backdrop for the creation of Tiriti training. Other events happening at the time included major Treaty Settlements - the 1992 Treaty settlement on commercial fisheries and the signing of the first major Treaty Settlement with Waikato-Tainui in 1995 and Ngāi Tahu in 1998, each at an estimated total value of $170m (Radio New Zealand, n.d). The year 1993, saw landmark legislative recognition of the Treaty of Waitangi when Te Ture Whenua Māori was enacted and in 1996, the first MMP election (Walker, 1990, 2004). A series of protests in the mid-1990s marked a new phase of activism on land and Treaty issues, a growth in Māori tertiary educational institutions (i.e. Te Whare Wānanga o Raukawa, Te Whare Wānanga o Aotearoa and Te Whare Wānanga o Awanuiārangi) (Walker, 1990, 2004) and a growing societal demand for bicultural education (Ritchie, 2003).

Te Ara Tōtika (TAT)

Against this backdrop, Te Ara Tōtika evolved in response to the demand for bicultural education. Waikato Hospital and Health Services[7] (HHS) advertised 'Expression of interest for providers to deliver Treaty training'. Training Provider 1 (TP1) applied and was successful in securing the contract. At the time, TP1 was delivering bicultural counselling

[7] The Hospital and Health Services was the name of the organisation prior to the establishment of District Health Boards which themselves were later replaced with Te Whatu Ora.

training sessions in the community which included Treaty education, so when the advertisement was brought to their attention, TP1 was perfectly positioned for the task. Thus began a long-standing partnership, beginning in 1995, between TP1 on behalf of the University of Waikato and Eru Beattie, Manager of Waikato Hospital's Māori Health Services. The focus was on improving health outcomes and access for Māori patients and became the overarching vision for the Treaty Training programme. Although Beattie was the only one overseeing Māori policy and direction (TP1, 2024), he was also part of a wider group of Board members of Rauawaawa, a Kaumātua Community Charitable Trust providing a range of services to enhance the wellbeing and quality of life for *kaumātua* (Sewell, 2016). This group was mainly made up of public servants who TP1 described as *"an incredible galvanizing force of Māori experience that wanted to make a difference…*" (TP1, 2024).

In the beginning, HHS wanted 2x2day sessions a month. Te Ara Tika Tuatahi and Te Ara Tika Tuarua were created. As TP1 explained: "*The first two days were just on Tiriti (Te Ara Tika Tuatahi) and the second two days were just on application to practice"* (Te Ara Tika Tuarua). The workload was too heavy to carry forward by one person, so TP1 enlisted the help of others to facilitate the learning – Dr Paul Meredith, Dr Robert Joseph (both law students at the time) and Dr Jenny Ritchie. This team became the foundational University of Waikato Treaty education team. TP1 recalled that the two-by-two sessions remained in place for three to four years but amid falling numbers, the funders decided to make attendance compulsory. Making the programme compulsory caused a negative reaction among some people who had to take part in it. As TP1 described the situation:

"There was some really challenging workshops, especially when it was compulsory and people actually ganged up to ensure that they were destructive. But I like to treat that as the most transformative training that I've ever had."

Compulsory attendance lasted for approximately two years before the health system was overhauled and attendance was no longer mandatory. In 2001, District Health Boards were established under the New Zealand Public Health and Disability Act 2000. Beattie was reappointed Manager, Māori Health Services Waikato District Health Board, and Ditre Tamatea was appointed General Manager, Māori Health (Te Puna Oranga) Waikato District Health Board, a position he remained in until 2016 when he left to take up another executive position with Nelson Marlborough Health. TP1 shared that her team of trainers worked closely with the policy unit and their Human Resource Development (HRD) sector during Tamatea's leadership describing the relationship as *"very beneficial"* and *"really valued"*. As TP1 explained:

> … *they wanted not only to check ideas about training, but they also wanted to check general ideas about the state of their policy. When they were renewing their Maori policy, they went out to communities. They'd always get me to peer review as well. So, it ended up that I was always kind of involved in their institutional changes when it came to Maori, because they wanted kind of like an outside critical perspective.* (TP1, 2024)

Regular checking in on the team, providing updates on policy changes and ensuring the training remained relevant were crucial to maintaining relationships between HHS and the TAT team. Tamatea held a very prominent Māori leadership position and under his mandate, TP1 believed they [all stakeholders of training] were making a difference (see further discussion in 6.4).

However, the beneficial relationship that had been sustained for more than fifteen years was not to last as organisational shifts began to change the terrain (see Section 6.3). Nonetheless, with its focus on improving health outcomes and access for Māori patients, the team hoped that would contribute to the broader goal of equity. Regardless of the changes, TP1 said:

"*It was the impact the training could make on health professionals to make our people healthy, you know, because they're so vulnerable...any difference we can make to health professionals, it was really my driving force*".

Public Health and Rautaki (PHR)

It was this same driving force that saw the creation of the Public Health and Rautaki training programme (otherwise referred to as 'The Equity and Tiriti training programme'; TP2, 2024). This programme was developed in 2020 following TP2's attendance at a Critical Tiriti Analysis workshop (see discussion at 3.7.1). A working relationship had been developed between Public Health and Rautaki (Māori Policy and Strategy team) through writing the Waikato DHB Equity Report, *Rapua Te Ara Matua* (2020) that the PHR team developed their programme. At the time, TP2, was working alongside other staff from Rautaki (Māori Policy and Strategy team). Rautaki were based in the hospital and part of Te Punga Oranga (Māori Health Hospital Services). Riki Nia Nia was the Executive Director of both Māori Health and Public Health, making it easy for TP2 and the team to work across services. TP2 was very keen to start using Critical Tiriti Analysis, especially when looking at and reading the research proposals that were being reviewed. This set off a process of thinking about how to apply Tiriti in their work. Together with the Rautaki team, TP2 started conversations with other health service staff, including Registrars, new staff entering the leadership training programmes and the Learning and Development (L&D) staff. The conversations turned to how they could do more Tiriti training. L&D had started developing a new training programme across the hospital and were keen to incorporate more Tiriti knowledge and Equity understanding into their leadership training programme. The responsibility for this work sat with Khalia Tapu and the PHR team worked closely alongside Tapu to deliver Tiriti and Equity training.

Pre-Covid the team comprising PHR with L&D support started working in Public Health and with Strategy and Funding, building relationships between the groups. Throughout Covid the team worked at building even stronger relationships with Māori, as all sectors collaborated to provide help through the pandemic. Post Covid, the team continued developing their relationships with other areas of the health sector, delivering training to Dietitians, Occupational Therapists and various Allied Health Groups. They frequently delivered training to the new Registrars and new Doctors arriving in the hospital environment and were soon given a one-day slot in the Leadership training programme (Aspiring Leaders). Afterwards, they put together a programme for the Public Health Strategy and Funding unit (See discussion at 3.7.2, p. 77). All staff were to prioritise attendance at these workshops and from the interviews, some took that to mean attendance was mandatory (see Chapter 6). The programme offered scaffolded learning from Tiriti 101 to Equity awareness, understanding Pākehā privileging and Critical Tiriti Analysis, in total five workshops of learning. It was these workshops I was keen to find out about. Unfortunately, by the time I discovered this programme, I was only able to analyse one workshop, i.e., the Critical Tiriti Analysis workshop.

6.2 Pedagogical design: Embedding mātauranga Māori and relational learning

The Te Ara Tōtika programme emerged after changes were made to Te Ara Tika Tuatahi and Te Ara Tika Tuarua, the forerunners of Te Ara Tōtika. Those changes included a move to online learning. TP1 explained that the Human Resource and Development (HRD) unit decided to move content covered in Te Ara Tika Tuatahi, to a self-paced digital online learning. As a result of this change, Te Ara Tika Tuarua was renamed, Te Ara Tōtika (TAT). It was understood that staff from health services (mainly those working in the hospitals including clinicians and administrative staff) would complete the online modules to build

foundational knowledge about tikanga, and te Tiriti o Waitangi before attending, TAT (see discussion at 6.4). TAT's new focus (while remaining committed to the vision and goal of improving health outcomes and access for Māori patients to contribute to health equity) prioritised application of Māori values and Tiriti. In this way, the programme supported learners' foundational knowledge and ability to apply tikanga best practises and te Tiriti in their work. However, as a training provider of this programme, there were several occasions when I was involved in facilitating a workshop to find that some participants had either not completed the online modules or having completed it, were still unclear about te Tiriti and the Treaty and its implications (also discussed by TP1 at 6.4). For this reason, TAT workshops oftentimes included a foundational knowledge learning session about te Tiriti, the Treaty and tikanga.

When reviewing the content of the TAT programme, the learning outcomes included the ability to identify and describe key Māori values and beliefs; learn tools of best practice to better serve patients in Waikato hospital, and in particular Māori patients and whānau; understand the importance of Māori health to te Tiriti o Waitangi and the Treaty of Waitangi; and identify key markers in the health history of Tainui. The latter part of the training was particularly relevant and unique to Waikato. As TP1 expressed:

"*This is Kiingitanga territory. What you want for this workshop is that when they go out, when they step out onto the lands of Waikato Tainui, after being in the office, they start to see the world a different way. Kiingitanga – opening up a different world.*"

Case studies of real situations experienced in the workplace were used as aids in applying learning. Examples were used to demonstrate how cultural principles guided decisions, prioritised manaakitanga, and illustrated whanaungatanga, *kaitiakitanga* and tino rangatiratanga (TP4, 2023). Participants were asked to contextualise the challenge or

situation presented, name the specific value that influenced their [participants] mindset and connect that value to the positive result or choice. These case studies were beneficial in providing increased understanding of the Māori world view (TP3, 2024 & TP4, 2023). Local stories served to provide understanding of the larger socio-economic problems faced by many Māori and their whānau such as poverty, inadequate housing and income, and discrimination. It was hoped that through understanding these markers of socio-economic deprivation coupled with a greater knowledge of cultural principles guiding decisions, might make a difference to how participants engaged with Māori.

The trainers encouraged active participation and engagement. They were mindful of the need not to overwhelm participants, especially as there was so much learning to impart. However, the programme suffered from prolonged, lecture-style delivery due to two main factors: an overwhelming volume of core content and the need to compensate for foundational gaps left by the e-learning platform and/or inadequate monitoring of training completions[8], and not enough time to deliver on all of the content. As TP3 and TP4 reasoned, "*…one day or part of a day is too short…and as a result, it was too lecture like."* In addition to favouring a two-day programme, both TP3 and TP4 expressed a preference for a learning environment that allowed space for group structured support and engagement such as marae. Culturally appropriate spaces such as the marae environment, provide an authentic setting that fosters a deeper, embodied understanding of tikanga, te ao Māori, and Kaupapa Māori principles (Lee, Pihama & Smith, 2012).

> *If we were in a marae setting, you would feel part of the Māori wairua; what we are teaching about but not in their [Te Whatu Ora's] environment, but in ours like the*

[8] During my analysis of the online surveys (see Chapter Four), I came across several instances where a participant enrolled in the online programme but showing no completion date. Sometimes, the completion dates were 6-12 months after enrolment. Data showing incompletes for the period of analysis, were eliminated.

Pā…we could teach them all about the pou. You can teach them there [at Bryant Education Centre] but it doesn't have the same vibe. (TP4, 2023)

TP4 noted the difficulties teaching about manaakitanga, tapu and noa in an environment like the Bryant Education Centre. It is a lecture theatre. Traditional lecture-style classrooms limit group activities and are not exactly conducive to discussions or interactions between students and teachers (Sandquist, 2014) or, in this case, between participants and trainers. Noting too the earlier criticisms of the teaching being too 'lecture like' or the need to shift away from 'didactic and traditional lecturing techniques' (Sandquist, 2014), would support the claim that the Bryant Education Centre was not the most appropriate venue to deliver this type of training (see also discussion at 3.3, p. 60 regarding Kaupapa Māori approaches).

Where training was occurring did not appear to be an issue with the PHR team. The workshops were being held in various locations, where rooms catered for space and group activities. This was needed especially, for example where Critical Tiriti Analysis (CTA) called for participants to work in group activities. TP2 was the only trainer I was able to interview. Earlier efforts to recruit others were unsuccessful as staff had either disbanded, transitioned to other parts of the health sector or had left the organisation altogether. Nevertheless, while the data came from a single training provider, the qualitative depth achieved through the semi-structured interview provided comprehensive insights into both the curriculum design and the underlying pedagogical strategies. At the same time, while TP2 covered the programme content well, the biggest takeaway was PHR's effective pedagogical approach to training, specifically relational strategies and a focus on inquiry-based exploration. As TP2 explained, they were reflexive in how they worked.

The PHR team developed a set of PowerPoint slides for their training programmes and would deliver on those. They would then debrief about what worked or did not work and make any necessary changes, something they shared in common, with the TAT providers. Te Tiriti o Waitangi was always covered throughout all the workshops. He Whakaputanga o te Rangatiratanga o Niu Tireni, 1835 (The Declaration of the Independence of New Zealand, 1835) was also discussed but TP2 conceded, *"...probably not as much as we could have..."* Another feature of the programme they shared with TAT, was the inclusion of local Māori stories and histories including stories of the Kiingtanga. If the training was delivered outside of the Waikato, the trainers encouraged participants to learn about the people and places of that area, always trying to align the loss of land with intergenerational health and wealth that comes from land.

Given that the training programmes were created off the back of the Equity Report, *Rapua Te Ara Mātua*, and arguably influenced by the Waitangi Tribunal's Hauora Report, it is unsurprising that one of the workshops was Health Equity. TP2 and another colleague, also a PHR trainer had both worked on the Equity report. During the workshop, the team shared information from that report, especially about the broader elements of health equity and the equity gaps and life expectancies. For many, it was their first time hearing about the Report. TP2 encouraged participants to read the report and whilst the report highlighted alarming negative statistics, they tried not to focus too much on those, opting instead to take a strength-based approach. This was a significant feature of the PHR training. As TP2 explained:

> *"So that was one of the starting points that we wanted to reinforce Māori as strong living vibrant culture and peoples…horrendously impacted by colonisation."*

Colonisation has severely impacted Māori through loss of land and cultural and language suppression. These had huge social and health impacts; introduced diseases,

urbanisation and systemic disparities. These are the facts that formed much of PHR's content in training. However, while the trainers were knowledgeable about some things, they were not the foundation of all knowledge (TP2, 2024). Participants were always encouraged to develop their own knowledge base by seeking more learning on the topic from the many peer-reviewed publications.

When I asked if TP2 thought the training was effective, she responded by saying that she believed Tiriti training was a life-long journey; that every time she was delivering Tiriti training, she was constantly learning more about te Tiriti. The effectiveness therefore was in the journey of learning and the relationships that were developed as they worked together with participants to find ways to deliver more equitable outcomes to and for Māori. TP2 believed that any given training has a limited effect which is why they encouraged participants to do their own homework about the Tiriti.

If the effectiveness of the training programme was in the relationships that were developed and how participants work together, I wanted to explore views about online learning. I had earlier raised this with TP1. Like TP1, TP2 believed that some online learning was acceptable, but believed that the real Tiriti and equity learning came in the relationships developed and the opportunities to work alongside Māori delivering the training. Essentially, she believed that online training was fine but kanohi ki te kanohi offered more learning, developmental, relational and transformative opportunities (TP2, 2024).

The majority (if not all) of the trainers/facilitators were Māori; Māori voices were clearly central in guiding what was taught. Māori personnel contributed to mātauranga Māori, including some with local knowledge. It seemed clear then that training supported Māori leadership and decision-making autonomy. TP2 said that whenever the opportunity arose, she would talk about respect for Māori authority, saying:

I didn't grow up with any sense that Māori had authority. So that's that kind of invisible superiority. So, when you start examining that, and we did that in the Pākehā privilege session…understanding how we might block that [authority], sometimes not even realising but bringing it to consciousness…some people find talking about privilege a bit confrontational. (TP2, 2024)

Because I was only able to examine the Critical Tiriti Analysis (CTA) workshop, I wanted to know more about some of the other workshops and in particular, whether those (a) addressed tino rangatiratanga as a critical aspect of te Tiriti partnerships; (b) whether the training equipped participants with the knowledge and skills to support tino rangatiratanga; (c) whether Māori aspirations were embedded in the training; (d) whether the training promoted accountability and cultural safety for participants and their Māori colleagues and patients; and finally whether there were clear pathways in the training to hold Te Whatu Ora accountable for ensuring equity and culturally safe healthcare. These are CTA questions and TP2 understood this. While she confirmed that the training addressed, promoted and supported all of these key components of CTA for compliance with te Tiriti, she shared the knowledge gained from Veronica Tawhai's Treaty workshop as part of 'Te Ata Kura' (Society for Conscientisation). Tawhai encouraged people to think about what the articles of te Tiriti provided for rather than focusing entirely on the words of the articles. TP2 explained:

"*…if one were to look at kāwanatanga and tino rangatiratanga the questions one could be asking are: "What did te Tiriti say about these? What did that mean? What did it provide for and then how has that been carried out over time?"*

It was argued that this line of questioning allows for more open, accessible and acceptable learning (TP2, 2024). A further benefit is that it moves the focus away from discussing Treaty principles.

Participants were always encouraged by the PHR team to return to their professional sectors to see how tino rangatiratanga is being supported. For example, TP2 explained there was a lot of work being done in Public Health medicine and in various areas of medicine but only doctors or clinicians working in that area could explain how that work supported tino rangatiratanga if at all. It was less obvious whether there were clear pathways in the training to hold Te Whatu Ora accountable for ensuring equity and culturally safe healthcare. Participants were encouraged, no matter which sector they worked in, to take the training forward and develop accountability in their workplaces but beyond that, responsibility lay with the organisation, itself.

6.3 Organisational Challenges and a Shifting Policy Landscape

In 2010, Catalyst, collaborated with the Waikato District Health Board (and later, Te Whatu Ora), to develop Ko Awatea Learn (Catalyst, 2020). The result of that collaboration was a restructured TAT programme, as discussed previously. This should have signalled to TP1 and her team, that change was on the horizon. Reflecting on that, TP1 said:

> *We didn't have any idea of the impact of that and part of that was them wanting to reduce what we did. But I remember us having a review of that. And while there were a couple of things that we did wonder about, certainly the idea was that many of the employees would watch that [the video] and come to our training afterwards. But we never found that many who actually watched it, and so I'm not quite sure…* (TP1, 2024)

As discussed at 6.2, these comments would seem to support the idea that some participants may not have completed the digital modules or if they did, they were still unclear about the learning. This was to be expected. TAT was designed to help staff review difficult areas of learning. But then there were others who had completed the digital modules but could not recall what the modules were about, other than 'cartoons' (see discussion in Chapter Four). Instead of strengthening the foundational learning modules (feedback from participants certainly indicated a need to do so; as discussed in Chapter Four), the organisation began to systematically introduce policies to accommodate funding priorities.

The reconfigured TAT programme and its forerunner was founded on strong beneficial relationships between HHS and TAT, sustained for over fifteen years. Regular check-ins, robust discussions including policy and programme reviews were key features of that beneficial relationship. Under the leadership of Beattie and Tamatea, TP1 believed they were making a difference. The goal had not changed, but after Tamatea left the organisation, TP1 noted a significant shift in the organisations' approach to the relationship.

According to TP1, the Human Resource Development (HRD) department, who were regularly checking participants evaluations of the TAT programme, expressed concern that TAT were only taking 30 people per session and on those numbers, it was clear that TAT would not deliver training to all of the staff at WDHB. HRD advocated for a change to TAT's programme:

> "*…the training became more of a quick-fire information session rather than a consciousness raising facilitation, growth session*" (TP1, 2024).

TP1 said that she tried to point out the losses and the advantages of training under the current programme, but HRD was keen on getting their people through as quickly as possible

with just a grounding in cultural responsiveness, rather than affecting any dramatic change leading TP1 to say:

> *But we're not paying out the money that they were paying out. They wanted more impact on the ground. And you know, when you're changing minds and hearts and there are softer outcomes…So that became a bit of a challenge, whereas if they could name the figures on how many were doing our training, that was kind of more important – not so much for the Māori policy unit, but for HR from whom this professional development was coming. So, you're always in that state of tenson.*

According to TP1, if they had not got something from the relationship, such as training a team to be good facilitators, then TP1 said that maybe she would not have stayed so long. But she stayed with the training because she believed they were making a difference. The goal of wanting to reduce inequities was even more important.

TP1 did not believe that effectiveness could be measured by the large numbers completing the training arguing instead that a cultural approach was more effective when dealing with Māori, not one that measures effectiveness by percentages of how many people completed the training. Importantly, has a person's practice changed because of the workshops? For example, have they become more accommodating of whānau? Have they allowed the mothers of newborn babies to have their placenta, and could Māori patients speak and access wairua to address their spiritual needs at their most vulnerable time? As TP1 pointed out, these were the outcomes she believed could be achieved within the context of what TAT could deliver.

But it was becoming increasingly difficult to deliver on those outcomes as more changes started happening. Some of those were a result of staff changes, other pressures, changes in circumstances and reforms. However, there were more subtle changes to come.

HRD stopped providing lunches and then later, stopped paying for parking for facilitators leading to the comment: *"So the manaaki started to reduce a little because of the pressure that they were under. So, it did feel that once that manaaki stopped, that it was time to stop* [the training]" (TP1, 2024).

6.4 Reflections on Effectiveness and the Future of Tiriti Training

Across the interviews, training providers consistently described Tiriti education as a relational rather than informational process. Instead of viewing learning as the transmission of historical facts, they emphasised whakawhanaungatanga, critical reflection, and experiential engagement as the mechanisms through which participants would begin to reconsider their professional responsibilities.

While described as a life-long, aspirational and enriching journey, Tiriti training offers the opportunity to be transformative. The framework provides for this in its relational intent beginning with the coming together of two peoples, Māori and non-Māori and extending into other relational areas, i.e., governance rights for the Crown and an obligation to uphold and protect Māori authority and rights of citizenship. These are not just aspirational; they are foundational requirements. When TP1 talked about the beneficial relationship established with Beattie and Tamatea, she was describing what a transformative Tiriti relationship should look like. It was not just about sharing information but effecting change.

All trainers shared similar credentials in terms of lived experiences, both personal and professional. They were all active researchers whose personal and professional background and ideologies led them to this work with some more than others. For example, TP1 had been working as a counsellor at the University of Waikato. She identified a gap in understanding te

Tiriti o Waitangi (te Tiriti), so began her journey into teaching te Tiriti. TP3 said she had worked for the most socially deprived people in a community in Hamilton. It was one of the reasons she enrolled in a law degree, so that she could become a lawyer and be a voice for her people.

As well as offering the potential to increase knowledge, Tiriti training also gave graduate students employment opportunities. TP1 was always looking to recruit graduate students in employment and encouraged them to welcome every question and use it as a critical analysis session (TP1, 2024). In this sense, then, Te Tiriti was a training ground for staff, students and facilitators (internal and external to the Waikato District Health Board/Te Whatu Ora). For the future of teaching the future generation, TP4 believed that Tiriti training offered opportunities to learn, something denied to those of us through the earlier education system where learning about other countries was more important than learning about what had happened in your own country.

Clear Intentions (Active and Direct)

There is little doubt about the intentions behind the creation of both Te Ara Tōtika and the Public Health and Rautaki training. These training programmes aimed to embed te Tiriti obligations and contribute to eliminating health inequities by shifting health professionals' mindsets, addressing systemic bias, and fostering culturally safe care. The content of the training included knowledge of te Tiriti obligations while case studies and local stories highlighted culturally safe care practices.

The trainers believed that there were genuine commitments in various areas of health to improving the health outcomes of Māori. The fact that the Te Ara Tōtika and its forerunner programme was allowed to continue for almost 30 years, was testament to that commitment. But the real evidence of just how effective the training was in meeting the goals came through participant feedback. As TP1 said;

"I always get a bit of a buzz from people who feel that they've learnt and tell you what they've learnt and feel incredibly grateful that you've been part of their journey towards learning."

The trainers were aware they were not, nor did they pretend to be the source of all knowledge. Participants were encouraged to do their own research and in my interviews with participants, they talked about steps taken to extend that learning beyond the training. These ranged from enrolling in te reo classes to reading extensively about colonisation and its impacts, to working in local Māori communities (see Chapter Five for more discussions). The PHR workshop on Pākehā privilege forced participants to confront their own bias's (unconscious or otherwise) and while it was uncomfortable for some it gave participants an insight into how their actions and inactions could be construed as racist or biased. Participants were equipped with the knowledge and skills to deal with these.

Unclear Intentions

When thinking about the future of te Tiriti o Waitangi and Treaty of Waitangi training, trainers expressed hope that the training would continue. However, citing the recent action to disestablish Te Aka Whaiora, the introduction of a Tiriti principles Bill and other policy and legislative changes that side-lined or attempted to eliminate references to te Tiriti, TP3 believed it was less likely that kanohi-ki-te-kanohi Tiriti training would continue. Instead, she believed the government would look to see how savings can be made – "…*and when they talk about saving money, I think they're going to look at what is spent on Māori and will stop funding any programmes that are considered "race-based".*

TP2 echoed similar concerns about the future of Tiriti training. While working in health services, TP2 noted that the Tiriti work had gone quiet. Her impression of what was occurring was that staff were not to put too much emphasis on Tiriti into documents anymore, saying:

I think it has gone to ground…I think what the government has done is given a licence to the dominant way of working and to exclude Tiriti. I think there's been permission to not have to deal with Tiriti and it is probably the main barrier as to why we are not being asked to do more training at the moment because it's fallen off the agenda.

The changes that were proposed by the Labour Government following the introduction of the Pae Ora (Healthy Futures) Act, 2022 had the potential to be transformational. The trainers saw real value in what the changes were looking to address, namely systemic and structural issues. As TP2 noted:

"*I think the opportunities in Te Whatu Ora were immense…some of the complexities of the health system and all the layers and the sheer numbers of people make any sort of transformational process really tricky*."

One of those tricky situations was the complexity of trying to maintain relationships with Māori and their communities set up under Te Whatu Ora and Te Aka Whaiora. TP2 said that those had gone a bit underground, but because of the importance of those relationships they were reluctant to let them go. So, they devised workaround situations; instead of talking about te Tiriti, the discussions were framed around achieving Pae Ora.

Other policy changes were of equal concern. A prime example was the government's policy mandate that public agencies must justify targeting services using ethnic identity and show that ethnicity is not merely being used as a proxy for need (Cabinet Office, 2024). The arguments for and against this policy were debated in Parliament and in the media. But the statistics are clear: those who live in high deprivation areas, who suffer the worst health outcomes are Māori. As argued by TP2, even if one were to remove ethnicity from the picture, Māori would still be more worse off than non-Māori. As TP1 said:

I think health reforms are one thing, but as long as our people still make up the figures that die earlier, have least access to treatment…then there is always going to be a need for training, no matter what the policy reforms.

TP1 looked forward to the day when there would not be any need for this type of training because it would be a successful outcome, but she did not see this coming to fruition in our lifetime. Nevertheless, she believed that the growing number of migrants picking up health positions might see them a lot more receptive to Tiriti training as they have come with their own experiences of colonisation. TP1 also had high hopes for Te Aka Whaiora and felt sad that the coalition government acted in the way they did in what she believed was an undemocratic process without putting something in place so that everyone was very clear on what the next move would be. She acknowledged the cases before the Waitangi Tribunal on addressing health issues and thought that was a step forward. While it is the unconscionable intentions of government that has created uncertainty with trainers about the future of Tiriti training, what is clear is that no matter what the policy reforms are, Māori will continue to feature in disproportionate numbers when it comes to iniquitous health outcomes and because of that, TP1 believes that there will always be that call for training and to do better by Māori.

Summary

This chapter captures the voices of the Training Providers who delivered kanohi-ki-te-kanohi training to health service staff. It sought to ascertain how those programmes came into being by exploring the origins, purpose, vision and institutional drivers of the programmes. An exploration of the programmes content and pedagogical approaches gave insight into what educational philosophy informed the programmes. The chapter then turned to consider what constrained transformative Tiriti education. Politics, resourcing issues, health reforms and loss of Māori leadership were contributing factors to a shift in Tiriti training that saw the

end of the two kanohi ki te kanohi training programmes. A transformative Tiriti education in the future will require genuine commitment to improving equity and by doing so, honouring Tiriti obligations.

Chapter 7: Discussion and Conclusion

This chapter synthesises and describes the findings of the study in relation to the research questions outlined in Chapter One, drawing together empirical studies from the online Tikanga Best Practice (TBP) training evaluation, the Te Ara Totika (TAT) survey, the Public Health and Rautaki (PHR) Critical Tiriti Analysis (CTA) workshop, and interviews with participants and training providers. Rather than addressing each research question in isolation, the discussion integrates them thematically to examine how te Tiriti o Waitangi training prepares health professionals to honour their Tiriti responsibilities in ways that contribute to improved health equity for Māori. The findings are situated within Kaupapa Māori theory, Critical Tiriti Analysis, and relevant international scholarship to show how training both enables and constrains the enactment of Tiriti responsibilities in practice. The chapter then considers the significance of these findings for theory, policy, and applied settings, before addressing strengths and limitations, future directions and concluding reflections on the future of te Tiriti training in public health.

7.1 Training effectiveness: Transformation

In Chapters 4-6, my findings indicate that te Tiriti o Waitangi training was consistently experienced by participants as meaningful, affirming, and, in many cases, transformative. Participants described increased awareness of Māori histories, Māori values, a strong appreciation for structured, contextualised learning and a clear desire for local Māori relevance and applied models. There is also evidence that training prompts reflections as part of personal development and can elicit emotional responses such as shame, discomfort, and defensiveness. These findings align with international and local literature that suggests well-designed Indigenous health and cultural safety training can enhance awareness, confidence, and critical reflexivity among health professionals (Curtis et al., 2019, 2025; Browne et al.,

2016; Mohamed et al., 2024). Equally it supports Aotearoa-based scholarship that frames Tiriti education as a means of revealing, rather than obscuring, the structural roots of inequity (Came et al., 2021).

Framing Tiriti education as a process that reveals structural roots of inequity shifts attention away from individual attitudes alone and toward the enduring effects of colonisation, institutional racism, and Crown decision-making. As Reid, Cormack, and Paine (2019) argue, racism in Aotearoa's health system is not accidental but is produced through historical and contemporary structures that privilege Pākehā norms, governance, and knowledge systems. Similarly, Hamley et al.'s (2004) Critical Tiriti Analysis of a university Treaty statement demonstrates how institutional commitments can symbolically acknowledge te Tiriti while leaving intact the very arrangements that reproduce inequity. Within this framing, increases in participants' awareness, confidence, and reflexivity are significant not because they reflect personal growth alone, but because they indicate an emerging capacity to recognise and question the structural conditions shaping Māori health outcomes and Crown-Māori relations.

At the same time, participant reflections revealed that increased understanding did not always translate into confidence about how Tiriti knowledge could be enacted in everyday practice. While many participants described enhanced awareness of Māori worldviews and inequities, they also expressed uncertainty about what meaningful (decolonial) action could look like within Crown organisations that privilege western norms. The findings also reinforce a critical and well-established limitation identified across the literature: increased awareness and confidence do not, on their own, guarantee sustained behavioural change or structural transformation. Structural constraints, including time pressures, institutional hierarchies, inconsistent leadership support, and unclear accountability mechanisms - frequently limited the translation of learning into action.

A CTA framework highlights how this tension reflects a recurring pattern in Tiriti training, where emphasis is placed on individual cognitive learning while structural enablement, such as organisational authority, accountability, and system-level support, is insufficiently addressed. As Kidd et al. (2022; 2025) argue, training that is not accompanied by institutional accountability risks reinforcing individualised responsibility while leaving systemic power relations intact.

The way that training was delivered also shaped participants' experiences in other significant ways. Kanohi-ki-te-kanohi components offered opportunities for discussion, and relational approaches to learning and were frequently identified as enablers of engagement and reflection, particularly where participants felt supported to sit with the facilitators and colleagues to break down their discomfort. Conversely, comments linked to disrupted delivery conditions, such as the cyber-attack affecting early TAT workshops, suggest that contextual constraints, rather than content quality, influenced participants' assessments of effectiveness. This finding reinforces the need to distinguish between pedagogical design and the structural conditions within which training is delivered. This distinction is frequently underdeveloped in evaluation literature, which tends to attribute outcomes to training quality without sufficient attention to organisational context (Kirkpatrick & Kirkpatrick, 2006; Reeves et al., 2013; Cram, 2014).

In this study, te Tiriti training often functioned as a site of critical consciousness-raising, but participants were rarely positioned with the authority or institutional mandate to act on that learning in ways that meaningfully redistributed power. As a result, responsibility for honouring te Tiriti risked being individualised, rather than located within Crown obligations and organisational structures. This responsibility is not a failure of training per se, but rather a reflection of the limits of training when it is not aligned with system-level

reform. From a Kaupapa Māori perspective, transformation is relational, collective, and structural, not merely cognitive or individual (Smith, 1997; Pihama et al., 2019).

7.2 Te Tiriti as a Living, Transformative Framework

A central contribution of this study lies in how te Tiriti o Waitangi is positioned, not as an historical reference point or compliance instrument, but as a living, relational framework that continues to shape contemporary health responsibilities. Across the training programmes examined, te Tiriti was variously framed as a set of principles, a foundation for equity, and a guide for professional conduct. However, participants' experiences revealed ongoing tension between principles-based interpretations and Tiriti-centric approaches grounded in the Māori text, intent, and relational obligations.

Māori scholars have long critiqued the Crown's reliance on Treaty "principles" as a mechanism that dilutes tino rangatiratanga and recentres Crown authority (Mikaere, 2011; Jackson, 2018). Came et al., (2023) note the debates that have continued about the meaning of te Tiriti and various principles-based interpretations, arguing that "te Tiriti o Waitangi, as distinct from its principles, provides a potentially powerful policy platform to address racism and the burden of Māori health injustices and inequities" (p. 4). CTA was developed to offer a clear pathway towards commitment to te Tiriti. Came et al. (2023), argued that health policy was poorly aligned with te Tiriti and that a Tiriti-compliant health sector requires explicit alignment across legislation, policy, standards, and practice, not discretionary or interpretive application (Came et al., 2021). Nor does it need abstract principles.

The findings of this study suggest that where training remained anchored in abstract principles without explicit attention to power, governance, and accountability, its capacity to disrupt entrenched inequities was constrained. Conversely, training components that foregrounded relationality, historical truth-telling, and Māori knowledge systems were more likely to prompt deep reflection and a sense of ethical responsibility among participants. This

aligns with Curtis et al.'s (2025) argument that cultural safety requires an explicit focus on power relations, institutional racism, and Indigenous self-determination, rather than cultural awareness or competence alone. Participants' reflections indicate that when te Tiriti is taught as a living framework with contemporary implications, it can act as a catalyst for both personal and organisational reconsideration of roles, responsibilities, and relationships.

Importantly, this study also highlights the fragility of equity gains within volatile political and policy environments. In Aotearoa, te Tiriti is often understood as providing a stronger foundation, recognised through legislation, jurisprudence, and Waitangi Tribunal findings. Yet the current Pae Ora Amendment Bill underscores that Tiriti-based commitments remain politically contested rather than secure. From a CTA perspective, this does not weaken the claim that te Tiriti functions as a living, transformative framework; rather, it affirms it. Unlike contexts where equity initiatives can simply be withdrawn, challenges to Tiriti obligations in Aotearoa occur within an ongoing constitutional relationship that Māori continue to assert, reinterpret, and defend (Mutu, 2010; Mikaere, 2011; Turei et al., 2024; Edmonds et al., 2025). Te Tiriti does not guarantee protection from rollback, but it fundamentally reshapes the terrain of struggle, providing normative, legal, and ethical resources through which training, policy, and institutional accountability can be contested and re-imagined over time.

Recent rollbacks of DEI-related policies and research funding in the United States of America demonstrate how gains in awareness and capability can be reversed or rapidly dismantled when equity is framed as a discretionary policy choice lacking legislative protection and institutional commitment (Ng et al., 2025). This study contends that te Tiriti training holds transformative potential precisely because te Tiriti is a living framework that affirms Māori self-determination and Crown accountability and is always speaking (Tawhai and Gray-Sharp, 2011). However, this potential is realised only when training is aligned with

Tiriti-consistent governance, legislation, and institutional practice and positions health professionals not merely as learners, but as actors within a system accountable to Māori.

7.3 Kaupapa Māori and Critical Tiriti Analysis

This study demonstrates that evaluating te Tiriti o Waitangi training through conventional measures of effectiveness, such as post-training confidence, satisfaction, or self-reported understanding, provides only a partial account of "impact". While participants across the TBP, TAT, and CTA datasets frequently reported increased awareness and understanding, a Kaupapa Māori and Critical Tiriti Analysis (CTA) lens cautions against treating these outcomes as the sole evidence of transformation. Within both frameworks, learning is understood as relational, contextual, and ongoing, rather than discrete or individualised (Smith, L, 2012; Pihama, 2012; Came et al., 2020). In this study, this reframing shaped both how evidence was generated and how it was interpreted. I approached the interviews with workshop participants and trainers in ways that prioritised relational engagement, participant control, and narrative depth, reflecting Kaupapa Māori commitments to kanohi-ki-te-kanohi dialogue, whakawhanaungatanga, and respect for lived experience as a form of knowledge. Extending this approach, future Tiriti training and its evaluation would be strengthened through methods such as wānanga-based learning, marae-based delivery, and embodied engagement with tikanga practices, including pōhiri, which enable learning and evaluation to occur within Māori epistemological and relational contexts rather than abstracted institutional settings.

From a Kaupapa Māori perspective, knowledge acquisition is meaningful only insofar as it supports collective wellbeing, rangatiratanga, and relational accountability (Smith, G, 1997; Pihama, Cram & Walker, 2002; Durie, 2011). Similarly, CTA foregrounds the need to interrogate how power, institutional structures, and Crown obligations shape whether Tiriti commitments are enacted in practice. Taken together, these frameworks challenge evaluation

approaches that locate effectiveness solely within individual learners, instead directing attention to the broader systems in which learning is expected to operate.

The findings also suggest that awareness-raising, while necessary, is insufficient as an evaluative endpoint. When training evaluations fail to account for organisational conditions, leadership responsibility, and structural support, they risk overstating effectiveness and obscuring the Crown's obligations under te Tiriti. In this way, KM and CTA do not merely offer alternative analytical tools; they reframe what counts as evidence, shifting the focus from individual attitudinal change to institutional readiness and accountability. Awareness raising a preliminary part of improving one's ability to embody cultural safety; however, engagement in training on an ongoing basis is needed to benefit learning and make transformational changes.

Reframing evaluation in this way makes visible a critical insight: the effectiveness of te Tiriti training cannot be meaningfully assessed without attention to the organisational contexts in which that training is situated. If evidence of impact extends beyond individual awareness to include institutional conditions, then questions of leadership, resourcing, policy alignment, and accountability, all concerns raised by participants across the data, become central to understanding how, and whether, training contributes to equity in practice. Relational and collective learning enables a system approach, and provides reflexivity, rather than individualised. This approach is consistent with principles such as āko - reciprocal relational learning where everyone shares and learns from each other; whānau - responsibility and collective support; kaupapa – collective vision and; āta - nurturing respectful relationships. The following section discusses the organisational enablers and constraints that shape the translation of Tiriti learning into action within public health.

7.4 Enablers, Constraints and Institutional Accountability

The effectiveness of Tiriti o Waitangi training cannot be understood in isolation from the organisational and political contexts in which it is delivered. Training occurs within systems that are shaped by legislative reform, institutional restructuring, leadership priorities, and broader sociopolitical dynamics. As such, the impact of training is contingent not only on pedagogical quality but also on the stability, coherence, and accountability of the organisations that commission and host it.

7.4.1 Training Within Unstable and Reforming Systems.

The findings of this research are situated within a period of significant health sector reform in Aotearoa, including the disestablishment of District Health Boards, the establishment of Te Whatu Ora, and shifting interpretations of te Tiriti obligations following the Hauora Report. Participants' experiences of training were therefore embedded within environments marked by uncertainty, role changes, and evolving institutional priorities. This research was conducted during a time of considerable transformation in New Zealand's health system. The disestablishment of the twenty District Health Boards (DHB's) and the introduction of Te Whatu Ora under the Pae Ora (Health Futures) Act 2022, brought about substantial organisational change. The creation and later dismantling of Te Aka Whaiora, an independent agency set up alongside Te Whatu Ora designed to address Māori health inequity, further illustrate the political instability of institutional structures. Parallels can be drawn between that act and the inconsistencies in how te Tiriti o Waitangi training has been delivered across Te Whatu Ora, Waikato. The organisational shifts significantly impacted the delivery of te Tiriti training, culminating in the discontinuation of the two kanohi-ki-te-kanohi programmes in 2024, shortly after the interviews were conducted for this research.

Institutional instability shaped how training was received and enacted. While participants frequently reported increased awareness and confidence, the translation of learning into practice was uneven and often constrained by organisational pressures, competing demands, and unclear accountability structures. These findings align with international evidence that training delivered during periods of systemic change may struggle to generate sustained impact without accompanying organisational alignment.

7.4.2 Enablers of training effectiveness.

Despite these constraints, the study identified several organisational enablers that supported training effectiveness. These included Māori leadership and governance involvement, access to culturally grounded facilitation, and institutional support for learning spaces that acknowledged discomfort, reflection, and relational engagement. Where training was led by Māori or supported by Māori units, learning and development teams, or leadership endorsement, participants were more likely to describe training as meaningful and relevant to their roles. Participants were provided with the opportunity to engage and ask questions on topics pertinent to te Tiriti: colonialism, impacts of colonial policies, Indigenous histories, concepts of systemic racism toward Māori and other Indigenous peoples in healthcare systems, cultural humility and respect, and culturally safe practices.

International literature, highlight how equipping primary health care professionals with tools to raise awareness of systemic racism and unconscious bias embedded in healthcare systems enable self-reflection of their own personal actions and bias (Webb et al., 2023). Importantly, these enablers operated at the organisational level rather than solely at the level of individual motivation. This reinforces the argument that training effectiveness is enhanced when organisations actively create conditions that legitimise Tiriti-centred learning, rather than treating it as an optional or peripheral activity.

7.4.3 Fragility, and the limits of training.

At the same time, the study revealed significant organisational constraints. High staff turnover because of reform and restructuring; limited follow-up mechanisms evidenced in the lack of response to participants enquiries in evaluations (for example, requests for scaffolded learning, training in pōhiri processes, and marae-based learning), and the absence of embedded accountability structures, undermined the durability of training outcomes. In some cases, institutional knowledge about programme design and intent had been lost due to restructuring, limiting the capacity to evaluate or refine training over time. Te Whatu Ora's Health Workforce 2023/2024 Report (Te Whatu Ora, 2023) reveals that the health system is under considerable stress, as a result of high staff turnover. This has placed considerable financial stress on the organisation resulting in programme discontinuation of kanohi-ki-te-kanohi training. Programme discontinuation can also be attributed to reoriented organisational priorities, because of government removal of funding for te Tiriti o Waitangi training.

These findings illustrate a key limitation of training-led approaches to equity: training alone cannot compensate for fragile systems; systems that operate within shifting and often uncertain institutional and political conditions. Where organisational commitment is inconsistent or vulnerable to political change, offering Tiriti training to staff risks becoming *symbolic* rather than *transformative* as learners are asked to carry responsibilities that are not structurally supported, resourced, or enacted at the institutional level. This finding supports broader critiques within the literature that locate responsibility for equity not with individual practitioners, but with institutions themselves (Ng et al., 2025).

Changes associated with the Pae Ora (Healthy Futures) Act 2022 reduced dedicated provisions for Tiriti training, reflecting how political shifts can materially affect institutional support for equity initiatives. Yet, unlike contexts where training can be dismantled without

resistance, the current moment in Aotearoa also reveals active contestation and leadership from Māori health leaders, community advocates, and Treaty-aligned organisations. Prominent leaders such as Lady Tureiti Moxon, and scholars and facilitators including Came et al. (2023), Edmonds et al. (2025), Kidd et al. (2022), Māni Dunlop, and Professor Papaarangi Reid (1999), have been visible in their critique of policy rollback and in advocating for the centrality of te Tiriti in health system transformation. Equally, community-based organisations continue to lead and host Tiriti-informed training that centres mātauranga Māori, tino rangatiratanga, and kaupapa Māori pedagogy. Through a Critical Tiriti Analysis lens, these forms of resistance indicate that Tiriti commitments are not only legally contestable, but actively contested, anchored in relational practice and ongoing assertion of Māori aspirations. This suggests that, while training gains are fragile in unstable environments, transformative potential exists where collective leadership, activism, and sustained Māori engagement shape institutional responses rather than leave them to political whim.

Similar tensions have been identified across settler-colonial nations where Indigenous equity initiatives remain vulnerable to political change. International experience demonstrates that training unsupported by legislative protection, Indigenous governance and institutional accountability is readily weakened or discontinued. However, Aotearoa differs because Te Tiriti provides an enduring constitutional relationship that continues to shape Māori assertions of tino rangatiratanga and Crown accountability.

7.5 The unrealised impact of Tiriti training on Māori health equity

Te Tiriti o Waitangi is widely recognised across both academic and governmental literature as the foundational or founding document of Aotearoa New Zealand. The Cabinet Manual describes it as a “founding document of government in New Zealand” (Department

of the Prime Minister and Cabinet (2023). Constitutional scholars including Orange (1987); Matthew Palmer (2008); Geoffrey Palmer & Butler (2016); Waitangi Tribunal (2014); Jackson (2016) and, Came et al. (2017), similarly position Te Tiriti as a foundational constitutional agreement shaping the relationship between Māori and the Crown. Recognition of Te Tiriti alone is insufficient to achieve equity.

While Te Tiriti o Waitangi provides the foundational framework for equitable relationships between Māori and the Crown, the New Zealand government has consistently breached te Tiriti (Came et al, 2020a) and the persistent Māori health inequities demonstrate that the commitments promised in te Tiriti have not been fully realised. Scholars have long argued that such inequities are not solely attributable to socioeconomic disadvantage or individual level factors but are fundamentally shaped by institutional and structural racism embedded within health systems (Talamaivao et al, 2020; Reid, Cormack and Paine, 2019; Curtis et al, 2019, 2022; Came et al, 2017, 2020a). Racism influences the distribution of power, resources, and opportunities, while also shaping healthcare experiences and outcomes for Māori. Consequently, achieving Māori health equity requires more than recognition of Te Tiriti principles; it requires active disruption of the colonial and racist structures that continue to undermine Tiriti obligations.

This study set out to critically examine the effectiveness of Tiriti-based training in health services, and to explore whether that training equips staff to understand and act on their Tiriti-based responsibilities in ways that truly support equity (see discussion at Chapter 1.5). Tiriti education and training have been promoted as mechanisms for increasing knowledge of Te Tiriti obligations and supporting anti-racist practice within the health workforce (Came et al, 2020a). However, the findings of this study suggest that the potential of Tiriti training to contribute to Māori health equity remains only partially realised. The findings suggest that Tiriti training may increase awareness and understanding of Te Tiriti,

colonisation and its health impacts; however, increased knowledge alone is unlikely to influence health equity without transforming the structures that generate inequities for example, the organisational structures, accountability mechanisms, resource allocation, and shared decision-making with Māori.

The trainer interviews demonstrated that effective Tiriti education did not emerge from curriculum design alone, but from sustained relational work across organisational boundaries. Despite this, the organisation moved to an online delivery of Tiriti training, with no clear evidence that this type of delivery of training is effective, let alone evidence of changed practice or improved equity outcomes. The *Equity Report, Rapua Te Ara Matua* revealed staggering inequity gaps for Māori in healthcare (Kronast, 2021, March 31). The Waikato District Health Board undertook to address these inequity gaps through systems and structural changes, Māori-led approaches, long-term funding, resource provision and evaluation (Waikato District Health Board, 2021). Barely one year later, District Health Boards were disestablished, replaced by Te Whatu Ora (Health New Zealand) under the Pae Ora (Healthy Futures) Act 2022. Te Whatu Ora clearly required its staff to be trained in meeting its obligations to Māori in accordance with the Pae Ora (Healthy Futures) Act 2022. However, participant interviews reveal that efforts to implement Māori led kanohi ki te kanohi training programmes, aimed at improving health equity for Māori, was met with resistance and a lack of leadership support. Despite evidence that sustained relational work contributes to effective Tiriti education, Te Whatu Ora cancelled the kanohi ki te kanohi workshops. It remains unclear if the online training equips staff to understand and act on their Tiriti-based responsibilities in ways that truly support equity. Described by many participants as a tick-box exercise with results that can be manipulated to reveal a correct answer, it is doubtful that such a system is effective. Relying on superficial feedback is not proof of

effectiveness; nor is it proof of contributing to eliminating racism, a key determinant of health inequities.

This highlights an important issue in the accountability gap; organisations require training but do not require evidence of changed practice or improved equity outcomes. There are no clear guidelines to show how effectiveness is evaluated, how outcomes are measured beyond participant satisfaction or whether Māori health outcomes are improving. Furthermore, when responsibility for achieving equity is placed primarily on individual practitioners rather than the institutions within which they work, organisations risk reproducing the very inequities Tiriti training seeks to address. Workforce education is an essential component of change, but it cannot substitute for organisational commitment, structural accountability, and institutional transformation. The findings of this research show that when that learning cannot be enacted, its potential impact remains unrealised.

7.6 Implications for Research

This study makes several contributions to research on te Tiriti o Waitangi training, health equity, and evaluation methodologies, with implications for future scholarly inquiry across these fields. By integrating Kaupapa Māori principles with Critical Tiriti Analysis, the study extends existing approaches to analysing Tiriti obligations beyond policy texts and into the domain of workforce development and training evaluation.

7.6.1 Extending Critical Tiriti Analysis into Training Evaluation.

CTA has most commonly been applied to the analysis of legislation, policy documents, and institutional discourses to assess the extent to which Tiriti obligations are recognised, marginalised, or reframed within Crown activity (Came et al., 2020a; 2023, Kidd et al., 2022). This study demonstrates the value of extending CTA into the evaluation of training programmes, particularly in interrogating how evidence of "effectiveness" is

constructed and mobilised or simply ignored. In applying CTA to evaluating training programmes or in this case, to examining participants experiences of Tiriti training, the study showed how this methodological approach can provide an evaluative Tiriti framework that is grounded in the Māori text of te Tiriti o Waitangi. This study sought to examine to what extent the training programmes were upholding te Tiriti o Waitangi. It moved from what is written in policy, legislation and institutional discourse to capture participants lived experience of Tiriti training, including how te Tiriti is interpreted, enacted, or resisted in practice. Suggestions for strengthening practise included examining the different meanings attributed to te Tiriti and the Treaty, with greater understanding of the Preamble, utilising Kaupapa Māori initiatives, cultural safety including cultural responsibilities, enduring relationships, implementing scaffolded learning workshops and regular training for health services and a number of organisational responsibilities.

Interpreting te Tiriti and the Treaty: Understanding the Preamble

Te Tiriti and the Treaty are not the same documents and therefore should not be used interchangeably as though they are. Even though the online training positions these two documents as both legitimate, it is the Treaty that the government privileges over te Tiriti. The effect of this is that Māori authority is subservient to Crown authority, a situation not envisaged by te Tiriti. The Preamble is integral to any discussion about te Tiriti. It sets out the broader context and the intent behind te Tiriti, however, most participants were unable to make this link. Future Tiriti training needs to interrogate this intent more deeply. Te Whatu Ora must embed te Tiriti in their policies, practices and training, recognising Māori authority as sovereign partners including specific attention to the Preamble.

Kaupapa Māori initiatives

Kaupapa Māori approaches in Tiriti training provide greater opportunities for participants to understand their Tiriti obligations and how to make tangible improvements,

such as applying learning to healthcare practices. Participants shared how they gained greater understanding because of examples such as, learning how to reflect on and apply cultural values and responses to work, and how to support Māori aspirations for tino rangatiratanga. Te Whatu Ora has a Tiriti obligation to ensure that health services are culturally appropriate (Waitangi Tribunal, 2023). A Kaupapa Māori approach is the only approach that will make that obligation more achievable.

Cultural safety and cultural responsibilities

Responsibility for cultural safety and cultural responsibilities are Crown responsibilities (Waitangi Tribunal, 2023). As an agent of the Crown, this responsibility lies with Te Whatu Ora. Māori who are expected to carry out cultural responsibilities or who are not expected to but are often called upon to do so, should be fully supported. Te Whatu Ora must provide leadership support to all its staff but especially to Māori who find themselves in the position of carrying out cultural duties. This obligation extends to fiscal support.

Enduring relationships and scaffolded learning

The success of training programmes was attributed to enduring relationships rather than curriculum design, alone. The online Tiriti module delivered through the Ko Awatea eLearning platform is an introduction module; there is no ability to engage in discussions or interrogate concepts and information. A Kaupapa Māori-led kanohi ki te kanohi delivery has the greater potential to address concerns raised by participants in learning and is recommended for adoption. Furthermore, Te Whatu Ora should consider the marae style environment as a more appropriate environment to deliver some if not all the training as such an environment ensures cultural concepts of tapu, noa, manaakitanga, whanaungatanga and utu are strictly adhered to. This initiative would require establishing relationships that have the potential to be enduring and meaningful.

Scaffolded learning and regular training for health services.

The scaffolded learning suggestion applies to all health services within Te Whatu Ora but proposes that these are a mandatory part of staff's development similar to the professional standards in the NZ College of Public Health Medicine where staff are required to demonstrate how they are embedding te Tiriti principles in their practice and reflecting on their application. It is argued that this will address concerns raised by participants regarding the lack of regular training for hospital staff. To date, efforts to address equity and health disparities and improve cultural competency and cultural safety has seen little if any improvement in better health outcomes for Māori.

Organisational responsibilities

Organisational accountability, monitoring and measuring improvements in Māori health outcomes, and racism were referenced, but not specifically discussed in detail in the section on strengthening practices. The reason for this is because they are discussed throughout various sections of this chapter, and because it has already been identified that Te Whatu Ora is responsible for ensuring these are addressed. These matters were also discussed in detail in the Hauora Report, meaning that Te Whatu Ora as the Crown agency responsible for all public health systems in Aotearoa is aware of the need to demonstrate and adhere to organisational accountability for equity, monitoring and measuring improvements and eliminating racism. Any reiteration of that will not strengthen what they already know; they simply must implement those in practice, through policy, legislation and training.

Nevertheless, the overall findings do show that evaluation instruments themselves can reproduce forms of symbolic compliance, reporting gains in awareness or confidence while leaving unexamined the structural and organisational conditions that constrain transformative change. From a CTA perspective, this highlights the importance of analysing not only training content and intent, but also the epistemological assumptions embedded in evaluation

practices, including what counts as evidence, whose knowledge is prioritised, and which outcomes are deemed measurable or legitimate. Future research could build on this approach by applying CTA to the design and interpretation of evaluation frameworks across other forms of Tiriti-related training and organisational development initiatives.

Māori final word

Scaffolded Kaupapa Māori-led training programmes were successful in bringing awareness to participants of their Tiriti obligations and for advancing tino rangatiratanga aspirations. The cancellation of those programmes has silenced Māori voices and rendered them invisible. For Māori voices to be heard and tino rangatiratanga to be realised, Kaupapa Māori-led scaffolded training programme must be reinstated. Māori must be fully controlling the narratives around how they are being represented in the training. Such training programmes must be fully supported including financial resourcing and shared decision-making.

7.6.2 Contributing empirical evidence to an under-researched field

Empirical research examining the effectiveness of te Tiriti o Waitangi training in the health sector remains limited (Huygens, 2016), particularly research that explores how training is experienced by participants, how learning is interpreted and enacted in practice, and how trainers conceptualise their pedagogical role within institutional constraints. This study contributes to addressing this gap through a triangulated design incorporating survey data, workshop evaluation, and qualitative interviews with participants and training providers.

By situating these findings within the context of significant health system reform, the study also demonstrates how Tiriti training operates within shifting legislative, organisational, and political environments. Future research could extend this work through longitudinal designs that examine how learning is sustained or eroded over time, comparative

studies across different regions or organisational contexts, and research that more directly examines the relationship between training, organisational change, and equity outcomes.

7.6.3 Methodological implications for equity-focused health research

Methodologically, this study illustrates the value of combining Kaupapa Māori research principles with CTA to produce research that is relationally grounded, reflexive, and attentive to power. Within both frameworks, learning and knowledge production are understood as contextual, relational, and ongoing, rather than discrete or individualised processes. This orientation challenges dominant evaluation paradigms that privilege decontextualised measures of individual competence or confidence.

The study also highlights the importance of reflexivity in research conducted within complex institutional settings, particularly where researchers occupy dual roles as trainers, practitioners, or insiders. Rather than treating positionality as a limitation to be eliminated, Kaupapa Māori research reframes reflexivity as a source of analytical depth, ethical accountability, and interpretive strength. Future research in this field would benefit from continued methodological innovation that centres Māori epistemologies, relational ethics, and collective outcomes in the design and evaluation of training and organisational change initiatives.

7.6.4 Implications for Policy, Political and Practice

The findings of this study have significant implications for how te Tiriti o Waitangi training is positioned within public health, particularly Te Whatu Ora. While training is often treated as an individual capability-building intervention, the evidence presented here suggest that its effectiveness is fundamentally shaped by institutional settings, leadership commitments, and policy alignment. Participants across the multiple training programmes demonstrated increased awareness and understanding; however, their capacity to enact Tiriti-

based practice was frequently constrained by organisational priorities, resource limitations, and unclear accountability structures.

7.6.5 Policy and Political Context

Te Tiriti training should not be conceptualised as a standalone compliance activity, but as one component of a broader system of institutional responsibility. Embedding Tiriti obligations within organisational policy frameworks – such as performance expectations, workforce development strategies (for example, staff recruitment and promotion), and service design standards – would have aligned training with the Crown's duties under te Tiriti o Waitangi and the Pae Ora Act (Healthy Futures) Act, 2022 (Pae Ora Act). The Pae Ora Act was designed to uphold the principles of te Tiriti o Waitangi; however, the Government has introduced the Healthy Futures (Pae Ora) Amendment Bill which seeks removal of Tiriti obligations, Kaupapa Māori services, cultural safety and responsiveness of services, mātauranga Māori, and Māori perspectives of services (see Chapter 1). The current situation is that the Bill has been referred to the Health Committee for consideration, and the committee has recommended that the bill be passed. At this time, it has not yet been formally passed by the Government (Ministry of Health, 2025). Without aligning training with Crown's obligations under te Tiriti, any training risks reinforcing individual responsibility while leaving structural inequities unchallenged.

7.6.6 Practice

In practice, aligning training with the Crown's duties under te Tiriti o Waitangi and the Pae Ora Act would have seen a shift from one-off training models toward sustained, scaffolded approaches that are supported by organisational leadership and resourcing. Participants' experiences highlight the importance of reinforcement, opportunities for application, and culturally grounded learning environments – conditions that cannot be created through training alone, least of all, a one-off e-learning module. For Te Whatu Ora,

this underscores the need to ensure that Tiriti training is integrated into organisational systems, supported by clear leadership mandates, and accompanied by mechanisms for accountability and evaluation that extend beyond learner self-report.

Importantly, these implications resonate with Kaupapa Māori and Critical Tiriti Analysis framework, which emphasise that equity-oriented change must be structurally supported and relationally enacted. Positioning te Tiriti training within a wider institutional ecology – rather than as an isolated educational intervention – offers a more coherent pathway for translating learning into enduring practice and for advancing equitable Crown-Māori relationships within the health sector.

The findings of this study also align closely with the concerns raised in the Hauora Report, which identified persistent institutional racism, fragmented accountability, and a failure to meaningfully honour te Tiriti o Waitangi across the health system. Despite structural reforms and the establishment of Te Whatu Ora, participants' experiences in this study suggest that many of the systemic conditions identified in the Hauora Report continue to shape how Tiriti obligations are understood and enacted in practice. In this study, participants described increased awareness and confidence following training, yet also noted organisational constraints, limited authority to act, and uncertainty about how Tiriti obligations, translated into decision-making within their roles. From a CTA perspective, this reflects the very conditions highlighted in the Hauora Report: systems that acknowledge Tiriti principles rhetorically while failing to embed them consistently across governance, policy, and operational practice. These findings reinforce the Hauora Report's warning that training alone cannot compensate for the absence of structural reform, Māori governance, and enforceable accountability mechanisms, conditions that continue to shape the limits of how Tiriti obligations are enacted in everyday health practice.

In this context, te Tiriti training emerges as a necessary but insufficient response to structural inequity. As highlighted already, regardless of increasing awareness and confidence through engagement in training programmes, participants capacity to translate learning into practice, is constrained by organisational priorities, unclear mandates and limited mechanisms for accountability. These findings reinforce the Hauora's Report's conclusions that equity cannot be achieved through individual goodwill alone, but requires systemic transformation supported by leadership, policy coherence, and institutional commitment.

For Te Whatu Ora, this underscores the importance of positioning Tiriti training within a broader framework of organisational accountability. Training initiatives must be aligned with governance expectations, workforce policies, and service delivery models that explicitly reflect te Tiriti principles and Māori aspirations for self-determination. Without such alignment, training risks functioning as a symbolic response to inequity rather than a catalyst for structural change.

From a Kaupapa Māori and Critical Tiriti Analysis perspective, the ongoing relevance of the Hauora Report highlights the need for evaluation frameworks that move beyond measuring individual learning outcomes toward assessing institutional responsiveness and transformation. In this sense, Tiriti training should be understood not as an endpoint, but as one lever within a wider system of Crown accountability and relational obligation in the health sector.

Taken together, the findings of this study reaffirm the enduring relevance of the Hauora Report's call for systemic accountability in the health sector. Despite significant structural reform, the experiences of participants and training providers suggest that the challenges identified in that report, particularly the gap between policy commitment and everyday practice, remain unresolved. By foregrounding the limits of training as a standalone

intervention and emphasising the need for institutional alignment, this study contributes evidence to ongoing efforts to realise equitable Crown-Māori relationships in health.

7.7 Strengths of the Research

A central strength of this study lies in its relational and ethical rigour; grounded in Kaupapa Māori theory and its application of Critical Tiriti Analysis across methodology, analysis, and interpretation. This approach ensured that te Tiriti o Waitangi was treated not as contextual background, but as an active evaluative framework shaping how evidence was understood and mobilised. The use of multiple data sources, including training evaluations, surveys, and interviews with participants and training providers, enabled methodological triangulation and strengthened the credibility of the findings. This design captured both breadth and depth, allowing patterns to be examined alongside lived experience.

Consistent with Kaupapa Māori research principles, the research did not rely on institutional access or professional authority alone. Even where data were already available, informed consent was sought from participants, reinforcing commitments to manaakitanga, accountability, and respect for participant autonomy. Engagement with Māori governance and advisory structures within Te Whatu Ora (previously Waikato District Health Board, including Te Puna Oranga) as well as working alongside health sector structures further strengthened the Treaty-aligned conduct of the research.

My positionality as a Māori researcher navigating dual roles as trainer and researcher represents an additional strength. Rather than being treated as a source of bias to be eliminated, this positionality was engaged reflexively and transparently, enabling culturally grounded interpretation, relational access, and ethical responsiveness. This approach aligns with Kaupapa Māori scholarship that recognises situated knowledge as a legitimate and

necessary foundation for research involving Māori, and in particular, relevance for Māori communities.

The study also makes a significant empirical contribution to an under-researched area. There is limited/no empirical research examining the effectiveness of te Tiriti o Waitangi training in the health sector, particularly research that captures how such training is experienced by participants, how it is interpreted and enacted in practice and conceptualised by those who design and deliver it. By drawing on mixed-methods evidence across multiple training contexts, this thesis fills an important gap in the literature.

The timing of the study represents a further strength. Conducted in the period following the Hauora Report and spanning major health reforms, the research captures Tiriti training within a shifting legislative and institutional landscape. This temporal positioning enables the study to illuminate how training operates amid evolving commitments to partnership, Māori voice, and equity, as well as emerging tensions and rollbacks in Tiriti-related policy settings. In this sense, the findings speak not only to training effectiveness, but also to the broader limits of training in the absence of sustained systemic change.

7.8 Limitations

Several limitations should be acknowledged. While the study draws on rich qualitative data, the number of interviews, particularly with training providers, was constrained by time and access, limiting the extent to which institutional perspectives could be compared across settings. Much of the quantitative data relied on self-reported measures of learning, confidence, and perceived impact. Although this is a recognised limitation in training evaluation literature, it nonetheless constrains the ability to draw conclusions about sustained behavioural change. The study did not include direct measures of patient or service-

level impacts. As such, the findings cannot establish a causal link between Tiriti training and improvements in health outcomes for Māori. This limitation reinforces the central argument of the thesis: that training alone cannot carry the burden of equity without complementary organisational and system-level reform.

The use of pre-existing evaluation tools for some training components also constrained the scope of analysis, particularly where survey questions did not account for participants' prior learning or experience discussed in Chapter 4 in the TBP evaluation survey. Research on learning and teaching consistently shows that new knowledge is more effectively acquired when it is connected to what learners already know, rather than presented as discrete or standalone (Ambrose et al., 2010). Without explicitly accounting for learners' prior understandings, training risks being experienced as fragmented, and evaluation data may conflate perceived effectiveness with pre-existing knowledge. The tool highlights a broader limitation in evaluating training effectiveness; without accounting for prior learning or aligning survey items more closely with taught content, post-training evaluations risk overstating effectiveness and obscuring where learning has genuinely occurred. This reflects broader challenges in evaluating Tiriti training rather than shortcomings of the study alone.

The study demonstrated how participant responses may also have been influenced by social desirability bias, whereby respondents sought to present themselves as engaged, culturally responsive learners or to affirm the perceived effectiveness of training. This may help explain why some participants rated learning related to pōhiri protocols positively, despite the absence of explicit content on this topic with the module. Participants may have sought to present themselves in a positive light to demonstrate the effectiveness of the training, which could explain why they did not question the item on pōhiri. While such responses can reflect not only individual bias, equally they demonstrate institutional and

cultural expectations placed on health workers to demonstrate alignment with Tiriti commitments, even where training content or organisational support is incomplete.

The research is also context-specific, grounded primarily within Te Whatu Ora (Waikato). While this limits generalisability, it enables a depth of analysis that is closely attuned to the realities of health sector reform in Aotearoa. Rather than a weakness, this contextual specificity offers insights that are highly relevant to policy and practice within similar institutional settings.

My dual roles as Māori researcher, trainer, and partial insider within the health system could represent a strength of the research; however, there are potential power dynamics that need to be considered. While this positioning enabled relational access and culturally grounded interpretation, it could be perceived in positivist research as introducing bias. This risk was mitigated through reflexive practice including regular conversation with supervisors, transparency in reporting, triangulation of data sources, and explicit engagement with Kaupapa Māori and Critical Tiriti Analysis frameworks. Institutional instability associated with health reforms, staff turnover, and programme changes constrained access to complete design and implementation information for some training components, particularly the e-learning module. While this limited the ability to fully analyse programme intent, it also revealed organisational fragility in training continuity and accountability, an important finding.

This study is also limited by its cross-sectional design, capturing participant perspectives at a single point in time following training. While this provides valuable insight into immediate reflections and perceived learning, it cannot assess how understandings, confidence, or practice evolve, or diminish, over time. A longitudinal approach could be useful in illustrating the development of individuals or groups across multiple time points and

would allow for the examination of how Tiriti learning is sustained, deepened, or constrained within organisational contexts.

A further limitation of the training, signposted in Chapter 4, was inconsistent assessment. As identified in the Tikanga Best Practice (TBP), Tiriti o Waitangi e-learning module, an evaluation question related to the inclusion of a survey item to assess learning about pōhiri protocols, despite this content not being explicitly taught within the module. Participant ratings in this area therefore cannot be assumed to reflect learning gained through the TBP module itself, but may instead draw on pre-existing knowledge, prior experience, or cultural familiarity with pōhiri practices. Additionally, this discrepancy could also be a result design limitation.

The findings also point to the limits of one-off or stand-alone training. While participants valued introductory learning, there was widespread recognition that sustained change requires reinforcement, leadership commitment, and integration into organisational systems. International evaluations, similarly, caution against "one-off" or symbolic training initiatives that raise awareness without embedding learning into organisational systems, policies, and governance structures (Paradies et al., 2014; Wang et al., 2024; Mohamed et al., 2024).

Finally, while the study demonstrates how training is experienced and interpreted, it was not designed to measure long-term behavioural change or health outcomes. Overall, these strengths and limitations highlight both the contribution of this study and the work that remains. They point toward a need for future research, policy development, and practice innovation that move beyond training as a discrete intervention and toward more enduring, Tiriti-centred systems of accountability in the health sector.

7.9 Future Directions for research, Policy and systems, and training design

Future research should examine the longer-term impacts of Tiriti training on professional practice, organisational behaviour, and service delivery. Longitudinal and mixed-methods studies would enable deeper understanding of how learning is sustained, or constrained, over time. There is also a need for research that integrates organisational and policy analysis with training evaluation, rather than treating training as an isolated intervention.

At a policy level, the findings underscore the need for Tiriti training to be embedded within clear legislative mandates, accountability mechanisms, and governance arrangements (Kidd et al., 2025). Without such alignment, training remains vulnerable to political change and institutional drift. Future policy work should therefore focus on how Tiriti obligations are operationalised across workforce development, leadership expectations, and performance frameworks within Te Whatu Ora.

For training providers, the study highlights the importance of scaffolded learning, contextual relevance, and alignment with organisational realities. Future training initiatives should move beyond one-off delivery models and be designed as part of coherent learning pathways that support reflection, application, and collective responsibility. Indigenous leadership and partnership must remain central to this work.

7.10 Future Directions for improved health outcomes

Tiriti training represents one potential mechanism through which health professionals and organisations can contribute to improved health outcomes for Māori, but its transformative potential depends upon the structures, relationships and accountabilities within which learning is enacted.

Racism is a determinant of health inequities. It is produced through structures that privilege Pakeha norms, governance and knowledge systems (Reid, Cormack and Paine (see

page 187). It influences the distribution of power, resources, and opportunities, while also shaping healthcare experiences and outcomes for Māori. Inequities are not solely shaped by socioeconomic disadvantage or individual level factors but by institutional and structural racism embedded within the health system; a health system that privileges western norms (Talamaivao et al., 2020). The question is, what would meaningful decolonial action look like within Crown organisations that privilege western norms?

Te Tiriti reveals structural roots of inequity (Came et al, 2021) and therefore, positioning Te Tiriti as a living relational framework that continues to shape contemporary health responsibilities, offers the potential to disrupt entrenched power, governance, and accountability. As the findings show, training that foregrounds relationality, historical truth-telling, and Māori knowledge systems were more likely to prompt deep reflection and a sense of ethical responsibilities. From this perspective, the focus moves beyond cultural competence to cultural safety. As Curtis et al. (2025) argue, cultural safety requires an explicit focus on power relations, institutional racism and Indigenous self-determination. When te Tiriti is taught as a living framework with contemporary implications, it can act as a catalyst for personal and organisational reconsiderations of roles, responsibilities, and relationships.

This research highlighted areas that frequently limit the translation of learning into action; structural constraints including time pressures, institutional hierarchies, inconsistent leadership support, and unclear accountability mechanisms. As the findings show, training that is not accompanied by institutional accountability risks reinforcing responsibility at individual level while leaving systemic power relations intact (Kidd et al., 2022, 2025).

Institutional accountability requires clear evidence of changed practice or improved equity outcomes. The findings show that training effectiveness is enhanced when

organisations actively create conditions that legitimise Tiriti-centred learning and equipping staff with the tools to raise awareness of systemic racism and unconscious bias. There must be clear guidelines, monitoring and measuring for changes in practice, and in health outcomes. Te Tiriti offers the best chance for Pae Ora and should not be treated as peripheral or optional.

The Hauora Report were provided with examples of community-based organisations that continue to lead and host Tiriti-informed training that centres matauranga Māori, tino rangatiratanga and Kaupapa Māori pedagogy. There are similar examples in many other communities who provide Hauora Māori services, including in our own communities in Waikato Tainui. The Waikato District Health Board were encouraged to learn from those examples to help the organisation effect change.

To effect change, requires collective leadership, activism, and sustained Māori engagement to shape institutional responses rather than leave them to political whim. The latest move by the coalition government in passing the Healthy Futures (Pae Ora) Amendment Act 2026 adjusting how the Crown's obligations are framed, provide evidence that te Tiriti does not guarantee protection. Nevertheless, te Tiriti can fundamentally reshape the terrain of struggle through which training, policy, and institutional accountability can be contested and re-imagined over time. If training is aligned with Tiriti-consistent governance, legislation, and institutional practice, there is potential for transformative outcomes, including the potential for improved health outcomes.

Concluding Comments

What kind of change is possible through Tiriti training, under what conditions, and what must shift beyond training for equity to be realised?

This thesis set out to examine how te Tiriti o Waitangi training in the public health sector is experienced, interpreted, and enacted in practice, and the extent to which such training contributes to improved health equity for Māori. Drawing on Kaupapa Māori theory and Critical Tiriti Analysis, and informed by mixed-methods evidence from training evaluations, surveys, and interviews, the study demonstrates that Tiriti training can meaningfully enhance awareness, confidence, and critical reflection among health professionals. However, it also reveals the limits of training when it is positioned as a discrete intervention rather than as part of a wider system of institutional accountability.

Across the empirical chapters, participants consistently described increased understanding of Māori perspectives, structural inequities, and the historical foundations of Tiriti obligations. These gains were evident across different modes of delivery and cohorts, suggesting that Tiriti training has an important role in building foundational capability within the workforce. At the same time, participants' accounts highlighted persistent challenges in translating learning into practice, particularly where organisational structures, leadership signals, and resourcing did not support Tiriti-centred action.

By applying Critical Tiriti Analysis to both training content and evaluation practices, this study reframes conventional notions of "effectiveness" and "evidence". Rather than treating training outcomes as endpoints in themselves, the analysis demonstrates how evaluation can inadvertently shift responsibility from institutions to individuals, obscuring the Crown's ongoing obligations under te Tiriti o Waitangi. From this perspective, the question is

not whether training works, but what work training is being asked to do—and whether that burden is appropriately located.

Importantly, this thesis affirms te Tiriti o Waitangi as a living, relational framework that continues to shape contemporary health practice. The findings suggest that Tiriti training is most impactful when it is aligned with Māori aspirations for tino rangatiratanga, embedded within organisational mandates, and supported by mechanisms that extend beyond individual learning. In the absence of such alignment, training risks becoming symbolic, episodic, or vulnerable to political and policy change.

Taken together, this study contributes to scholarship on Tiriti training, Kaupapa Māori research, and evaluation in public health by demonstrating that training is a necessary but insufficient condition for transformation. Enduring progress toward health equity for Māori requires systems that honour te Tiriti not only in learning spaces, but in governance, policy, and everyday institutional practice.

The evidence presented in this thesis suggests that the critical question is no longer whether Tiriti training changes people, it does. The critical question is whether institutions are prepared to change in ways that allow that learning to improve Māori health outcomes.

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Appendices

Appendix 1

Ethics Approval (Te Pua Wānanga ki te Ao)

Faculty of Maori & Indigenous Studies
Te Pua Wānanga ki te Ao
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Dr Haki Tuaupiki
Phone +64 7 858 5017
haki.tuaupiki@waikato.ac.nz

Te Kāhui Manu Tāiko: Human Research Ethics Committee
Faculty of Māori & Indigenous Studies
Te Pua Wānanga ki te Ao

13 April 2021

Ethics Approval

Tēnā koe e te manu tāiko e rere atu nā i ngā huarahi o te rangahau.

This letter is to confirm that Moengaroa Edmonds has received ethical approval for the study, ***"A Treaty of Waitangi complaint approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care."*** The ethics application was reviewed by members of Te Kāhui Manu Tāiko and was signed off by the chair of the committee on 13/4/21. Good luck as you embark on your research.

Mahia te mahi hei painga mō te iwi – Nā Te Puea Herangi.

Ngā manaakitanga.

_____

Dr Haki Tuaupiki
Convener, Te Kāhui Manu Tāiko
Te Pua Wānanga ki te Ao
Te Whare Wānanga o Waikato
Faculty of Māori & Indigenous Studies
The University of Waikato

Appendix 2

Research Approval (Waikato District Health Board)

30 March 2021

Moengaroa Edmonds
Faculty of Māori and Indigenous Studies
University of Waikato

Moe.edmonds@waikato.ac.nz

Dear Moe,

Research Project (our ref RD021040)

Thank you for providing information on your proposed research project "A Tiriti o Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care".

I confirm that your study has been registered at Waikato District Health Board and has been approved in principle by the relevant staff. Final sign-off will be contingent upon you gaining approval from University of Waikato, and ethics approval if required.

We confirm that participation or non-participation in the research will not have any effect on staff employment or relationship with the DHB, and that by giving approval to your research, permission to access employees is granted.

I look forward to seeing the outcomes of your research.

Yours sincerely,

Sarah Brodnax
Coordinator - Governance
Quality & Patient Safety

Appendix 3

Datasets for the three programmes analysed

THE STUDIES AT A GLANCE

Three programmes · datasets · analysis

Programme	Mode	Key aim	Cohort	Years	Completed responses	Analysis
Tikanga Best Practice (TBP)	Online e-learning module.	Foundational Tiriti / tikanga awareness.	Health service staff at Te Whatu Ora.	Jul 2021 & August 2022-2023 (2 periods).	1007	Secondary analysis of post-training survey data
Te Ara Totika (TAT)	Kanohi-ki-te-kanohi one day workshop (Tiriti + Treaty).	Cultural awareness; relational learning.	Health service staff at Te Whatu Ora.	May 2021 – Mar 2023 (5 periods).	103	Secondary analysis of post-training survey data.
Public Health & Rautaki Team (PHR) CTA workshop.	Kanohi-ki-te-kanohi Scaffolded workshops	Applying CTA to health service work.	Public health staff / service managers.	5 October 2023	11	CTA-informed analysis.
Interviews	Semi-structured (kanohi-ki-te-kanohi).	How training is interpreted & enacted.	Participants (staff) + training providers.	2023-2024	16*/15 participants	CTA embedding content analysis + KM/Thematic analysis

9

Appendix 4

Research Information Sheet – Questionnaire

Research Information Sheet

Te Kāhui Manu Tāiko
Human Research Ethics Committee
Te Pua Wānanga ki te Ao
Faculty of Māori and Indigenous Studies

Private Bag 3105
Hamilton 3240
Phone: 64-7-838 4737
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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

A Treaty of Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care.

Research Information Sheet - Questionnaire

Tēnā koe,

My name is Moengaroa Edmonds. I am conducting research on Tiriti o Waitangi training curriculum and training programmes available within public health care with a particular focus on the Waikato District Health Board region. The aim of this research project is to examine the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training to enable systemic transformation of public health practises and delivery to Māori. This questionnaire seeks to collect data about the ascertain the rationale for the training curriculum, alignment of curriculum goals and objectives with Ministerial expectations and with DHB plans and strategies. Your contribution to the research through completion of the questionnaire would be greatly appreciated. However, you are under no obligation to participate. If you do participate, and if you do supply your name (which you need not do), it will NOT be revealed to anyone except my research supervisors. The identity of participants will remain strictly confidential in the writing up and presentation of the research. If you wish to contact me to learn more about the research, please use the email address and/or telephone number below. Please send completed questionnaires to me using the pre-paid envelope attached.

Whether or not you decide to participate in the research, I would like to thank you very much for taking the time to read this message.

Thank you very much for your time and help in making this study possible. If you have any queries or wish to know more please phone me or write to me at:

[Your name]
Te Pua Wānanga ki te Ao - Faculty of Māori and Indigenous Studies,
Te Whare Wānanga o Waikato - The University of Waikato
Private Bag 3105
Hamilton, New Zealand
Email: [insert details]
Phone: [insert details]

NB. For students you will need to include details for your supervisor (e.g. see below)
For any queries regarding ethical concerns please contact my supervisor:
Te Pua Wānanga ki te Ao

Supervisor: _____

Email: _____

Office phone: _____

Appendix 5

Memorandum of Understanding (Te Whatu Ora)

7 August 2023

Te Whatu Ora
Health New Zealand

Memorandum of Understanding

Between:
Te Whatu Ora National Public Health Service Waikato and Faculty of Māori and Indigenous Studies, University of Waikato

With regard to:
Doctor of Philosophy research by Moengaroa Edmonds

Research title:
A Treaty of Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care

1) Te Whatu Ora National Public Health Service Waikato and Faculty of Māori and Indigenous Studies, University of Waikato agree to collaborate and share resources to enable Moengaroa Edmonds to obtain the agreed data to contribute to her PhD research.

2) Te Whatu Ora National Public Health Service Waikato will facilitate access to the resources including presentations and recordings of the Te Tiriti o Waitangi workshop series facilitated by Rautaki and Public Health staff in the earlier part of 2023 for the purposes of evaluation by Moengaroa Edmonds.

3) The results and outputs of the evaluation will be made available for both parties to use in their respective sphere of work.

4) Te Whatu Ora National Public Health Service Waikato recognises that ethical approval has been granted for the research and that the project is registered with the Research Office (Te Whatu Ora Waikato). The confidentiality of any individuals engaged with will be respected.

4) Key relationships will be between Dyfed Thomas and Rose Black, Waikato Public Health service, along with Nicola Birch and Areta Ranginui Charlton, Te Aka Whai Ora and Moengaroa Edmonds, Waikaremoana Waitoki and Kyle Tan, Faculty of Māori and Indigenous Studies.

Appendix 6

Critical Tiriti Analysis Training Questionnaire

Critical Tiriti Analysis Training Questionnaire

Date: 5th October 2023

Demographics:

Ethnicity:

Have you previously attended any Te Tiriti o Waitangi training? Yes/No **(circle)**

Please rate the extent of how much you agree with the following statement after completing the Critical Tiriti analysis training.

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**	**Don't know**
I understand that writing a Tiriti-aligned policy is crucial for addressing health disparities experienced by Māori.						
When designing health policies/interventions I will be more conscious of my obligations and responsibilities to Māori (including biases, and assumptions) as Tangata Whenua or Tangata Tiriti.						
I have more confidence to critically review health policy based on Te Tiriti articles						
I have more confidence to design Tiriti aligned policy, intervention, and/or projects.						
I feel confident in working collaboratively with colleagues to						

evaluate a policy using Critical Tiriti analysis.						
I wish to further develop my skills in Critical Tiriti analysis.						

Name new actions you will take to apply Critical Tiriti Analysis.

What did you learn about Te Tiriti o Waitangi in the context of the health system changes that was particularly useful and/or interesting?

When reflecting on this workshop:

What did we do well? You can comment on the workshop content and/or trainer's style of teaching.

What could we improve on?

Any other suggestions or comments about this workshop?

Kō Moe Edmonds tōku ingoa. I am recruiting participants to be interviewed for my PhD to answer the research question: How might Te Tiriti o Waitangi training facilitate transformation of public health practices and delivery to Māori? Please leave your email address here if you are interested to be contacted. You will receive koha for your valuable time and contribution.

Email:

Appendix 7

Consent Form for Participants

1

Consent Form for Participants

Te Kāhui Manu Tāiko
Human Research Ethics Committee
Te Pua Wānanga ki te Ao
Faculty of Māori and Indigenous Studies

Private Bag 3105
Hamilton 3240
Phone: 64-7-838 4737
E-mail: fmis@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

A Treaty of Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care

Consent Form for Participants Workshop

I have read the **Participant Information Sheet** for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers under the conditions of confidentiality set out on the **Participant Information Sheet**.

I agree to participate in this study under the conditions set out in the **Participant Information Sheet**.

I would like my information: (circle option)

a) returned to me
b) returned to my whānau
c) other (please specify) _____

I consent / do not consent to the information collected for the purposes of this research study to be used for any other research purposes. (Delete what does not apply)

Participant's Signature: _____

Participant's Name: _____

Date: _____

Researcher's Name and contact information:

Supervisor's Name and contact information: (if applicable)

Not Applicable

_____

2

Additional Consent as Required

Examples:

I agree / do not agree to my responses to be tape recorded.

I agree / do nor agree to my images being used

Signed: _____

Name: _____

Date: _____

Appendix 8

Research Interview Questions for personnel at Te Whatu Ora/Te Aka Whaiora training participants

Research Interview Questions

Te Kāhui Manu Tāiko
Human Research Ethics Committee
Te Pua Wānanga ki te Ao
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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

A Tiriti o Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care.

Interview Questions for Personnel at Te Whatu Ora/Te Aka Whaiora training participants

Kia ora,

Please see included in this document a list of questions to help guide and facilitate our interview. If you have any questions or concerns at all please do not hesitate to get in touch with me. My contact details are included on the attached Information Sheet.

The following questions are about you and the training received:

- Who are you and what is your role at Te Whatu Ora/Te Aka Whaiora?
- Can you tell me about the last Tiriti training/education programme you attended?
- What training have you attended in relation to Te Tiriti o Waitangi and cultural competency (inside and outside of the organisation)?
- Why did you do the training and why do you think that is important? How long have you been learning about Te Tiriti?
- Do you have any responsibility for reporting on training outcomes?
- How are the staff able to access the training/workshops?
- How is the training/workshop promoted?
- In your opinion, is the time allotted to Tiriti learning sufficient? If no, why not?
- Is the training environment suitable for learning about Te Tiriti Mātauranga Māori (Māori knowledge, practices, concepts, customary ways)?

The following questions relate to the workshops attended:

- Reflecting on the recent workshop completed, what did the trainers do well? You can comment on the workshop content and/or trainer's style of teaching.
- What do you think they can improve on?

The following questions relate to transfer of knowledge:

- How are you implementing the knowledge gained from the training you have completed? Please share your experiences.
- Are you involved in designing health policies/interventions?
- Having completed the training around Te Tiriti o Waitangi, has that helped you in terms of understanding obligations and responsibilities to Māori (including biases and assumptions) as Tangata Whenua or Tangata Tiriti?
- How are Māori concepts incorporated into your practise when dealing with clients/patients after training? (Some examples of tikanga Māori will include, manaakitanga, rangatiratanga, oritetanga, whanaungatanga, mana).

The following questions relate to Critical Tiriti Analysis and only for those who have completed this training

- How confident do you feel to critically review health policies and practices based on Te Tiriti articles?
- How confident do you feel to design Tiriti aligned policy, interventions, and/or projects?
- How confident do you feel about working collaboratively with colleagues to evaluate a policy using Critical Tiriti Analysis (CTA)?
- Do you wish to further develop your skills in CTA or do you believe you have received sufficient skills in this area.
- Can you name any new actions you will take to apply CTA?

The following questions relate to organisational changes and ongoing training:

- Thinking back to the training programme(s), what did you learn about Te Tiriti o Waitangi in the context of the health system changes that was particularly useful and/or interesting?
- What further support or assistance do you need to increase your learning in Te Tiriti o Waitangi/Mātauranga Māori? E.g., refresher courses, professional development courses, other?). Please discuss.
- There have been a number of changes to your organisation and legislation relating to the Health sectors. Thinking about these changes….
- Can you share with me your thoughts about the changes – i.e. from DHB to Te Whatu Ora?
- A new coalition government has recently been formed and there are further changes being proposed. What do you think about the ongoing/proposed changes?
- Has the Tiriti training you have undertaken contributed in any way to your thinking about the changes?
- What are the barriers and enablers to your learning/to your ongoing learning?
- How do you see Te Tiriti being implemented across the organisation/within public health?

Are there any questions you have for the interviewer?

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY

foreground

Appendix 9

Research Interview Questions for Personnel at Waikato District Health Board (management) and Training Provider(s).

Appendix #

Research Interview Questions

Te Kāhui Manu Tāiko
Human Research Ethics Committee
Te Pua Wānanga ki te Ao
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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

A Tiriti o Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within a public health institution

Interview Questions for Personnel at Waikato District Health Board (management)

Kia ora,

Please see included in this document a list of questions to help guide and facilitate our interview. If you have any questions or concerns at all please do not hesitate to get in touch with me. My contact details are included on the attached Information Sheet.

- Who are you and what is your role with the Waikato District Health Board (WDHB)?
- Can you tell me about the Tiriti training/education curriculum?
- Did you have input into the Tiriti training/education curriculum when it was first developed? If yes, what was your contribution? If no, do you know who were or was involved in the decisions regarding the training curriculum?
- Do you know what the rationale is for the Tiriti training/education curriculum?
- Do you now have input into the Tiriti training and/or curriculum? What is your input?
- Do you have any responsibility for planning in the training space? If yes, can you please explain what that is?
- Do you know how many Tiriti training courses/workshops are operating under the WDHB? What are these?
- How is training delivered? Face to face or online or both?
- How often is training delivered? Are there any plans to hold training over a longer period of time? (This latter question is only relevant if training is for one day or less).
- Can you tell me about the development of the Tikanga Best Practice Guidelines?
- How are staff informed or made aware of Tikanga Best Practice Guidelines?
- What training outcomes do you measure?
- Do you have any responsibility for reporting on training outcomes?
- What happens with the staff evaluations that are completed by staff?
- Are online course(s) evaluated for effectiveness? If yes, are the evaluations the same as they are for the Te Ara Tika Tuarua training/workshop or different? If you don't evaluate the online courses for effectiveness, why not?
- How are the staff able to access the training/workshops?
- Are any of the training/workshops compulsory?
- How is the training/workshop promoted?
- What incentives are there for staff to attend a training/workshop if it is not compulsory?
- Do you offer follow up or refresher courses for staff after they have completed the Tiriti training/workshop? If yes, can you tell me about that? If no, can you tell me why not?
- Where is the training/workshop carried out?
- Is kai provided for staff and trainers/facilitators who are involved in the training/workshop provided face to face?
- What other resources are provided to staff and trainers (parking, paper, pens, etc)?
- How are Māori concepts incorporated into your practise when dealing with staff in training and providers of training? (Some examples of tikanga Māori will include, manaakitanga, rangatiratanga, oritetanga, whanaungatanga, mana).

Interview Questions for Training Provider(s)

Kia ora,

Please see included in this document a list of questions to help guide and facilitate our interview. If you have any questions or concerns at all please do not hesitate to get in touch with me. My contact details are included on the attached Information Sheet.

- Who are you and can you tell me about your role as a provider of Tiriti training/education?
- How did you become involved in the Tiriti education programme delivery at the WDHB?
- How did you develop your training programme?
- What influenced the design of your programme?
- How does your training align with the organisations goals and objectives?
- Do you incorporate new knowledge into your training? Can you provide some examples of this?
- What outcomes of training do you measure? Do you report to WDHB on your outcomes?
- How often do you meet with WDHB personnel to discuss the training?
- Do you get copies of the evaluations staff complete? If yes, what do you do with those?
- Do you make any adjustments to your training delivery or content as a result of what staff say?
- Can you provide an example of a time when you had to make an adjustment and the reason why?
- How do you plan for each training session?
- How often do you carry out training?
- In your opinion, is the time allotted to Tiriti training sufficient? If no, why not?
- How do you recruit your trainers or facilitators?
- Do regional, national or global issues impact or have any influence on your programme?
- Since you first started delivering your training, have you made any changes to your initial design? What have been the changes and why?
- How are Māori concepts incorporated into your practise when dealing with staff in training and WDHB personnel? (For example: Te Punga Oranga and the Training Development Unit (Some examples of tikanga Māori will include, manaakitanga, rangatiratanga, oritetanga, whanaungatanga, mana).
- Is the training environment suitable for your delivery of training?
- What assistance are you provided with from the Training Development Unit? From any other sector of the WDHB?
- Do you provide kai to staff in training?

See attached for survey questions

Appendix 10

Research Interview Questions for Training Provider(s).

Interview Questions for Training Provider(s) – PHR

Kia ora,

Please see included in this document a list of questions to help guide and facilitate our interview. If you have any questions or concerns at all please do not hesitate to get in touch with me. My contact details are included on the attached Information Sheet.

Section 1: **About your Training Programme**

- Who are you and can you tell me about your role as a provider of Tiriti training/education?
- Did you develop your training programme?
- What influenced the design of your programme?
- What is the focus of the training programme you deliver(ed)?
- What/Who is the target audience of your training programme? How was this determined?
- Since you first started delivering your training, have you made any changes to your initial design? What have been the changes and why?
- How does your training align with the organisations' goals and objectives for Māori?
- What are your perspectives on Tiriti training? Is it effective?

Section 2: **Māori Leadership in Training**

- Is the Tiriti training grounded in Māori knowledge systems (mātauranga Māori), values and belief systems?
- Are Māori voices central in guiding what is taught? How?
- What is the role that Māori play within the training process/programme?
- Does the training support Māori leadership and decision-making autonomy? If not, can the training be adjusted to promote this more effectively?
- Within your training, **are participants encouraged/guided to develop** their confidence in Māori ways of knowing, being, and doing to effectively partner with Māori or to maintain partnerships with their Māori clients/patients?
- Does your training address colonisation?
- Does your training address tino rangatiratanga as a critical aspect of Te Tiriti partnerships? Does your training equip participants with the knowledge and skills to support this?
- Are Māori aspirations embedded in your training?
- Within your training, do you examine structural or systemic barriers that may limit Māori tino rangatiratanga? What are these barriers?
- Are local Māori stories, histories incorporated in your training?
- Does/Did your training offer an in-depth, critical exploration of Māori health beyond a deficit focus on inequity and poor health outcomes to cultural strengths and Indigenous ways of knowing.

Section 3: **Accountability & Equity**

- What outcomes of training do/did you measure? Do/Did you report to Te Whatu Ora on your outcomes?
- How often do/did you meet with Te Whatu Ora/personnel to discuss the training?
- Do you get copies of the evaluations staff complete? If yes, what do you do with those?

- Do you make any adjustments to your training delivery or content **as a result of what staff say?**
- Do you believe that your training contributes to the goal of reducing health inequities and why? (May already be answered in Section 1 above)
- Do you believe that participants see a direct link between Te Tiriti and the advancement of equity in the health sector? How is that reflected in your training programme?
- What assistance are you provided with from the Training Development Unit? From any other sector of the Te Whatu Ora?
- Do you promote accountability and cultural safety in your training? For participants and their Māori colleagues and patients?
- Are there clear pathways in your training to hold Te Whatu Ora accountable for ensuring equity and culturally safe healthcare?

Section 4: **General**

- Do regional, national or global issues impact or have any influence on your programme?
- Do you incorporate new knowledge into your training? Can you provide some examples of this?
- Does the training integrate a holistic approach to healthcare that respects Māori spirituality and cultural perspectives.
- Does your training address bias, prejudice, racism? If so, how have trainees reacted to those issues? (May be answered above in Section 2)
- Are you involved in designing health policies/interventions? Please share your experiences of this if you are involved.
- I have shared some of the Findings from the participants surveys and interviews. Can you provide your thoughts/reflections of these? Can you identify any gaps?

Section 5: **Organisational changes (Health Reforms, restructuring, government, other)**

- There have been a number of changes to the health organisation and legislation relating to the Health sector. Thinking about these changes….
- Can you share with me your thoughts about the changes – i.e. from DHB to Te Whatu Ora?
- A new coalition government has recently been formed and there are further changes being proposed. What do you think about the ongoing/proposed changes?
- Do you see long-term commitments to kāwanatanga partnerships that go beyond the training?
- How do you deal with structural changes in training?
- How do you see Te Tiriti being implemented across the organisation/within public health?
- What do you see as the future of Te Tiriti training?
- What are the barriers or challenges faced in your training?

Are there any questions you have for the interviewer?

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY

Appendix 11

Research Information Sheet – Interviews with training providers

Research Information Sheet

Te Kāhui Manu Tāiko
Human Research Ethics Committee
Te Pua Wānanga ki te Ao
Faculty of Māori and Indigenous Studies

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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

A Treaty of Waitangi compliant approach towards a healthy Māori future: Evaluating the effectiveness of Tiriti o Waitangi/Treaty of Waitangi training programmes within public health care

Research Information Sheet – Interviews with training providers

Tēnā koe,

My name is Moengaroa Edmonds. I am conducting research on Te Tiriti o Waitangi training programmes/workshops available within public health care with a particular focus on the Waikato District Health Board region. The aim of this research project is to examine the effectiveness of Te Tiriti o Waitangi/Treaty of Waitangi training to enable systemic transformation of public health practises and delivery to Māori.

As part of this research I will be conducting interviews. I would like to interview you for this project as a Training Provider/Trainer/Facilitator to:

1. Discuss your thoughts on the training programme/workshop or eLearning that you provide to health care workers of the Waikato District Health Board;
2. I am also interested in learning about accountability mechanisms for planning, measuring and reporting on training outcomes. If you are involved in any of those areas of responsibility or have some knowledge of those, I would like to discuss this with you;
3. Discuss your programmes design, content and delivery; and
4. Discuss and obtain feedback, insights and reflections on post training.

Interviews would take up to one hour and would be set at a time and place convenient for you. All information you provide in an interview is confidential and your name will not be used, unless indicated by yourself. If possible we would like to record the interview on audio tape in order to develop clear and full transcripts of the interview. You have the right to, among other things:

- refuse to answer any particular question.
- ask any further questions about the study that occurs to you during your participation.
- withdraw your material and participation at any time.
- receive to change and comment on the summary transcript of your interview.
- be given access to a summary of the findings from the study, when it is concluded.

I expect the major outcome from this research to be a full and complete thesis. A summary of the research findings will be sent out to you.

Thank you very much for your time and help in making this study possible. If you have any queries or wish to know more please phone me or write to me at:

Moengaroa Edmonds
Te Pua Wānanga ki te Ao - Faculty of Māori and Indigenous Studies
Te Whare Wānanga o Waikato - The University of Waikato
Private Bag 3105

Te Kāhui Manu Tāiko – Human Research Ethics Committee **FMIS**
Version revised 10 April 2017

Hamilton, New Zealand
Email: moe.edmonds@waikato.ac.nz
Phone: 07-8384020

For any queries regarding ethical concerns please contact my supervisor:

Te Pua Wānanga ki te Ao – Faculty of Māori and Indigenous Studies

Supervisor: Professor Linda Tuhiwai Smith

Email:

Office phone:

Appendix 12

Interview Questions for Training Provider(s) Te Ara Totika

Interview Questions for Training Provider(s) Te Ara Totika

Kia ora,

Please see included in this document a list of questions to help guide and facilitate our interview. If you have any questions or concerns at all please do not hesitate to get in touch with me. My contact details are included on the attached Information Sheet.

Section 1: About your Training Programme and Māori leadership in Tiriti/cultural training.

- Who are you and can you tell me about your role as a provider of Tiriti training/education?
- Did you develop your training programme?
- What influenced the design of your programme?
- What is the focus of the training programme you deliver(ed)?
- How does your training align with the organisations goals and objectives for Māori?
- What are your perspectives on Tiriti training? Is it effective? Is it grounded in Māori knowledge systems? How?
- Are Māori voices central in guiding what is taught?
- What is the role that Māori play within the training process/programme?
- Are local Māori stories, histories incorporated in your training?
- How are Māori concepts incorporated into your training when dealing with staff in training and Te Whatu Ora personnel? (For example: Te Puna Oranga and the Training Development Unit (Some examples of tikanga Māori will include, manaakitanga, rangatiratanga, oritetanga, whanaungatanga, mana).

Section 2: Accountability & Equity

- What outcomes of training do/did you measure? Do/Did you report to Te Whatu Ora on your outcomes?
- How often do/did you meet with Te Whatu Ora/personnel to discuss the training?
- Do you get copies of the evaluations staff complete? If yes, what do you do with those?
- Do you make any adjustments to your training delivery or content as a result of what staff say?
- Do you believe that your training contributes to the goal of reducing health inequities and why?
- Do you believe that participants see a direct link between Te Tiriti and the advancement of equity in the health sector? How is that reflected in your training programme?
- Since you first started delivering your training, have you made any changes to your initial design? What have been the changes and why?
- What assistance are you provided with from the Training Development Unit? From any other sector of the Te Whatu Ora?
- Do you promote accountability and cultural safety in your training? For participants and their Māori colleagues and patients?
- Are there clear pathways in your training to hold Te Whatu Ora accountable for ensuring equity and culturally safe healthcare?
- Within your training, are participants encouraged to maintain partnerships with their clients/patients?

- Does your training address tino rangatiratanga as a critical aspect of Te Tiriti partnerships? Does your training equip participants with the knowledge and skills to support this?
- Within your training, do you examine structural or systemic barriers that may limit Māori tino rangatiratanga?
- Does the training support Māori leadership and decision-making autonomy? If not, can the training be adjusted to promote this more effectively?

- Do regional, national or global issues impact or have any influence on your programme?
- Are you involved in designing health policies/interventions/training programmes? Please share your experiences of this if you are involved.
- Do you incorporate new knowledge into your training? Can you provide some examples of this?
- Does the training integrate a holistic approach to healthcare that respects Māori spirituality and cultural perspectives.

- There have been a number of changes to the health organisation and legislation relating to the Health sector. Thinking about these changes….
- Can you share with me your thoughts about the changes – i.e. from DHB to Te Whatu Ora?
- A new coalition government has recently been formed and there are further changes being proposed. What do you think about the ongoing/proposed changes?
- Do you see long-term commitments to kāwanatanga partnerships that go beyond the training?
- How do you deal with structural changes in training?
- How do you see Te Tiriti being implemented across the organisation/within public health?
- What do you see as the future of Te Tiriti training?
- What are the barriers or challenges faced in your training?

Are there any questions you have for the interviewer?

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY

Appendix 13

Course aims and descriptors

Tikanga Best Practice:

Aim – The topics covered in this course will help to enhance your workplace, and align your daily work with the Tiriti/Treaty Relationship Framework. This relationship is underpinned by a set of Māori values and concepts which have stemmed from key principles founded in Māori tradition. The course is comprised of two learning modules:

1. What is Tikanga
2. Te Tiriti o Waitangi.

Descriptor - What is Tikanga? This module will introduce you to Tikanga and equip you with some practical guidelines on how to apply its principles in a healthcare setting.

Te Tiriti o Waitangi – This module has been developed to help increase your understanding of the influence and impact of a Māori worldview: Pre & Post – Treaty of Waitangi contact through interactive activities.

The above information has been sourced from the Ko Awatea LEARN portal (Waikato District Health Board/Te Whatu Ora, n.d.).

Te Ara Tōtika:

Aim – Workshop participants will:

1. Identify and describe key Māori values and beliefs.
2. Learn tools of 'best practice' to better serve patients in Waikato hospital and in particular Māori patients and whānau
3. Understand the importance of Māori health to Te Tiriti o Waitangi/ the Treaty of Waitangi to:
4. Identify key markers in the health history of Tainui

Descriptors:

1. This section assists us to identify and describe key Māori values and beliefs and the relationship to Māori health. It is important to remember that there is no one Māori world view. Rather a Māori world view in contemporary times is as diverse as the population itself.

2. Through working in partnership, this section helps us to explore our practise applying Tikanga Best Practise to case examples.

3. This section assists us to know the policy framework in which Waikato DHB operates and how it upholds Te Tiriti o Waitangi/the Treaty of Waitangi.

4. This section assists us to understand our local context and the formation of the Kingitanga as a response to Te Tiriti o Waitangi/the Treaty of Waitangi.

The above information has been sourced from the Te Ara Tōtika workbook (Waikato District Health Board, 2016).

Public Health and Rautaki Critical Tiriti Analysis Workshop

Aim – The purpose of this series is to become Tiriti literate in your everyday practice. Achieving Tirit literacy comes with un-learning and re-learning the stories of Aotearoa.

Descriptors:

Critical Tiriti Analysis is a practical tool for applying Te Tiriti o Waitangi analysis to work programmes, and documents, e.g. Policy/Strategy/Reports.