NEWS

Decision time for members – new offer on the table from Te Whatu Ora

By Mary Longmore and Joel Maxwell

April 24, 2026

It's decision time for the 36,000 NZNO Te Whatu Ora-Health NZ (HNZ) members as they consider new potential terms of settlement in bargaining.

HNZ members on strike in Whanganui last year.

Members around the motu are being urged to attend NZNO meetings next week, to discuss the new HNZ offer — the first in nearly a year.

It comes after 18 long months' of bargaining, after the expiry of the last NZNO-HNZ collective agreement in October 2024.

Whangārei emergency nurse Rachel Thorn, a member of the NZNO bargaining team, said it was now up to members to decide.

‘It will now be up to our 36,000 Te Whatu Ora members to decide collectively and democratically whether the offer is good enough or they want to continue campaigning.’

NZNO will be running a series of in-person and online meetings next week from Thursday, April 30, around the country to discuss with members its analysis of the offer and get feedback.

An online ballot will then be held from May 11, closing at 5pm May 15.

NZNO’s bargaining team, from left, Glenda Huston, Allister Dietschin, Nano Tunnicliff (on screen), Noreen McCallan, Lyn Logan, front, Maria Tutahi (on screen), Rachel Thorn, Debbie Handisides and Dawn Barrett.

NZNO chief Executive Paul Goulter said the offer was the first received since June 2025.

“It will now be up to our 36,000 Te Whatu Ora members to decide collectively and democratically whether the offer is good enough or they want to continue campaigning.”

The NZNO bargaining team would spend the next few weeks speaking with members about the details of the offer, he said.

“While this process is underway in the lead up to a membership ballot, it is not appropriate for me to go into any details in the proposed terms of settlement. It is important that members hear the details first.”

Paul Goulter

Bargaining team member and Christchurch enrolled nurse (EN) Debbie Handisides said it was time for members to collectively decide on what happened next – agreement or further action.

"We're looking forward to hearing what the decision will be from members . . . this is your turn to have your voice – an informed-decision voice."

She said emails with details of member meetings would be sent out. Meetings would be in person, in workplaces or nearby hospitals, or online hui.

The offer can be seen in summary here (https://assets.nationbuilder.com/nzno/pages/4407/attachments/original/1776983722/Headline_summary_of_the_Te_Whatu_Ora_offer_to_NZNO_members_24_April_2026.pdf?1776983722) or in detail here (https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fassets.nationbuilder.com%2Fnzno%2Fpages%2F4407%2Fattachments%2Foriginal%2F1776918090%2F20260423_NZNO_Bargaining_Terms_of_Settlement__Final_Signed.pdf%3F1776918090&data=05%7C02%7CKaty.Watabe%40nzno.org.nz%7C493dbfdd3436401cf07d08dea0f04d54%7Cddd1e190237c4a86a2b758dc452c5162%7C0%7C0%7C639125151135872684%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=GaOGJMYXBTOXt2M87UwWlNN6wHIJImbQO7fVQHKQE7A%3D&reserved=0).

Timeline of action

- Bargaining between NZNO and HNZ began in September 2024 with a focus on safe staffing, pay and conditions in health care.
- The ongoing bargaining saw unprecedented levels of industrial action in 2025 — with the most strikes by public hospital nurses in New Zealand's history.
- Action included a 24-hour NZNO strike in August, two days in September and then nationwide strikes on October 23 by nurses, midwives, teachers, principals, doctors, social workers and other public service workers. Then members went on partial strikes in November.
- This followed on from rolling strikes in December 2024.

NEWS

Community health nurses win six per cent pay rise after ‘humiliating’ bargaining

By Mary Longmore

April 22, 2026

Access community health nurses endure eye rolls and being told their concerns are ‘boring’.

District health nurse and delegate Hollie Ashmore during NZNO strike action last year.

After six months of bargaining, Access Community Health nurses are celebrating a six per cent (three plus three) pay rise, professional development, long-service leave and yearly salary scale progression for the first time.

But delegates on the bargaining team say they felt disrespected throughout, dealing with eye rolls and concerns being described as "boring".

"I could not understand why I had to go in there, fight tooth and nail for what is standard across the sector," NZNO delegate Rachael Webb told *Kaitiaki.* "Having eye rolls and being told I'm 'boring' — fighting for things that should just be given. . . It makes me angry."

NZNO collective bargaining for about 140 community and district nurses who work at Access kicked off last October with a three per cent (1.5 per cent now and 1.5 per cent in a year) offer — and nothing else.

> **'It's not just us they hurt, it's the humans we look after. We're looking after the community.'**

But the workers stood firm — despite being told by Access it was "very comfortable" being one of the sector's lowest-paying employer and with its high staff turnover, delegate Hollie Ashmore said.

"Maybe what changed is that Rachael and I were very hardcore with them, as much as they were with us."

Rachael Webb, second left, in 2024 when Access community nurses went on strike over poor pay.

Webb said they had to go through two mediations before finally taking an acceptable offer back to members.

"We got there because we just kept pushing, coming up with examples about why they needed to support us," Webb said. "But we shouldn't have had to go back so many times and two mediations to get

that message across because it's just standard practice for nurses."

Members this month accepted the offer for a two-year agreement, with:

- A professional development and recognition programme (PDRP) for the first time, with an allowance and start date in 12 months.
- Long-service leave for the first time (after seven years).
- Automatic yearly progression through the salary scale for enrolled and registered nurses.
- A three per cent increase from March 29 plus another three per cent increase in March 2027.

The previous collective only allowed workers to progress a single step during the agreement, meaning some had worked for years with little-to-no pay progression.

And while happy with the wins — especially the yearly step progression — they were relatively basic for nurses and the bargaining had been "horrible", Ashmore said.

"It was blackening your soul, going in with this bargaining team. You just felt like you were just up against it," she said.

'We deserve respect'

Ashmore said nurses devoted their lives to helping people and did not deserve such disrespect.

"It's not just us they hurt, it's the humans we look after. We're looking after the community."

NZNO kaiwhakahaere Kerri Nuku, left, with striking Access nurses in 2024, including Rachael Webb, right.

Disrespect 'disappointing' says Access

Access chief executive Androulla Kotrotsos told *Kaitiaki* she was pleased Access and its nursing workforce were able to agree on "a number of important matters" like pay increases, PDRP support, automatic step progression and the introduction of long service leave.

But it was "disappointing to hear that some participants may have felt disrespected, as that does not reflect our intentions or the values we seek to uphold".

> **'In this context, it is not uncommon for there to be differing perspectives and expectations during negotiations.'**

Bargaining took place in a "challenging environment" at time of tight health funding constraints and high living costs.

Androulla Kotrotsos

"In this context, it is not uncommon for there to be differing perspectives and expectations during negotiations."

Kotrotsos said Access approached bargaining professionally, respectfully and in good faith.

Community nurses played a vital role in supporting individuals, whānau and communities across Aotearoa New Zealand, she said.

"We remain committed to providing fair and sustainable pay and conditions, supporting professional development, and maintaining a strong and stable workforce within the realities of a publicly funded health system."

Access Community Health provides nursing and home help care at home for older people and people with disabilities or medical needs.

Its specialist mobile nursing service, Total Care, is also in bargaining. After a proposed 2.5 per cent pay offer over 13 months was rejected, it has now offered members a two-year agreement with three per cent now and 2.5 per cent in a year. Voting closes this Wednesday, April 22.

> **'Maybe what changed is that Rachael and I were very hardcore with them, as much as they were with us.'**

Access and Total Care were sold by Green Cross Health to Australian private equity firm, Anchorage capital Partners, in 2023 for $50 million. At the time of sale, the New Zealand stock exchange reported a pre-tax profit of $5.6 million from the two community health services.

Access community nurses went on strike in 2024 over their low pay rates compared to other nurses.

NEWS

Free bowel cancer screening cut-off 'racist' say NZNO cancer nurses

By Mary Longmore and Joel Maxwell

April 16, 2026

NZNO cancer nurses condemn the Government refusal to lower the free bowel screening age to 50 for Māori.

The Government ignored expert advice that lowering the free bowel screening age for Māori, would raise survival rates to those of non-Māori, cancer leadership network Hei Āhuru Mōwai has revealed.

Fears the health system would not cope with the number of colonoscopies likely to be needed was a key reason, the Māori cancer experts also reveal in a New Zealand Medical Journal article, *Tūtakarerewa*

(https://nzmj.org.nz/journal/vol-138-no-1627/tutakarerewa-indigenous-advocacy-and-structural-racism-in-bowel-cancer-screening-in-aotearoa-new-zealand).

> **‘We consider the current bowel screening programme eligibility age in Aotearoa, New Zealand to be an expression of structural racism.’**

Cancer nurse college (CNC) chair Heather Bustin said the decision was unethical, unacceptable and “structural racism”.

“Ignoring the evidence of an equitable age adjustment, on the grounds health system capacity is not an ethically acceptable justification,” she told *Kaitiaki.*

Heather Bustin

The inevitable result would be avoidable harm specifically to Māori, she said.

“We consider the current bowel screening programme eligibility age in Aotearoa, New Zealand to be an expression of structural racism.”

Māori have double the rate of bowel cancer under 60 than non-Māori: with a diagnosis rate of 21 per cent to just 10 per cent — a gap that is only widening, according to Hei Āhuru Mōwai.

Done well, national screening programmes could lead the way in achieving equity, accelerating Māori health gains and upholding Māori rights to health, suggests the article.

> **‘It doesn’t matter who was in Government. The paper shows these inequities were perpetuated successively, which is really disappointing.’**

Instead, structural racism delayed and ultimately stopped a lower bowel cancer screening age for Māori and Pacific (also harder-hit) — described as “deliberate inaction in the face of need”.

Hei Āhuru Mōwai co-chair Jacquie Kidd, who co-wrote the article, said denying Māori access to life-saving free screening because there was not enough capacity to respond was both unethical and racist.

“They don’t want clinical services to have to do too many more colonoscopies because they don’t have capacity” she told *Kaitiaki*. “So instead of addressing capacity, because we have all this evidence that there are all these people on the waiting list needing colonoscopies, they maneuver [screening thresholds] so they don’t have so many people on the waiting list.”

NZNO kaiwhakahaere Kerri Nuku said the decision was “absolutely” structural racism. “There’s no intention, there’s no resource, so we’re not a priority — we’ll just sit by and watch them die.”

NZNO kaiwhakahaere Kerri Nuku.

She said the Waitangi Tribunal's 2018 health service and outcomes inquiry identified structural racism and the need to deconstruct it.

There had been some research on the issue under the previous government, but the Coalition Government "built those walls again". "And they made it easier to embed racism."

It was sad for Māori mokopuna and whānau, Nuku said — "and sad to watch them pass away from something that easily could have been picked up earlier".

True need 'concealed'

Kidd — who was diagnosed with terminal bowel cancer herself at just 58 — said if the true need was never revealed, there would never be investment in more colonoscopies.

"It doesn't matter who was in Government. The paper shows these inequities were perpetuated successively, which is really disappointing."

If the advice had been followed, Kidd said she would have been screened earlier and may not now be facing an early death.

The fight for equitable bowel screening

When it launched in 2016, New Zealand's national bowel screening programme (NBSP) offered free screening to everyone aged 60-74 — ignoring its own pilot scheme recommendations that the programme needed an equity focus, the NZMJ article reports.

Jacquie Kidd

In 2019, after new figures showed indeed the gap was widening, cancer experts across the sector urgently recommended the eligible age be dropped to 50 for Māori and Pacific peoples.

But this was rejected in 2020 by the Government, because the rollout was not yet complete. However, Official Information Act requests by Hei Āhuru Mōwai found another reason.

"The incapacity of the health sector to provide colonoscopes was a significant consideration in the final decision not to extend the programme."

Finally, in 2022, the Government agreed to extend the bowel screening age for Māori and Pacific people to 50 the following year, beginning with Waikato, Tairāwhiti and Midcentral pilots.

But following a change of Government, the nationwide rollout was canned. Instead, Minister of Health Simeon Brown set the age at 58 for everyone — the same age Kidd was diagnosed, too late for her and many others.

Minister of Health Simeon Brown has previously said the Government wanted to keep its promise to match Australia's free bowel screening age of 45, but needed to increase colonoscopy capacity (https://www.rnz.co.nz/news/political/544033/government-promises-to-further-drop-bowel-cancer-screening-age). He would not say when this would happen.

At a glance

- Māori are more likely to die within two years of a bowel cancer diagnosis, compared to non-Māori.
- Pacific populations are also hard-hit, with bowel cancer the third most-common cause of death.
- Just 50.8 per cent of Māori get screened for bowel cancer compared to 62.1 per cent of non-Māori.
- Just 63.4 per cent of Māori get screened for breast cancer compared to 73.4 per cent for non-Māori.
- Just 66.8 per cent of Māori get screened for cervical cancer, compared to 81.6 per cent for non-Māori.

— Source: Tūtakarerewa — Indigenous advocacy and structural racism in bowel cancer screening in Aotearoa New Zealand, New Zealand Medical Journal, December 2025.

See also: *'Not a birthday I expected to see' — nurse, patient and professor Jacquie Kidd on stage-four cancer and racism*.

NEWS

‘It’s not about the pay’ – Auckland district nurses go on strike

By Mary Longmore

April 8, 2026

More than 60 district nurses in Auckland are on strike today, saying they are fed up with empty promises and being ignored.

Rosanne Maber, left, with other striking Waitematā district nurses outside Minister of Health Simeon Brown's Pakuranga office in Tāmaki Makaurau/Auckland today. Photo: Michelle Beard.

"District nursing has been like a silent service that people often forget about," Waitākere district nurse Rosanne Maber told *Kaitiaki*. "They have their big meetings at hospitals and reporting on staffing [there] but I think we often get forgotten about."

The Waitematā nurses — who help hundreds of homebound patients every day across west Auckland's Waitākere, North Shore, Wellsford and Hibiscus Coast — have been complaining for more than a year that understaffing was forcing them to cancel and postpone patient visits daily.

On just one single day this week — Tuesday — Maber said they were 29.5 hours short across the four district nursing areas, which meant 38 patients would have been affected by delayed or cancelled

appointments.

> **'So, for us it's not acceptable for the patients, but it's not acceptable for our profession, either.'**

Maber said it wasn't about pay — which was part of the wider bargaining still dragging on after 18 months — but safety.

"Patients are not receiving the care they need — they are being deferred on a daily basis," said Maber, an NZNO delegate. "So, for us, it's not acceptable for the patients, but it's not acceptable for our profession, either."

Loss of professional development

Crucial professional supports had also been cut, including portfolio days to meet ongoing Nursing Council practising requirements and a monthly "resource group" where nurses kept up-to-date with latest practice and policy, she said.

Waitematā district nurses and supporters striking in Auckland today, outside Minister of Health Simeon Brown's office in Pakuranga. Photo: Michelle Beard.

"Professional supervision, which to me is really vital for our nurses, also isn't happening. That's quite protected time for nurses to debrief, put out any concerns they've got with patients."

Te Whatu Ora – Health New Zealand (HNZ) promised a review of the service after the situation worsened a year ago — but has since told district nurses they had to work "better, faster and more efficiently", Maber said.

"It's not nice making those phone calls every morning, to tell patients we're not coming," she said. "And when do you defer them to? Because tomorrow's likely to be the same, the next day's likely to be the same. So we're feel like we're constantly trying to catch up."

> **'At the end of the day, we're doing this for our patients. I just hope that we're listened to.'**

District nurses dealt everything from chronic leg ulcers to changing catheters or feeding tubes. Many of their patients, were seriously unwell, with high needs, and included the terminally-ill, Maber said.

"We work alongside hospice quite closely, as well as with post-op patients, mastectomy patients — anyone who requires any kind of nursing in their home, who can't get out or get to a GP."

Due to pressure on hospitals, patients were often discharged early. Yet district nursing numbers had not risen to meet the higher, more acute, need, she said. And nurses were often not replaced after leaving — or not for several weeks or even months.

"We feel like our staffing levels aren't meeting the demand of the community."

Maber said striking was an absolute last resort, but the nurses were desperate.

"Nurses definitely don't like striking. But at the end of the day, we're doing this for our patients. I just hope that we're listened to."

Dozens of Auckland district nurses and supporters picketing outside Simeon Brown's Pakuranga office today. Photo: Michelle Beard.

The picketing comes off the back of two weeks of uniform strikes by the Waitematā district nurses to try and highlight staffing woes.

Nurses were infuriated when managers confiscated their safe staffing pamphlets, demanding they stop handing them out to patients.

However, the move only "fired up" members, who have carried on giving out the pamphlets.

NZNO chief executive Paul Goulter has said NZNO would support any member being bullied for taking part in strike action during collective bargaining, which was a legal right.

The district nurses are picketing today, Wednesday, at the Auckland electorate offices of Minister of Health Simeon Brown, and those of his Cabinet colleagues Mark Mitchell and Chris Penk.

HNZ responds

HNZ national chief nurse Nadine Gray said HNZ was "always looking at ways to improve our system, quality, and safety". The district nursing service was being reviewed, as part of a new national programme of work to assure safe staffing across the organisation.

A survey had recently been completed and was being analysed, with a working group being set up to consider "next steps", she told *Kaitiaki.*

"We value the significant contribution of our nursing and healthcare assistant workforce and remain dedicated to ensuring we have the right people and skill mix to deliver quality and safe patient care."

Waitematā district nurses were defiant after management confiscated their safe staffing pamplets last month.

NEWS

Aotearoa's 1000th nurse practitioner stoked to join 'kick-ass' circle

By Mary Longmore

April 6, 2026

Auckland sexual health nurse Rose Hutchinson says while it's pretty random, she is "humbled and proud" to be Aotearoa's 1000th mātanga tapuhi/nurse practitioner.

Rosie Hutchinson, right, with fellow NP Delvene Steven at a Pacific nurses' event.

"It's extremely significant for nurse practitioners, but not so much about me," said Hutchinson, who qualified in December.

"I feel really proud but ultimately really humbled to be stepping into that circle — because it does feel like a circle where everyone's got their own strengths and superpowers."

She said it felt a little like joining a "good coven of witches, everyone doing their good work and being really kick-ass people".

Hutchinson's own journey began in 2006, when she trained as a nurse through Massey University in Wellington.

> **'Nurses consistently step up and step out for our population to fill the breach and they deliver.'**

But it was at Otago Polytechnic, where she completed her degree, that she met an inspiring tutor who was adamant newly-established nurse practitioners (NPs) were the future.

"She was so passionate about it and to me it seemed so daunting — that people would be working independently."

Hutchinson went on to work at Wellington Hospital in post-surgery recovery, neurosurgery, cardiothoracic surgery and intensive care over the next few years.

And along the way, her interest grew in the "sociological aspects of nursing, relationships and the human experience of life".

"Not necessarily so much the tasks and hands-on work but people's journey through their lives and the fact that everybody wants to be a healthy functioning person to be able to achieve what they want to achieve in their lives."

Rosie Hutchinson, far right, supporting striking firefighters in 2025.

She did her masters of nursing while working at a supportive sexual health service, then — with her wise tutor's words bubbling up from the past — took the leap when a colleague resigned.

After an "unbelievably challenging" year-long nurse practitioner training, Hutchinson qualified at the end of 2025, making history.

"It was 10 times harder than most grad papers, as it's a synthesis of all the papers at the same time," she said. "It's like a remodelling of your brain — a birthing process!"

But three months into her newly expanded practice, she is finding it "incredibly rewarding . . . stretching beyond collecting the evidence and developing the confidence to put a name on everything you see".

"It's really great to be expanded and interested and engaged in the more complex care."

Hutchinson is already diagnosing conditions such as acute pelvic inflammatory disease, proctitis and skin conditions, as well as caring for people living with chronic disease like HIV or syphilis.

"I'm plugging syphilis testing for all women of reproductive age, especially wāhine Māori and Pacific!"

Later this year, Hutchinson is also starting work in gender-affirming care, alongside another NP.

> **'Awhi each other along and support each other and use each other's help and knowledge – because you're all there to get the job done.'**

Hutchinson, whose grandad is from Atiu in the Cook Islands, also loves working with the Pasifika community, in her sexual health role — but notes there is no single Pacific culture.

"Everybody's approach to virginity, sex and gender and sexual orientation is different on every island and culture — but it's also different because of Christianity and popular culture."

'Remember why you're here'

Those early NPs, in the past 25 years, had forged the way for today's generation Hutchinson said.

"It's amazing what the NPs have done and continue to do to make it easier for the NPs coming through. They were feeling in the dark — there was an enormous amount of frontierment, just out in the middle of nowhere scraping it together."

Her message to patch protectiveness from some doctors worried their roles will be lost to NPs is this:

"Remember why you're there. All of us should be here really to address the health needs of the population and those needs are not being met. Nurses consistently step up and step out for our population to fill the breach and they deliver on what they try to do."

NPs were not "mini doctors" but "super nurses" with a very broad, person-centred brief.

"You're always looking not just at the person but behind them, beside them — for all the factors that might contribute to the success of their care or the failure of their care."

Whether GP, NP, specialist, clinical nurse specialist or nurse prescriber, she suggests: "Awhi each other along and support each other and use each other's help and knowledge – because you're all there to get the job done".

Nurse practitioner boom

After a slow start after the workforce was established in 2001, NP numbers have soared since the national training programme unrolled in 2016.

Since hitting 1000 in December, another 80 NPs have registered so far this year bringing the total number close to 1100, a Nursing Council spokesperson said.

Usually about 100 new NPs register in New Zealand every year.

Te Whatu Ora's funded annual NP training (https://www.tewhatuora.govt.nz/for-health-professionals/health-workforce-development/nursing/nurse-practitioner-in-primary-care) places have more than doubled since 2024, to 180 this year. Of those, 120 of those must be in primary health and the rest in specialist areas such as mental health and emergency departments.

The Government recently extended prescribing powers for NPs, who can now prescribe everything a GP can.

NEWS

New uniforms a 'cost saving', claims chief nurse after backlash

By Mary Longmore

April 4, 2026

Thousands of new uniforms being rolled out around the country for senior nurses, registered nurses and health-care assistants will save costs, claims Te Whatu Ora-Health New Zealand (HNZ) chief nurse Nadine Gray.

The new RN, EN, senior nurse and HCA uniforms being phased in at HNZ.

Information leaked to Tōpūtanga Tapuhi Kaitiaki o Aotearoa-NZNO recently revealed plans to provide 200,000-plus new uniforms for more than 60,000 staff around the country.

The changes were part of a wider effort to build a "more unified, modern health system" with nationally consistent standards, according to the leaked email.

But Waikato nurse Tracy Chisholm said safe staffing should be the priority, not "shiny new uniforms".

"Every day, nurses and health-care assistants arrive at work to face short-staffed wards and old under-resourced systems in rundown and no longer fit-for-purpose buildings," she said, in a statement released by NZNO.

Chisholm challenged HNZ to reveal the cost and "explain why they are being prioritised over employing more nurses and health-care assistants and fixing our crumbling hospitals".

On top of that, Chisholm noted members had been unsuccessfully fighting for safe staffing and a cost of living wage rise for more than 18 months, through NZNO-HNZ bargaining.

Tracy Chisholm, right, pictured with Jacqui Bunyan in 2024, says Te Whatu Ora staff are questioning a new uniform rollout at a time when staff are struggling with understaffing.

But HNZ chief nurse Nadine Gray claimed the new uniforms would cost less than the current arrangement.

"The standardisation of uniforms will reduce management cost of uniforms for over 60,000 staff," she told *Kaitiaki.*

Gray said they would be phased in gradually, from May, when existing uniforms needed replacing and costs "absorbed by existing operational provision for uniforms".

A spokeperson clarified that meant they would fall within current uniform budgets.

Cost savings were a "benefit but not the main driver", Gray said.

Incoming new uniform for HNZ registered nurses.

Those were "improving comfort for staff, simplifying uniform supply, strengthening professional identity and improving the patient experience".

The fabric was "lighter, more comfortable and flexible" and did not need to be ironed. It had been tested by 200 nurses across seven districts with 93.5 per cent positive feedback, she said.

An internal email seen by *Kaitiaki* refer to a "national nurse uniform programme" with "three bold colours" replacing more than 40 currently being used by nurses and HCAs.

New health-care assistant uniform.

HNZ's new senior nurse uniform.

Staff have been told it would enhance their professional identity and help patients to better identify their roles.

"What nurses wear at work is incredibly important for them, and their patients and whānau," the leaked email said.

It would also allow staff to move more easily between districts, it said.

Uniforms for other HNZ staff, such as midwifery and allied health, would be considered "over time", Gray said.

- *This article was amended on April 16 to include enrolled nurses and midwifery staff.*

NEWS

Nurses forced to car-pool as fuel prices spiral, hammer HCAs

By Joel Maxwell and Mary Longmore

April 1, 2026

It's their job to keep caring — but amid spiralling fuel prices nurses and kaiāwhina are pleading for support as they scrabble to get to work.

Te Whare Wānanga o Awanuiārangi students Bailey Hunt, Anthea Bryant, Krystal Baker, Dave Dix and Aānaliese Cassidy have started carpooling to get to class in Whakatāne.

Far-flung nursing tauira/students are biking, walking and carpooling to class as fuel prices start to bite.

NZNO Te Rūnanga Tauira representative at Te Whare Wānanga o Awanuiārangi, Aānaliese Cassidy, said several first and second year students had started carpooling from Tauranga to the nursing school's Whakatāne campus.

> **'I've got a spare bed, if you fellas need somewhere to come and stay for the night.'**

"We have students who travel from Ōpōtiki, Ruatāhuna, Otūmoetai in Tauranga, Pāpāmoa, Murupara – we have lots of students coming from different areas," Cassidy told *Kaitiaki.*

NZNO Te Rūnanga Tauira student representative at Whakatāne's Te Whare Wānanga o Awanuiārangi Aānaliese Cassidy has started walking 45 minutes to school.

"I've personally started walking. I've got two tamariki so . . . I go from my house to kindy then to school so it's about 45 minutes.

Cassidy was even willing to provide a bed to her fellow students, some of whom lived more than an hour's drive away.

"I've offered some of our tauira who live further out – Ōpōtiki, Murupara – I've got a spare bed, if you fellas need somewhere to come and stay for the night."

Average 91 petrol prices were expected to hit $3.70 this weekend, with no end in sight to the war between the United States and Iran, which has blocked key oil transit point, the Strait of Hormuz.

Fuel fear: An RN faces a decision no parent should have to make.

Cassidy said many students were anxious about upcoming five-week clinical placements, as travel was already a challenge for cash-strapped students even before petrol prices rocketed.

"Whakatāne is not very big. I could be out at Kawarau, which is a 35 minute drive, I could be over in Ōpōtiki, I could have to go to Tauranga — we just don't know."

Te Whare Wānanga o Awanuiārangi nursing students pile into the Mitsubishi for the one-hour drive from Tauranga to Whakatāne.

The school was also considering allowing more online classes outside of labs and exploring other ways of financially supporting students, Cassidy said. So far, nobody had dropped out.

"Hopefully it stays that way – hopefully we're able to keep uplifting and supporting each other".

Calling for more support, NZNO's national student unit co-leader Poihaere Whare said tauira, already facing financial pressure, unpaid placements and long travel, were disproportionately affected by the fuel crisis.

Auckland nurse Liandra Conradie with her family, who are struggling to pay for food, childcare and petrol.

Auckland nurse and delegate, Liandra Conradie, who lived an hour's drive away from the hospital she worked at, said she could now only afford to drive two days a week.

Instead, she was catching the train — but with a 25 minute drive to the station, her daily commute had doubled to four hours.

"We're not living pay cheque to pay cheque anymore we're kind of just trying to live on the bare minimum. We have to cut down on the food we buy, [and] I've had to take more annual leave for school holidays because I can't book my daughter into school holiday programmes because I can't afford it."

A public transport subsidy would help, Conradie said — but there had so far been no communication from Te Whatu Ora-Health New Zealand (HNZ) on what support it could provide staff.

Many, particularly those living further out in West Auckland, had no idea how they would manage, Conradie said.

HCAs 'struggling'

Co-chairperson of the kaiāwhina national committee, Natasha Greig said her fuel bill had "gone up a shit ton", as her vehicle used diesel, which has been hard hit.

Co-chair of the kaiāwhina national committee Natasha Greig.

"I know HCAs are struggling with the cost of living anyway — food costs have gone through the roof, and this is just adding to it."

She knew of staff who were solo parents who were thinking "we're going to get to the point where we're not going to afford to get to work".

Greig, who works in aged care in Hawke's Bay, said she was lucky as she only had a five-minute drive to work. "But a lot of our staff are driving from Hastings to Napier every day and that's a huge toll."

One of her colleagues told her that she was paying $80 a week just to get to work — and that was before fuel prices jumped. "I'd hate to know what she's paying now."

Last October, NZNO released a report on health-care workers in aged care, *Care in crisis/Manaaki i te raru* (https://www.nzno.org.nz/resources/nzno_publications#6_254), revealing a critically under-funded sector.

Greig said the fuel crisis drove home the need for the Government to pay more money to HCAs. "Particularly aged care — aged care gets screwed over all the bloody time."

Oil shock at a glance

- On February 28, US president Donald Trump announced Operation Epic Fury — a joint attack, with Israel, on Iran.
- Although the attack killed a swathe of Iranian leaders, it failed to topple the regime in charge of the country.
- Now Iran's defence forces have blocked the Strait of Hormuz, choking off oil supply, and launched missile and drone attacks on its neighbours.
- As of publication, Aotearoa has 58.7 days of petrol supplies left.

'Kick in the teeth'

NZNO kaiwhakahaere Kerri Nuku said people were already being forced to think carefully about how they were spending their money.

"Look at the impact on students as well, in placements, and all they have at risk because they're still expected to go on placements regardless."

Better pay rates for the health-care workforce had always been about workers being recognised for their mahi, and connections they made within whānau, said Nuku.

"It's now more amplified . . . it's actually impacting on them being able to live a decent quality of life and then going to work and being valued there. They're being kicked in the teeth all around, really."

NZNO kaiwhakahaere Kerri Nuku.

HNZ 'monitoring'

HNZ national director people and culture, health and safety Robyn Shearer said HNZ was keeping a "close eye" on the Middle East situation.

"We know the increasing cost of fuel and other economic knock-ons from the Middle East conflict is a concern for our people."

She said HNZ valued the work of staff and was "planning and monitoring to better understand impacts on our people, and to identify opportunities to support our staff and maintain health service delivery".

OPINION

‘Missed meds, delayed treatments, staff pushed beyond limits’: Nurses have a right to safety

By Tina Giles

April 28, 2026

When nurses hesitate to enter ward doors then something has gone wrong. On workers’ memorial day, enrolled nurse Tina Giles shares her thoughts on fighting for workplace safety.

Wellington enrolled nurse Tina Giles speaks at the annual workers' memorial day event on the Wellington waterfront. NZNO organiser Jo Coffey holds the loudspeaker.

When we talk about health and safety, people often picture yellow wet-floor signs or sharps containers.

But for those of us on the front lines of health care, health and safety is as essential as the air we breathe.

It's the difference between a shift where we provide the care our patients deserve, or one where we go home exhausted, worried we've missed something critical.

For my colleagues, for myself, and for the people we care for every day, health and safety is not a box to tick. It is a basic human right.

Tina Giles flying the flag for safer workplaces on the Wellington waterfront.

It is the assurance that when we come to work to care for others, we are also cared for in return.

We know what happens when these systems fail.

Poor health and safety is not just about physical injuries. It shows up as chronic understaffing, insufficient resources, and a lack of specialised training.

It's visible in our emergency departments (EDs) and mental health units, where security is no longer a luxury – it's a necessity.

We've seen the headlines. But more importantly, we've lived it.

Cross-union support for workers memorial day on the Wellington waterfront.

When a nurse hesitates before entering a room; when a ward is so understaffed that basic monitoring becomes impossible — that is a health and safety failure.

The result is care in crisis — missed medications, delayed treatments, and a workforce pushed beyond its limits.

And it doesn't stop there.

When systems are stretched, even critical documentation suffers. Continuity breaks down, risks increase, and the safety of both patients and staff is compromised.

This year, there is a global focus on psychosocial harm — and it could not be more relevant here in Aotearoa.

The workers' memorial stone near Te Papa where the annual event was held.

Psychosocial hazards — stress, fatigue, burnout — are just as dangerous as physical ones. In many cases, even more so.

Fatigue is not just being tired. It impairs judgement, slows reaction time, and increases the risk of clinical error.

Burnout is not just stress. It is the erosion of compassion, of energy, and ultimately, of the ability to care.

We must treat these risks with the same seriousness as any physical hazard.

That means safe staffing levels, proper training, strong peer support, and workplaces where taking a break is recognised as a safety requirement — not a weakness.

> **'The result is care in crisis – missed medications, delayed treatments, and a workforce pushed beyond its limits.'**

This brings me to why our voices are so incredibly important.

Under the Health and Safety at Work Act 2015, we are the workers — and we are the true experts of our own work environments.

Management might see spreadsheets, but we witness the reality of the 2am rush.

We know which doors are faulty, which equipment is unreliable, and precisely how many staff are needed to safely manage a volatile situation.

Without our input, risks are overlooked and critical issues fall through the cracks.

Safe staffing levels are part of worker health and safety.

It is both our duty and our right to speak up, to elect health and safety representatives, and to insist that our insights are acted upon.

The New Zealand Nurses Organisation (NZNO) is at the forefront of addressing these issues. Through the Maranga Mai campaign (https://maranga-mai.nzno.org.nz/), the focus remains steadfast on safe staffing and the *Care in Crisis* report – which underscores the urgent need for culturally and clinically safe staffing levels.

NZNO is also pursuing legal action against Health New Zealand, asserting that safe staffing is a contractual right.

They are calling for enforceable ratios because we understand that 'doing more with less' inevitably leads to disaster.

We are also witnessing a significant push for enhanced security in EDs and mental health settings; and moving away from the dangerous notion that being assaulted is simply part of the job. It is not.

Care in Crisis report lead author Nathalie Jacques speaks at its October 2025 launch in Wellington.

The trade union movement has always been at the heart of progress in workplace safety. Every protection we have today was fought for by workers who refused to accept harm as part of the job.

And that fight continues.

We are calling for safe staffing. For enforceable standards. For workplaces where violence is not tolerated – and where every worker is protected, physically and psychologically.

Because we know the truth: You cannot deliver safe care in an unsafe system.

Today, we remember those who have lost their lives, and those who have been injured or made unwell by their work.

But remembrance alone is not enough. We honour them through action.

Through speaking up.

Through standing together.

Health and safety is not about policies on paper. It is about people. It is about dignity. It is about ensuring that those who care for others are not broken by the system they serve.

A safe workplace is not a privilege. It is a right.

Yet too often, it's a right we are still forced to fight for.

- ***Tina Giles*** *is an enrolled nurse and NZNO delegate working at Wellington hospital. She delivered this speech at the workers' memorial stone at Te Papa on the Wellington waterfront. Workers' memorial day on April 28 aims to protect and improve laws keeping workers safe and healthy at work. In New Zealand, every week 18 workers are killed as a consequence of their work; every 15 minutes a worker suffers an injury that requires more than a week off work.*

OPINION

Why community health screening and education events are crucial

By Sione ʻUlufonua.

April 22, 2026

Auckland emergency nurse Sione ʻUlufonua is moved by the hard mahi and passion of health professionals at a recent free community screening day in Tāmaki Makaurau.

Sione 'Ulufonua, front second from left, with other health care workers at Auckland's free screening event recently.

Earlier this year, in March ProCare Pacific's Healthy Village Action Zone team partnered with The Fono and several other health providers to host a free community health screening day in Three Kings, Auckland.

It was my first time being involved with such an event and I was genuinely moved by the hard mahi these organisations are putting into our communities.

By making these events a routine part of community life, we can ensure proactive health care and foster stronger, healthier communities.

A free breast-screening stand.

The dedication and passion shown by their staff deserve recognition, and the turnout on the day reflected the positive impact of their work. Judging by the number of people who attended, the event was clearly a success.

The event offered a wide range of health checks, including bowel screening education, blood pressure and heart rhythm assessments, dental checks, measles immunisation, and many more.

I was fortunate to help out with Arthritis New Zealand's gout tests and education, which provided a valuable learning opportunity for me.

Totara Hospice' stand.

Through this experience, I gained a deeper understanding of gout—its symptoms, treatment options, and the importance of early detection and management for our community.

> **Hats off to our primary health sector for their unwavering commitment to serving our community.**

Increasing the frequency of community health check events would greatly enhance our ability to detect health issues early, which is essential for meeting key health targets. Regular screenings empower individuals with timely information and interventions, reducing the risk of complications and supporting overall wellbeing. By making these events a routine part of community life, we can ensure proactive health care and foster stronger, healthier communities.

It was also an opportunity to meet nurses and other health experts who are doing the heavy lifting in our community, to share their knowledge and hear their perspectives on the challenges they face.

A sexual health stand.

Engaging with these professionals not only deepened my appreciation for their commitment, but also highlighted the realities of frontline health care—from resource constraints to the complexities of reaching diverse populations. Their insights underscored how vital community events are for bridging gaps in health-care access, empowering individuals with both information and support and fostering collaborative efforts toward better outcomes.

Hats off to our primary health sector for their unwavering commitment to serving our community. Their tireless efforts and dedication are the backbone of community health initiatives, making a real difference in the lives of so many. We are incredibly fortunate to have such passionate professionals championing our collective wellbeing.

Arthritis New Zealand's stand, where Sione 'Ulufonua (right) was helping out with gout testing and education.

— Sione 'Ulufonua is an emergency nurse based in Tāmaki Makaurau.

OPINION

Lack of staff sparks 'grave fears' for patients, striking district nurses tell local MP Erica Stanford

By Rosanne Maber and Michelle Beard

April 22, 2026

Auckland district nurses say a lack of resources mean they are having to use incontinence pads to dress patients' leg ulcers.

Striking district nurses outside Auckland East Coast Bays' MP Erica Stanford this month. Photo: Michelle Beard.

At a meeting with National MP Erica Stanford during strike action recently, we raised concerns about patient safety and staffing shortage.

Stanford was the only Government MP willing to meet with us. About 20 of us packed into her Auckland East Coast Bays' office to warn her that tight budgets were driving substandard care — including the use

of incontinence pads to dress ulcerated legs.

We told her we held grave fears for our patients.

Waitematā's district nursing dervice operates from North Shore and Waitākere to the Hibiscus Coast, Helensville and Warkworth. Our service is designed to prevent avoidable hospital admissions, support early discharge, and promote patient independence.

However, staffing shortages are seriously undermining that goal.

> **How dire is the situation when, in 2026, nurses in Aotearoa are resorting to incontinence pads to treat ulcerated legs?**

"We're given so many patients each morning that I have to decide who will be seen today and who won't," one nurse said in the hui.

Along with the struggle to provide safe wound care, we told her that severely limited staffing was also forcing us to make difficult decisions about who to treat and who to defer.

Erica Stanford (supplied)

We explained that these are not small wounds. There are ulcerated legs — some patients even have them on both legs.

We are trying to manage higher and more complex case loads, with limited time. This forces us to make difficult decisions that affect Kiwis' lives.

We also highlighted the social impact of missed visits, noting that for some patients, district nurses provide their only regular human contact. Repeated deferrals left patients frustrated. At times, they directed their anger at frontline staff. Nurses reported experiencing verbal abuse as a result.

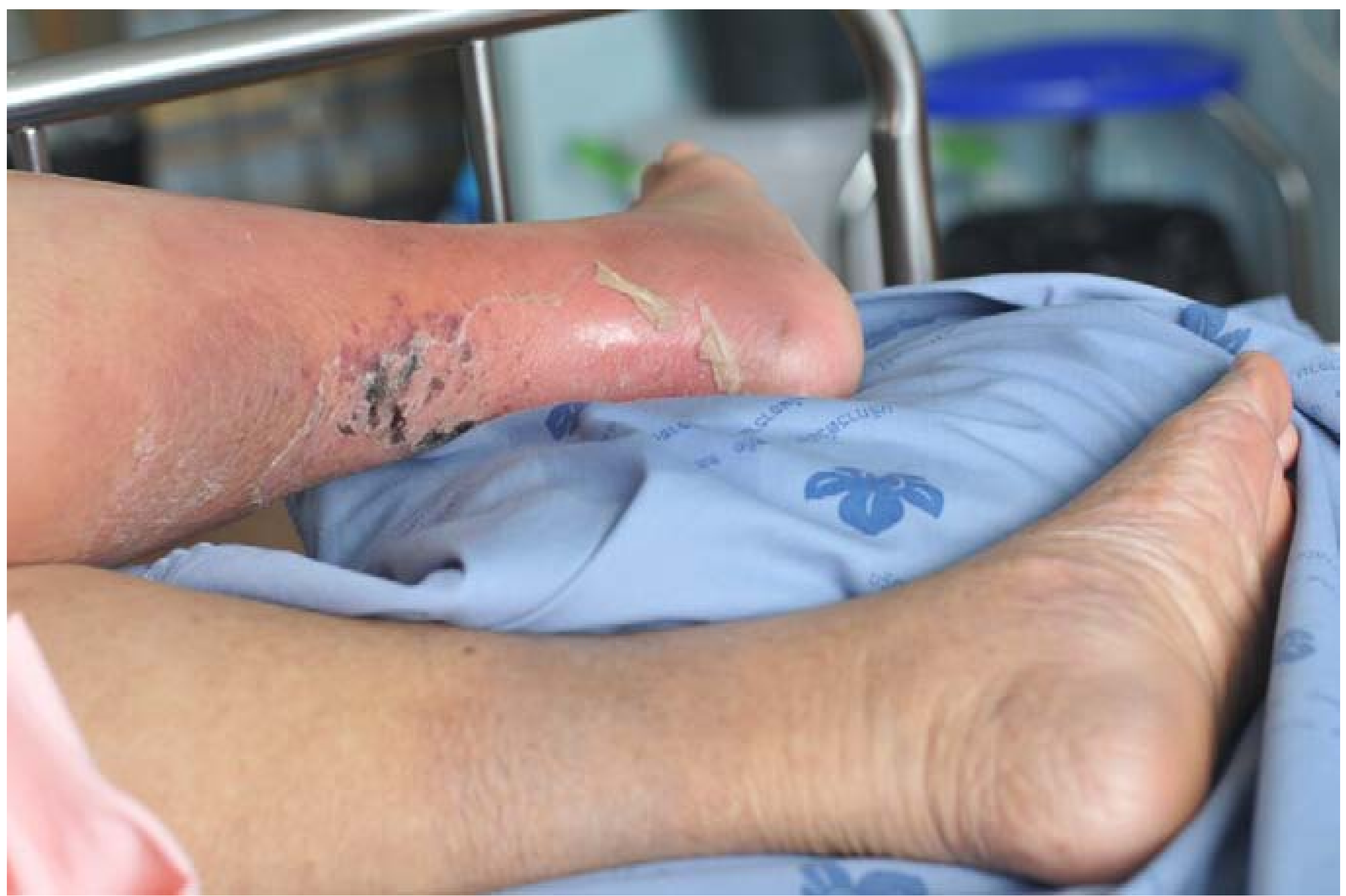
We told her that when patients were not seen promptly, their condition often deteriorated, requiring more intensive treatment and extending time in the service or requiring hospital care.

One of the most confronting examples we shared is the use of incontinence pads to dress leg ulcers, which is far from best practice. This is both humiliating for patients and deeply frustrating for us.

Inadequate funding 'punishing'

With the current budget pressures and workforce shortages, we questioned whether funding has kept pace with rising demand given population growth, an ageing demographic, increased administrative requirements and higher costs for wound care supplies.

"It feels like a direct punishment," one nurse said at the meeting, of the budgetary constraints.



District nurses in Waitematā say they are having to use incontinence pads to dress leg ulcers, due to a shortage of resources.

How dire is the situation when, in 2026, nurses in Aotearoa are resorting to incontinence pads to treat ulcerated legs?

Stanford acknowledged and voiced her understanding that delays in care can lead to hospital admissions and poorer long-term outcomes.

For some patients, district nurses provide their only regular human contact.

However, as district nursing did not fall within her ministerial portfolio, she said she could not comment directly. However, she agreed to raise the nurses' concerns with Minister of Health Simeon Brown — noting that a system review was already underway.

"Will he listen to you, though?" we asked.

"He is a pragmatic guy," Stanford replied.

And you know what, pragmatism is exactly what is needed now!

But a pragmatic approach means dealing with these problems realistically, with a focus on practical outcomes.

Rosanne Maber, left, was among 60-odd district nurses striking for safe staffing in Auckland this month.

In wound care, the consequences of delayed treatment are clear: wounds worsen, require more intensive care, demand more staff time, consume more resources, and ultimately increase hospital admissions. In some cases, the consequences can be life-threatening.

The solution, we believe is equally clear: adequate staffing to ensure timely, effective care at the first point of contact.

We fear the current review of the service is trying to turn health care into a money-driven business.

How do we bring it back to a care-based approach?

–Roseanne Maber is a district nurse based in Waitākere. Michelle Beard is a freelance photojournalist.

The nurses also visited Labour's Te Atatū MP Phil Twyford; Green Mt Albert MP Ricardo Menéndez March and Labour's Auckland spokesperson Shanan Halbert. Labour's North Shore candidate Sam Collins also attended.

Both ministers respond

Auckland East Coast Bays' MP Erica Stanford — also Minister of Education and Immigration — said she would be passing on her local district nurses' concerns to the Minister of Health Simeon Brown.

Brown told *Kaitiaki* district nurse staffing shortages were a matter for Te Whatu Ora-Health NZ (HNZ). However, he "greatly values the work of our district nurses and appreciates everything they do for their patients and communities", a spokesperson said.

National chief nurse Nadine Gray has said the district nursing service is being reviewed nationally to assure safe staffing across HNZ. No time frame has been provided.

OPINION

Weaving together the strands – why we updated kawa whakaruruhau

By Waikura Kamo and Annette Huntington

April 20, 2026

The Nursing Council has updated its 2011 cultural safety guidelines. Kaiwhakahaere Waikura Kamo and chief education advisor Annette Huntington share the past, present and future of a document that has grown through generations of nurses.

Irihapeti Ramsden who was the force behind kawa whakaruruhau. Photo: Adrian Heke.

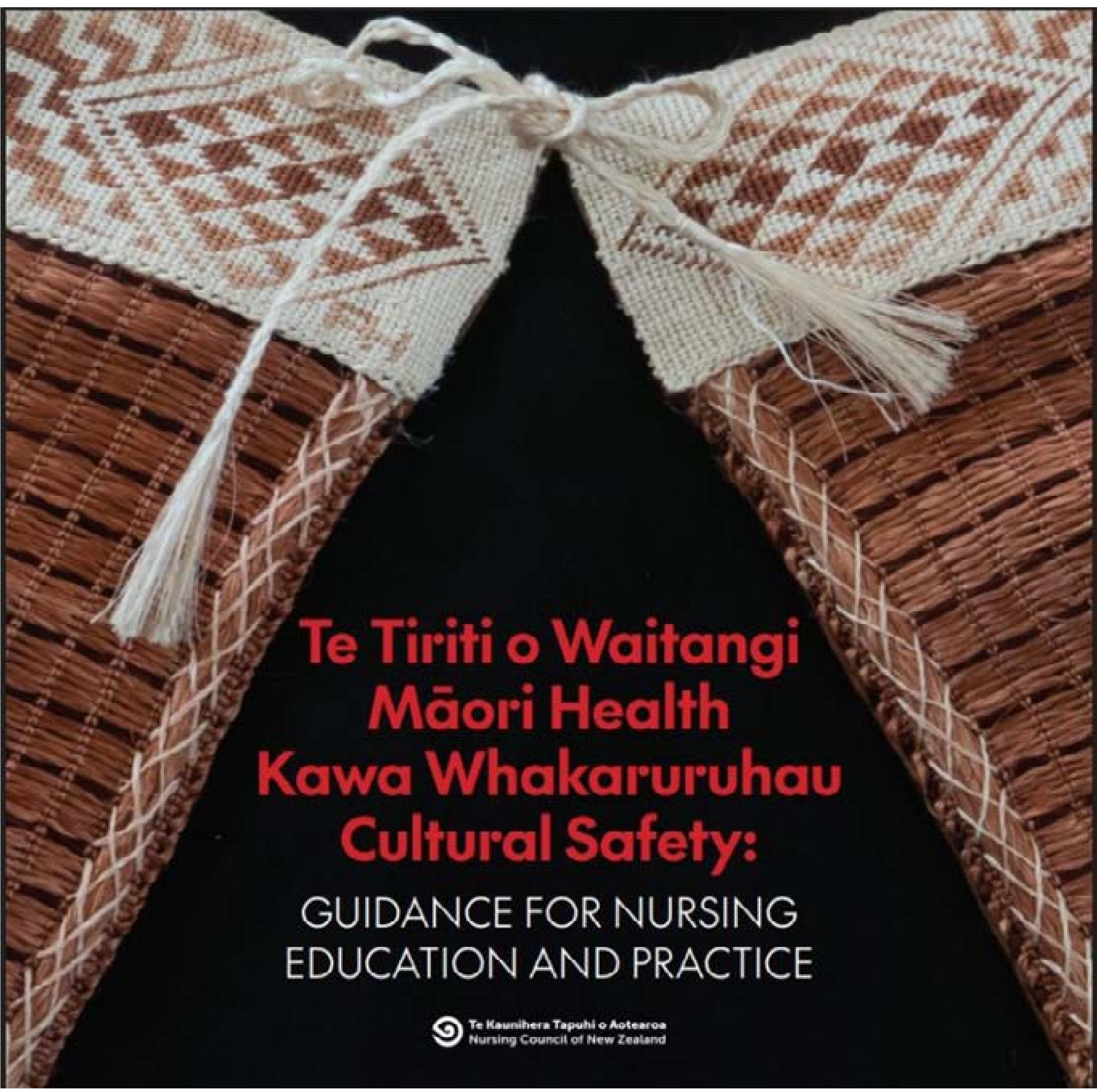
In 1988, nurse, anthropologist and educator Irihapeti Ramsden was at a hui of Māori students when a student asked why, if legal, clinical and ethical safety were considered part of nursing practice, we didn't also include cultural safety.

It was from this grassroots beginning that Ramsden took on and developed the concept of cultural safety, which has now been part of nursing for 35 years.

She was astute enough to know that the council was one of the places that could help bring the concept into everyday nursing. Ramsden was appointed to our education committee. Elaine Papps was council chair – she and other people around the council table immediately committed to the kaupapa, realising its importance.

Read our launch story here, and hear about growing up with Irihapeti Ramsden from her daughter, here.

After all, the evidence was there — data clearly showing worse health outcomes for Māori. Ramsden had done the research and had support in the Māori world. There was a genuine feeling that we had to do something.



It was quickly implemented into the nursing curriculum and the state final exam: but then throughout the entire 1990s it was constantly challenged by the public, in the media, by politicians, and by some nurses.

That decade was really difficult — but it reflected the nursing profession's commitment to cultural safety being woven through the education and practice of nursing.

We needed to be working together. Cultural safety is often presented as a specific thing that Māori are responsible for but that's not true. The whole nursing profession must accept that this is essentially a social justice issue that we need to address within nursing education.

Nevertheless, back when it was first implemented, society was not ready for kawa whakaruruhau. That influenced why it had to be general cultural safety for everyone.

That's one of the reasons the 2011 guidelines needed updating because kawa whakaruruhau – cultural safety in the Māori world – had got lost. What we really needed in this new guidance was to return to the real intent — and it was kawa whakaruruhau.

Guide co-authors at the Wellington launch last month, from left to right: Auckland University of Technology kaiwhakaako/senior nursing lecturer Kiri Hunter with Nursing Council kaiwhakahaere Waikura Kamo, chief education advisor Annette Huntington and chief executive Catherine Byrne. Photo by Adrian Heke.

In 2018, Māori nursing leaders up and down the country challenged the council and asked us to look inwards at our own systems. How were we demonstrating being culturally safe?

We didn't have a good relationship with our Māori nurses at the time. We realised we needed to repair this relationship. But how were we going to be culturally safe, and what did kawa whakaruruhau mean for us and working with our Māori nurses?

That's where this conversation started.

Every time we pulled back a layer there was something else we had to work with. It wasn't just purely a document we put out, saying 'here do this', we actually had to work on the relationships that needed repairing, and work out how to strengthen and maintain those relationships so we could be trusted as an organisation.

Nurses must be culturally safe says council
16 July 1993 THE DOMINION

It's culture out of kilter
18 July 1993 SUNDAY NEWS

Polytech nurse row shows dangers of Maori 'culture'
25 July 1993 NZ TIMES

Nurses must think again
6 August 1993 THE DOMINION

How to divide people
6 August 1993 THE DOMINION

Australian nurses not given cultural studies
5 August 1993 THE DOMINION

Cultural safety stays 20pc of nursing exam
5 August 1993 THE DOMINION

Students need to challenge

Nursing studies cultural content may be reviewed
3 August 1993 THE DOMINION

Brainwashing exercise

Cultural respect
20 august 1993 EVENING POST

The silence of the exams
27 July 1993 THE DOMINION

Nursing grievances instead of patients
20 August 1993 THE DOMINION

Political correctness now invading our ivory towers
15 August 1993 THE DOMINION

Some of the media headlines in the 1990s at the time cultural safety became a part of the nursing curriculum. (Source: Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu — Irihapeti Ramsden's 2002 thesis)

We met thousands of nurses across the country from different sectors to discover what kawa whakaruruhau meant to them. There were pockets where they had no idea what it was — others had very different understandings of the concept.

> **'How were we going to be culturally safe, and what did kawa whakaruruhau mean for us and working with our Māori nurses?'**

We also realised that this guidance, along with our standards of practice, nursing education and our code of conduct, are much stronger working together, as opposed to being standalone.

There was no way we could go out and just focus on cultural safety, we had to bring along everyone doing all that mahi in these different areas to make sure it was all interwoven and linked in.

The profession is now at a level where it can take responsibility for kawa whakaruruhau. Not be told what to do by the council but actually accept that this is now part of what we do in nursing education and practice: accepting accountability.

NZNO Pacific nurse leader Abel Smith, centre, laughing, enjoys the launch. Photo: Adrian Heke.

Hence the move away from guidelines to a guidance document. It's actually a really important difference in language. It is now not simply guidelines where you just have to tick these boxes.

At the end of the day, anything that makes engagement with nurses more acceptable and relevant, and makes people feel more cared for and comfortable is a positive.

It's all about respect and dignity and authenticity. So that's what the guidance hopes to demonstrate. That's what we were trying do by talking to all those groups. It's also about that approach being a key element in nurses' practice.

For nurses, cultural safety is being aware of power imbalances when they're engaging with whānau. It's about mana motuhake — people being able to take control of their decisions, being well-informed and feeling that they're empowered.

Te Tiriti is the foundation of the new guidance, at a high level, for nurses out in practice, education and in clinical rooms.

After all, health is historical. We need whakapapa-centered, intergenerational care. We need to ask why our whānau are not coming and accessing health care.

This goes back generations. This is multi-layered. We have to peel it back – there's more to the person right in front of you than what you see.

Council kaiwhakahaere Waikura Kamo at the launch. Photo: Adrian Heke.

It's for nurses to understand that, be aware of it and recognise it. It's up to every individual, every group, organisations. It's all of our responsibility.

So we can ask ourselves, where do we go to from here? What am I going to do tomorrow to make patient outcomes better?

Because ultimately you're not going to find cultural safety here in this guidance: it's what we do tomorrow. And it's up to every single individual — and not just nurses.

- *Te Tiriti o Waitangi, Māori Health, Kawa Whakaruruhau, Cultural Safety: Guidance for Nursing Education and Practice (https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/About/Guidance_CulturalSafety_2025.pdf)* was launched in February.

OPINION

‘Growing up with Irihapeti’: Revealing the human behind the nursing leader

By Pirimia Burger

April 1, 2026

Even while being extraordinary, Irihapeti Ramsden was extraordinarily human, daughter Pirimia Burger revealed in her speech in February, reproduced here, marking refreshed kawa whakaruruhau guidance.

Irihapeti Ramsden with Pirimia Burger: 'Growing up in the 80s and 90s with Irihapeti as a mother, meant growing up inside a movement.'

Today has a note of resonance – it would have been Irihapeti's 80th birthday.

For many years she celebrated it on the 24th — yesterday — but as she was ever the truth-finder, and asker of questions, in the last few years of her life she discovered it was actually the 25th.

She was 57 when she died in 2003. Too young. As I get closer to the age when she died, myself, I see her differently: as we all do as our parents age and leave us.

Which brings me to my humble moment today. I stand here not as an academic, nor as a nurse, nor as someone who can speak to policy or curriculum — but as a daughter growing up with Irihapeti.

She wouldn't allow my brother Peter and I to call her mum: as a feminist she felt it objectified her. Mummy or mama was fine for a while but it got weird. So from about 14-years old, we simply called her by her name, our great grandmother's name – Irihapeti.

Find our story on the refreshed kawa whakaruruhau guidance here.

Pirimia Burger, delivering her kōrero at the launch of the refreshed kawa whakaruruhau guidance in February. Photo by Adrian Heke.

Growing up in the 80s and 90s with Irihapeti as a mother, meant growing up inside a movement.

Kawa whakaruruhau or cultural safety was not an abstract theory in our house. It was at the kitchen table. It was hearing her educate nurses while breathless with chronic asthma on her 40th hospital

admission that year, and cringing at 'why can't you be like all the other mothers?'.

It was overhearing her being grilled by Kim Hill. It was waving her off to something called a select committee hearing. Having her in other parts of the country three to four times a week, while other mothers attended school sports days or recitals.

It was in the late-night phone calls. The stream of people who came to seek advice, or offer it — solicited or otherwise.

It was in the piles of papers and books.

Irihapeti Ramsden died in 2003 from cancer, aged only 57.

It was in the long silences when the weight of resistance sat heavily on her shoulders.

We knew, somehow, she was far from being like other mothers.

As teenagers, my brother and I didn't fully understand the scale of what she was taking on. We just knew that what she was saying was unsettling the system.

She was asking nursing, and the health system, to look at itself. To confront power. To confront racism. To accept that safety is not defined by the professional — but by the person receiving care.

That was radical. And it was threatening. Even our friends were a bit scared of her, until they met her and were immediately charmed and fed!

> **"What we didn't know until years later was that while she was standing firmly and publicly in that space, she was also receiving death threats – threats to her children."**

However like us, she tested her thinking as it evolved and she relished young peoples' input into what she thought, what they thought and how it could inform the philosophy. She never patronised us, but encouraged us always to enquire and ask 'why' and be able to contribute something useful to a discussion.

What we didn't know until years later was that while she was standing firmly and publicly in that space, she was also receiving death threats — threats to her children. To us. Such was the power of the work she was doing, the disruption — she was seriously disturbing the status quo.

She never told us at the time. She carried that alone. She protected us from the fear, even as she absorbed it herself. Yet she remained a dedicated, though profoundly busy, loving mother and aunt.

But we did see the toll. We saw the exhaustion. We saw her health decline. We saw the hurt when her work was misrepresented.

Nursing Council kaiwhakahaere Waikura Kamo at the launch of the new guidance. Photo by Adrian Heke.

We saw the loneliness of leadership. Her frustration at newspaper articles that pitched Kiri Te Kanawa as a Good Māori, and her as a Bad Māori.

We also saw her unwavering clarity. She was crystal clear in writing and the spoken word, professionally and personally. And she never wavered from the belief that kawa whakaruruhau or cultural safety was about dignity. About accountability. About ensuring that Māori — and all people — could receive care without being diminished.

At home she was our mother – warm, fierce, funny, uncompromising. In the world she was courageous. She held her ground with integrity, not aggression. With intellect, not ego. She wasn't fighting individuals — she was challenging structures.

Yet as a woman, a mother and a taua – she made sure that Peter and I would prevent our children, her mokopuna, (she only briefly met the first of four) from growing up around some distant cold, calcified, statue-like image of her.

Instead, they would know that she loved music, Spike Milligan, art, food, flowers, bad jokes, colour and flapjacks with lots of whipped cream.

"At home she was our mother – warm, fierce, funny, uncompromising."

By speaking today I hope Irihapeti remains to some degree a real person, not deified by history but as a registered nurse who came from a legacy of unjust health outcomes in her own family and who wanted something better for everyone, simply starting with her own people because they were suffering the most.

Today, to see cultural safety refreshed and reaffirmed with integrity — not reduced to a checklist, not softened into something comfortable — fills our whānau and Irihapeti's friends and intellectual supporters, with immense pride.

Because this was never about compliance. It was about transformation. It was about shifting power so that those receiving care define what safe means.

As her children, we carry both the memory of the cost and the certainty of the legacy. The cost was real. But so is the change.

Irihapeti stoically believed that discomfort was necessary for growth. That justice required courage. And that aroha and accountability could sit side by side.

Pirimia Burger speaks at the launch, with cousin Mananui Ramsden and Arawhetu Gray. Photo by Adrian Heke.

We are so proud of her. And we are deeply grateful to see her work continue — not as history, but as living practice.

To those who helped Irihapeti create and birth kawa whakaruruhau, aku mihi. To those who kept it alive once she was not, aku mihi. To those who have now given it new refreshed mauri, aku mihi.

To all involved, thank you.

- ***Pirimia Burger**, Ngāi Tahupōtiki, Rangitāne, is a deputy chief executive at Te Taura Whiri i te Reo Māori.*

OPINION

'Fuel in the car or food for the kids?' – registered nurse faces spiralling fuel costs

By Jonathan [last name withheld by request]

April 1, 2026

I am a registered nurse and a solo father of two children — five and under.

Spiralling fuel costs have made life incredibly difficult for health-care workers. Photo: AdobeStock

I'm doing my best to provide stability, safety, and care not only for my patients, but for my own family. Right now, I am struggling in a way I never expected.

The rising cost of living in New Zealand has placed me in an impossible position.

Everyday essentials such as fuel, food, childcare are no longer manageable on a single income, even in a profession that is meant to be valued and supported.

I am currently still waiting, three months later, for my childcare subsidy to be reviewed and approved.

During this time, I have been relying on the goodwill of childcare providers and others who have shown understanding and compassion, allowing me to continue working despite the delays.

> **'Everyday essentials such as fuel, food, childcare are no longer manageable on a single income, even in a profession that is meant to be valued and supported.'**

The ongoing cost of fuel in particular is forcing me into choices that no parent should ever have to make. I am having to choose between putting fuel in my car to get to work, or using that same money to provide basic essentials for my children.

Without fuel, I cannot work. But without meeting those basic needs, I am failing my children.

It is an impossible position to be in. Public transport does not allow me to drop the kids off at school or day care and get to work on time.

Without the goodwill of others, I would not be able to continue working at all. And if I cannot work, I cannot provide for my children.

I now find myself making decisions no parent should ever have to make: balancing the cost of getting to work against food on the table and other basic needs for my children.

No parent should have to choose between food on the table or fuel in the car, says a registered nurse.

These are not choices that reflect a functioning or supportive system.

As a nurse, I care for people at their most vulnerable. But I am now experiencing that same vulnerability in my own life. It is deeply concerning that those of us working in essential roles are being pushed to this point.

This situation is not just about me, it reflects a wider issue affecting many New Zealanders who are working hard, doing the right thing, and still falling behind.

It raises serious questions about whether current systems and policies are truly supporting families, or whether they are out of touch with the realities people are facing every day.

I am not asking for special treatment. I am asking for timely support, fair systems, and the ability to provide a basic standard of living for my children without having to sacrifice their wellbeing.

No parent, and no essential worker, should be put in this position.

- *Jonathan [last name withheld] is a registered nurse in Waitematā district.*

PROFESSIONAL

Nurse practitioners in Aotearoa: what national surveys tell us

April 30, 2026

This year we celebrate 25 years of nurse practitioners in Aotearoa. It is a timely moment to reflect on their contributions to health care, how the role has grown — and what still needs to change, suggests New Zealand's first NP Deborah L Harris.

Youth health NP Mikey Brenndorfer. Supplied.

Why research matters for everyday nursing practice

Our recent manuscript, published in the *New Zealand Medical Journal,* 1 draws on findings from five national nurse practitioner (NP) surveys undertaken between 2014 and 2022. Together,

'We're able to do really awesome things'

Alongside prescribing, nurse practitioners (NPs) bring diagnostic and complex case management skills to their existing holistic

these surveys provide an important picture of how the role has developed over time.

This matters because the voices of NPs are not always clearly heard in policy, planning or public discussion. These surveys help bring that mahi into view. They show where NP practice is occurring, how it has evolved and what practitioners identify as the barriers and enablers to providing care. Stories from practice remain essential, but survey data allow us to see patterns, growth and change over time.

Key messages from the surveys

The surveys show that NPs are now an established and growing part of the health workforce in New Zealand.

Over time, NPs have worked across a broader range of settings, including primary care, community services, private practice, non-government organisations and self-employed models of care.

> **'The overall message is clear: NPs are making an important contribution to health care in New Zealand, but the system is not yet consistently enabling them to work to their full potential.'**

Their clinical contribution is clear. By 2022, prescribing was almost universal among respondents, and most were also ordering laboratory and radiology investigations as part of routine practice.

approach, says youth and primary health NP Michael Brenndorfer.

Mikey Brenndorfer. Photo: Becki Moss.

"I often argue that NPs have a broader scope of practice than GPs do because our scope of practices includes not only the biomedical but also the psychosocial, in a much more advanced way."

Brenndorfer — who is involved with both NZNO's college of primary health care nurses and college of child & youth nurses — said qualifying as an NP four years ago gave him a whole range of extra skills and tools.

"For me, it was acknowledging the gaps in access and supports that I could provide to the young people I see in my clinic and realising that if I really want to do my best to support them I really need to do my best to increase my scope and my skill level."

When NPs were able to "fully manifest our scopes of practice and our paradigm we're able to do really awesome things", Brenndorfer told *Kaitiaki.*

Deborah Harris, New Zealand's first NP.

The findings also suggest that NPs are improving access to care, often in communities and services where access might otherwise be delayed or difficult.

At the same time, the surveys highlight persistent barriers. These include variable support for full-scope practice, limited succession planning, and structural constraints that continue to shape how the role is used.

The overall message is clear: NPs are making an important contribution to health care in New Zealand, but the system is not yet consistently enabling them to work to their full potential.

What was this survey programme?

This work draws on five national NP surveys conducted between 2014 and 2022. The surveys examined trends in demographics, prescribing and clinical practice, work settings and role development over time.

A major strength of this work is that the surveys were sustained over many years.

NP Diane Williams recognised early that collecting this data was important. She understood that if we wanted to show the growth of the role, and better understand the barriers and enablers to care, we needed to continue gathering the voices of NPs over time.

That commitment has given the profession something valuable. This survey programme provides evidence to inform service planning, workforce development, and policy. It also preserves an important professional record as NP practice in New Zealand reaches its 25-year mark.

About the NP workforce survey

This work has now developed into the NP workforce survey (NPWORKS), a more deliberate and sustainable programme of NP workforce research in New Zealand. NPWORKS is co-designed with Māori and non-Māori NPs and nursing leaders and was established because we recognised that these stories and data are too important to lose.[2]

We are keen to strengthen the NPWORKS steering group and would welcome expressions of interest from NPs who would like to contribute. We are particularly interested in hearing from a Pacific NP and an Asian NP, so that the steering group better reflects the diversity of the profession and the communities we serve.

> **'This is not only a story about one workforce group. It is also a story about nursing leadership, advanced practice and what becomes possible when nursing expertise is recognised and supported.'**

The NPWORKS data is carefully stored, with a clear protocol to guide access and use. Researchers or groups interested in using the data can apply through a formal process outlining the proposed purpose and use. Applications will be reviewed by the steering committee to help ensure that the data are used thoughtfully, ethically and in ways that strengthen NP practice and knowledge in New Zealand.

Why share this research beyond academic journals?

Academic journals are important, but they are not the only place where nursing knowledge should sit. Sharing this work in *Kaitiaki Nursing New Zealand* brings it back to the profession in a form that is accessible, relevant and connected to practice.

This is not only a story about one workforce group. It is also a story about nursing leadership, advanced practice and what becomes possible when nursing expertise is recognised and supported.

The surveys remind us that data matter. They help the profession speak with greater confidence about its contribution, its challenges, and what is needed next.

What does this mean for nurses?

There is much here to celebrate. Over 25 years, NP practice has become a significant part of health care in New Zealand. The surveys show a role that has grown in reach, visibility, and clinical contribution.

They also show that progress does not happen by accident. NPs need supportive services, clear pathways, and policy settings that enable full-scope practice. Without these, the contribution of the role is constrained.

For nurses more broadly, this work is an important reminder that both stories and data matter. Survey data help make our mahi more visible, show change over time, and provide evidence to support better decisions for the future.

As we mark 25 years of NP practice in New Zealand, these surveys offer both celebration and challenge. They show how far the role has come, while making clear that more is needed to ensure NPs are fully supported to contribute to the health and wellbeing of the people and whānau they serve.

See also: *After 25 years of NPs in New Zealand, where are we now?*

Deborah L Harris, **NP, MHS, PhD** was New Zealand's first registered NP. She is now professor of nursing and midwifery research at the University of Newcastle and Hunter New England Health, Australia. She wrote this article with **Diane Williams, BN, MClinPrac**, one of New Zealand's first primary health-care NPs; **Lisa Woods, PhD, BSc, BA**, a statistical consultant at Victoria University of Wellington(VUW)'s school of mathematics and statistics; **Julia Liu, MNP, BSc**, a research assistant at VUW; and **Nadine Gray, BN, MHS**, national chief nursing officer at Te Whatu Ora-Health NZ.

References

1. Harris DL, Williams D, Woods L, Liu J, Gray N. *Evolving roles and workforce trends among nurse practitioners in Aotearoa New Zealand* (https://nzmj.org.nz/journal/vol-139-no-1631/evolving-roles-and-workforce-trends-among-nurse-practitioners-in-aotearoa-new-zealand-2014-2022)(2014-2022). N Z Med J. 2026;139(1631):66-75.
2. Harris DL, Brennan P, Hina A, Gray N. *Navigating the Pathway to co-designed Nurse Practitioner Research in Aotearoa New Zealand* (https://www.npjournal.org/article/S1555-4155(25)00315-0/fulltext). J Nurse Pract. 2026;22(1):1105632.

PROFESSIONAL

Strengthening Māori nursing in Aotearoa – helping beat our whakamā

By Maryann Wilson, Te Arahi Mahanga-Graham, Ella Copper and Anna Richardson

April 28, 2026

Academic kaiāwhina can offer powerful assistance to Māori nursing students. Now a proposed study for 2026 aims to explore this 'bridge' to whanaungatanga from the students' perspective.

Two of the authors, from left, Maryann Wilson and Ella Copper.

Nāu te rourou, nāku te rourou, ka ora ai te iwi

With your basket, and my basket, the people will thrive

This whakataukī, or proverb, speaks to working in a collaborative approach. It acknowledges that everyone has something of value to contribute, and it further declares that by working together, we can all flourish.

Tēnā koutou, tēnā koutou, tēnā koutou
Ko Aoraki te maunga

Ko Waitaki te awa

Ko Murihiku te marae

Ko Wharetutu rāua ko Tahu Pōtiki ngā tipuna

Ko Takitimu te waka

Ko Ngāi Tahu, ko Kāti Māmoe ngā iwi

Ko Wilson te whānau

Ko Maryann Wilson taku ingoa.

Nō reira Tēnā koutou, tēnā koutou, tēnā tātau katoa.

Ka whakawhiti au ki te ihi o Manaia.
Ka haruru au ki te wehi o tōku awa ko Taiharuru.

Ka whakakī au i te tapu o tōku waka ko Uruao.

Ka wehi momona au i te marae ko Tepaia.

Ka moiahi au ki te iwi o Te Waiariki.

Ka mongapiho au ki te hapū ko Ngāti Kororā.

Nō reira tēnā koutou.

Ko wai ahau? Ko Te Arahi Mahanga tōku ingoa.

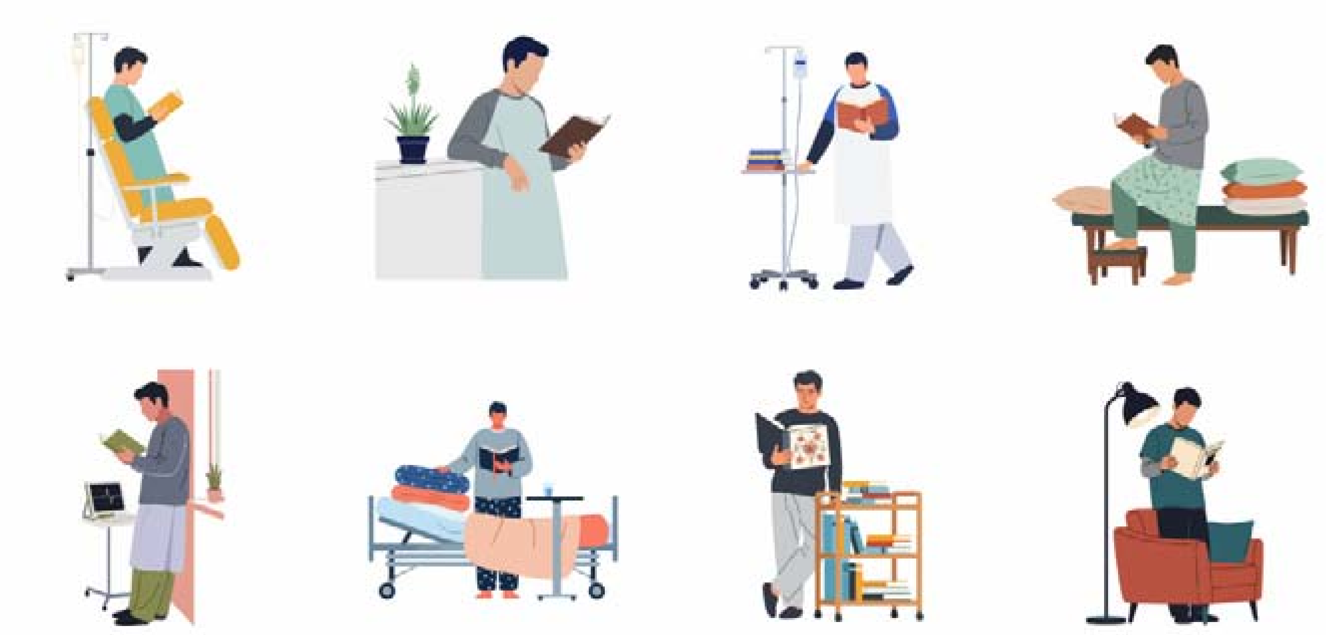
The aim of this article is twofold. Firstly, to identify the factors affecting the retention of Māori ākonga (students*) across* nursing education and secondly identify strategies which support ākonga to remain successful in their study.

The authors hope that the findings contribute understanding to the world of the ākonga and strengthens their transition to practice as nursing graduates.

Despite the nursing workforce being in a key position to improve health outcomes, health disparities are widening between Māori and non-Māori.

Education providers such as polytechnics and universities continue to increase enrolments for nursing degree and diploma programmes, then due to funding constraints there can be a long delay for graduates to obtain full-time nursing positions across the motu.

These delays slow the educational investment made by providers, iwi and whānau into the nursing workforce, and contribute to on-going health disparities for Māori and non-Māori.



The student life is challenging without the additional challenges for ākonga Māori. Photo: AdobeStock.

Currently there are seven per cent of the New Zealand nursing workforce who identify as Māori [1] and they tend to practice for a shorter length of time: 27 per cent of Māori had been practising for fewer than six years compared with 20 per cent of non-Māori, and 45 per cent had been practising for more than 15 years compared with 51 per cent of non-Māori. [2]

As nurses we know foundations of relational nursing practice [3], and the ability to engage authentically with health consumers, whānau, hapū and iwi are fundamental to being able to provide quality nursing care that improves health and wellbeing.

Through nursing education ākonga will become critical thinkers who are confident and competent as they progress through their nursing programme.

Historically nursing education providers have had a proven role adapting their programmes to meet the needs of the health workforce and nursing education.

The appointment of Māori academic staff enables polytechnics and universities to support Māori ākonga, which can be beyond that of engaging with course content. [4]

Tikanga-informed practice and teaching approaches reflecting Māori values and beliefs enhance the educational experience of ākonga. Capitalising on such approaches requires an understanding of te ao Māori, the educational experience of ākonga and the nursing view of the health workforce.

More research needed

The following is part of a study we have proposed focusing on exploring kaiāwhina and Māori success in nursing education at Ara Institute of Canterbury: Enabling ākonga to be an active participant in the co-development of this role.

As a background our literature review was undertaken in 2025 and spanned a four-year timeframe: 2016 – 2020.

The original search strategy identified peer-reviewed literature from New Zealand, Australia, and the United States. We identified 12 articles that discussed factors and strategies relating to the retention of indigenous/Māori nursing students or health professionals in nursing education or the health workforce.

Co-author Anna Richardson.

Interestingly, while strategies to improve workforce retention were published, there appeared to be no evaluation of these strategies.

The literature identified key factors impacting retention of ākonga, reported by students, as whānau, peer support, competing obligations, prior educational experiences, access to student support, economic hardship, racism, and discrimination.

In addition, strategies such as the importance of relationships/whanaungatanga, cultural nurturing, and connectedness in the learning environment enabled a sense of empowerment, built a cultural-support network and promoted 'cultural practice' within a given programme. 5

The gap in the literature, however, was the lack of measurement of the effectiveness of those strategies.

Gaining an awareness of the educational experience of the ākonga through their chosen programme is essential for their academic success. 6

Kaiāwhina Ada Campbell.

We will be utilising a mixed-method study approach, which will be undertaken by a quantitative survey and qualitative interviews and focus groups.

The study will be guided by mātauranga Māori world-views and undertaken by Māori kaiako. Participants will be recruited from all years of the bachelor of nursing (BN) and the diploma in enrolled nursing programmes (DEN) in 2026.

While the term kaiāwhina can have different meanings, in the context of our proposed study this role refers to being a key point of connection for ākonga, acting as a bridge between the structures and requirements of undergraduate nursing education, and actively contributing to Māori self-determination through equitable educational outcomes for Māori.

At Ara, the kaiāwhina role has existed for more than a decade and forms part of the Māori/nurse lecturer role. This supports, ākonga from year one through to completing and successfully exiting the BN or DEN programmes across the Manawa and the rural southern campus.

However, this is a fluid relationship; for example, as ākonga move through their study they tend to seek out the kaiāwhina with whom they have established whanaungatanga, rather than move through the programme with that year's allocated kaiāwhina.

The kaiāwhina role was originally developed through interactions with other nursing lecturers at the Te Kaunihera o Ngā Neehi Māori o Aotearoa/National Council of Māori Nurses. The role was refined over

time, to further āwhina Māori student nurses navigating the BN and DEN programmes, while supporting them academically and with scholarship applications.

Rather than only have one or two lecturers it was better to have lecturers spread across the programme. It was too difficult to fully support students in other courses as we were not fully conversant with the content and assessments.

In addition, kaiāwhina prepared students to attend the annual national Māori nurses hui. For some this requires researching their whakapapa, gaining confidence and opportunity to practice waiata, karakia and learning the kawa/protocol of the given marae.

> **‘Gaining an awareness of the educational experience of the ākonga through their chosen programme is essential for their academic success.’**

For other students the fostering of these connections often reflects the tuakana/tēina relationship embedded in te ao Māori — the relationship between older (tuakana) and younger (tēina) siblings. This is found at the national hui, when students who have previously attended, āwhina students attending for the first time.

Here, recent BN graduate and registered nurse (RN) Te Arahi Mahanga-Graham provides additional insight, and supports findings from the literature review, as she reflects on her experience with kaiāwhina.

Patua te taniwhā o te whakamā

I completed my BN in 2025. Throughout my journey at Ara, it has been quite challenging for me. I remember in my first two years I was struggling to understand the course content, as my first language is te reo Māori.

Te Arahi Mahanga-Graham and husband Daniel celebrate her academic success.

I was also very whakamā to ask for help from kaiāwhina that tautoko Māori ākonga throughout this degree. The kaiāwhina tried reaching out many times, however once again feelings of whakamā held me back and it was not until I was falling behind in my studies and experiencing challenges in a clinical placement that I had to put my whakamā behind me and ask for awhi.

Over time, I came to understand how valuable it is to reach out for help and make use of the support available to me at Ara.

My feelings of whakamā initially held me back, but once I finally sought awhi, I realised how much it strengthened my learning and confidence.

Meeting with the kaiāwhina was a turning point as she became a major support system throughout my nursing journey. Seeing

how much she helped me, I hope that other ākonga will also feel comfortable, not whakamā, to go to a kaiāwhina for guidance.

Many Māori tauira (students) experience similar challenges, when they feel hesitant to ask for help.

Through this experience, I grew both personally and professionally, becoming more confident in advocating for myself and seeking guidance when needed.

As an RN, I want to continue building confidence in my practice and ensure I seek support when I need it, just as I learned to do with the help of people like my kaiāwhina.

I also hope to uplift other Māori tauira and new nurses who may feel unsure or experience feelings of whakamā, encouraging them to reach out just as I eventually did.

Moving forward, I will carry these lessons with me throughout my nursing journey and strive to be the kind of supportive presence for others that my kaiāwhina was for me.

As mentioned earlier, we identified a gap in the literature — little evidence of measurement of the effectiveness of strategies to support ākonga.

Therefore, it is appropriate that the role of the kaiāwhina is measured. The research question has been established, which is: What are Māori students' perspectives on the role of the kaiāwhina Māori in supporting their educational journey through the nursing degree at Ara?

Conclusion

Addressing the persistent underrepresentation and attrition of Māori within the nursing workforce requires more than increasing enrolment numbers; it calls for intentional, culturally-grounded strategies that support Māori ākonga throughout their educational journey and into practice.

The literature highlights the significance of whanaungatanga, culturally-safe learning environments, and meaningful institutional support, yet reveals a critical gap in evaluating the effectiveness of such strategies.

The proposed study responds directly to this gap by centering the voices of Māori ākonga and exploring the kaiāwhina role as a relational bridge within nursing education at Ara. By grounding the research in mātauranga Māori and co-developing insights with ākonga, this work has the potential to inform evidence-based practices that enhance retention, strengthen transitions to practice, and contribute to equitable educational and health outcomes for Māori.

Ultimately, strengthening Māori success in nursing education is foundational to achieving a sustainable, culturally-responsive nursing workforce capable of reducing health inequities across Aotearoa.

Maryann Wilson RN, MN, is a senior academic nursing lecturer and kaiāwhina Māori ākonga support at Ara Institute of Canterbury; **Te Arahi Mahanga-Graham BN, RN** works in primary health; **Ella Copper RN,**

academic nursing lecturer Ara Institute of Canterbury; **Anna Richardson RN** principle academic nursing lecturer**,** BN programme leader, Ara Institute of Canterbury. The authors acknowledge the support and assistance of **Ada Campbell**, **RN**, kaiāwhina.

References

1. Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand. (2024). *Te Ohu Mahi Tapuhi o Aotearoa/The New Zealand Nursing Workforce 2022-2023*.
2. Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand. (2019). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses, and Enrolled Nurses* 2018-2019.
3. Doane, G. H., & Varcoe, C., (2021). *How to nurse: relational inquiry in action* (Second edition.). Wolters Kluwer.
4. Zambas, S. I., Dewar, J., & McGregor, J. T., (2023). The Māori student nurse experience of cohorting: Enhancing retention and professional identity as a Māori nurse (https://www.nursingpraxis.org/article/73358-the-maori-student-nurse-experience-of-cohorting-enhancing-retention-and-professional-identity-as-a-maori-nurse). *Nursing Praxis in New Zealand*, *39*(1).
5. Chittick, H., Manhire, K., & Roberts, J., (2019). Supporting Success for Māori Undergraduate Nursing Students in Aotearoa/ New Zealand. *Kaitiaki Nursing Research, 10*(1), 15-21.
6. Milne, T., Creedy, D. K., & West, R. (2016). *Integrated systematic review on educational strategies that promote academic success and resilience in undergraduate Indigenous students*. *Nurse Education Today, 36*, 387–394. https://doi.org/10.1016/j.nedt.2015.10.008.

PROFESSIONAL

From hospital to home – the power of good written information after discharge

By Claire Samuel, Sieun Kim, Kiran Karaka, Francine Llanillo, Lorenzo Marcelo, Chenhao Yang & Kim Ward

April 17, 2026

A simple, well-written pamphlet can make a huge difference to patients after discharge. Auckland University nursing students explain why simple language cuts readmissions.

This article examines how well-written discharge materials can improve patient health. Photo: AdobeStock

During our second-year clinical inpatient placements, some of us observed that written information, provided in pamphlets and handouts, was effective in facilitating patient education and enhancing health literacy.

Our observations are supported by recent research[1], [2], which identified that written information following patient discharge significantly enhances and supports patient health literacy and self-management.

We have seen written information used to educate patients regarding kidney stone prevention, stent removals and physical recovery, such as after hip replacement surgery.

This article examines how well-written discharge materials can improve patient health by smoothing patient discharge, and helping self-management and health literacy.

We examine this in the context of the integration of care domain (the red circle, below) — part of the fundamentals of care (FoC) framework.[3]

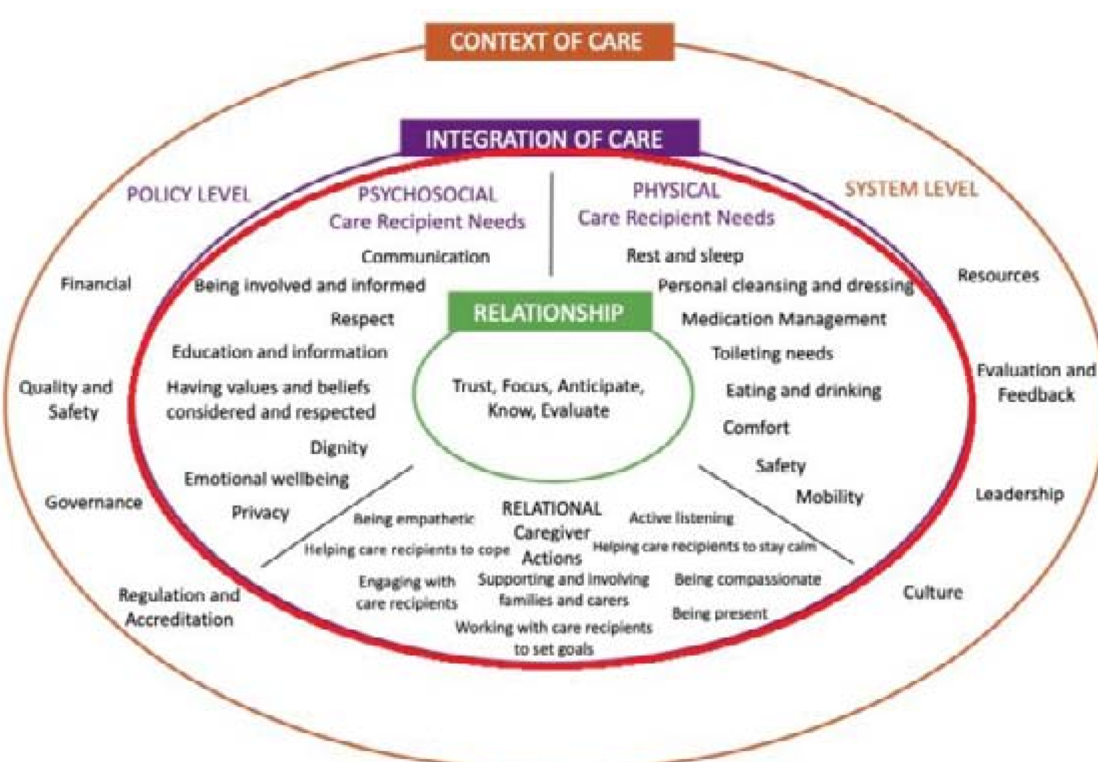


Figure 1. Fundamentals of care framework.

Student reflection

Observations from our clinical placements showed that written information enhanced condition management and health outcomes.

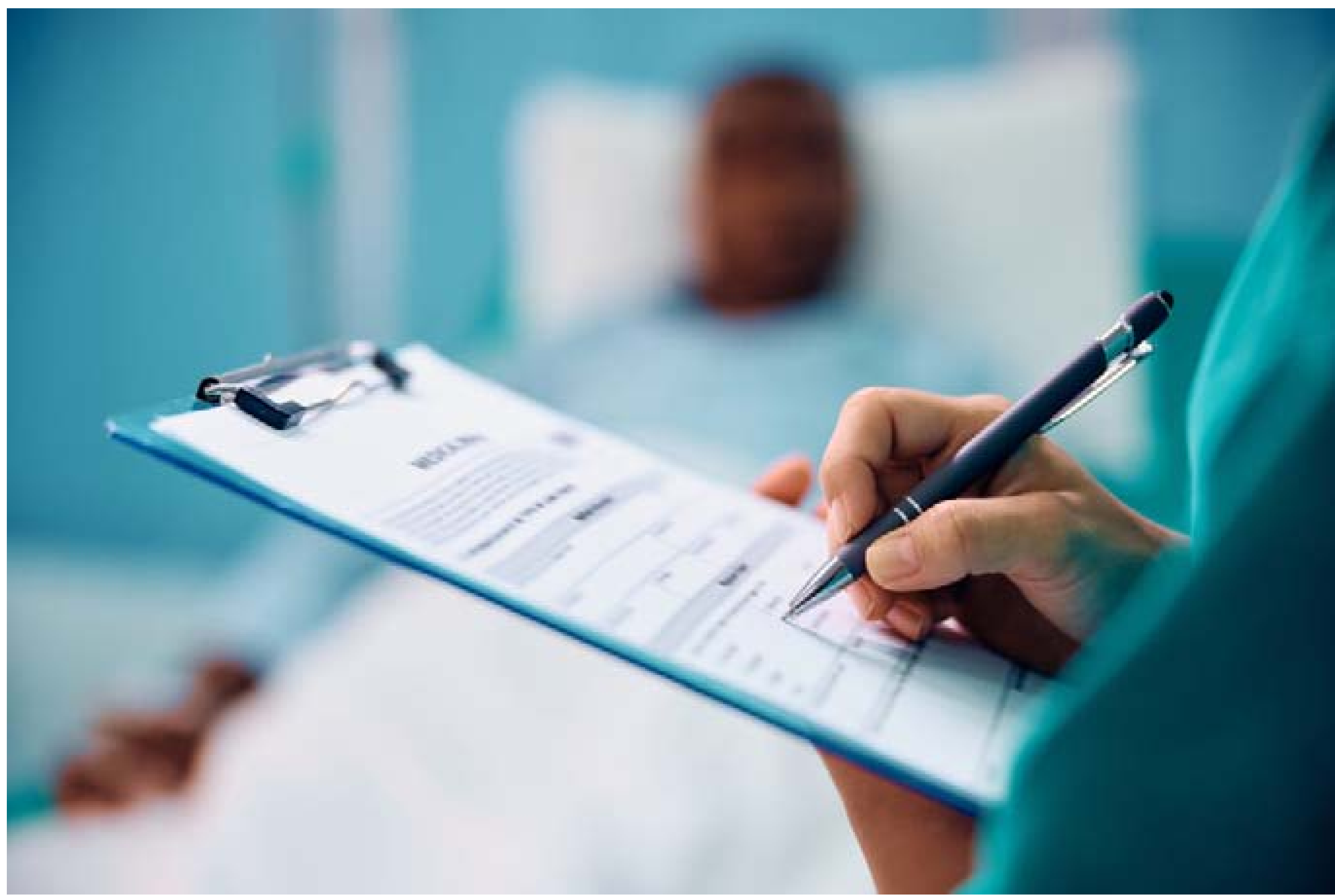
Across clinical specialities, patients who received written resources such as exercise sheets, intercostal chest drain care instructions, or crutch-use pamphlets demonstrated greater engagement and understanding.

They demonstrated confidence in self-care after discharge when reviewed during weekly follow-up clinics in the ward. In this context, we chose to explore the most effective forms of information-sharing for patients on discharge.

Background

Many patients face challenges in managing their health after hospital discharge due to a lack of clear information.[1]

While clinicians — nurses, doctors, and other health professionals — provide verbal education during hospitalisations, much can be forgotten without written information.



'Written information, such as pamphlets, handouts and leaflets, can support verbal education.' Photo: AdobeStock

Patients struggle to retain discharge instructions, increasing risks of non-adherence to treatments, medication errors, overlooked adverse symptoms, and missed follow-ups.[1]

Written information, such as pamphlets, handouts and leaflets, can support verbal education by providing clear and accessible details on symptoms, surgical procedures, medications, recovery, and risks, using simple and understandable language.[4]

Holistic patient education reduces hospital readmissions, improves adherence to care after discharge, and decreases anxiety and stress.[5]

However, despite its benefits, some clinicians perceive written information as having little practical value, viewing it merely as a "nice thing to do for patients".[5]

Benefits of written information

Involving patients in care planning and providing clearly-written information enhances their knowledge, supports informed decision-making, and strengthens health literacy, ultimately fostering better self-management and overall health.[2, 5, 6]

'Written content should use minimal medical jargon and be available in multiple languages to support understanding across all health literacy levels.' Photo: AdobeStock

Patients with well-designed written information have reported increased knowledge, improved information recall and enhanced health literacy, which has led to better health management and reduced hospital readmissions.[2,5,6]

Additionally, a Canadian study identified that a quarter of patients who were not provided written information about symptom monitoring were readmitted within 43 days of discharge.[7]

Over half of patients who were not included in care planning and did not receive written information also had an increased risk of readmission.[7]

Therefore, active collaboration between nurses and patients is essential to reducing readmissions and improving health outcomes.

Limitations of written information

A key limitation involves language appropriateness.

> **'While clinicians – nurses, doctors, and other health professionals – provide verbal education during hospitalisations, much can be forgotten.'**

We observed that nurses faced challenges delivering safe and comprehensive discharge education due to limited interpreter availability and a lack of translated resources.

These barriers contributed to prolonged discharge wait times and made timely interpreter scheduling difficult.

This reflects New Zealand's diverse population, where over one quarter of people speak languages other than English.[8]

The shortage of interpreters and translated resources hindered effective communication and patient education, compromising discharge safety and outcomes, which are essential to meeting physical care needs within the FoC framework.[3,9]

Delivery of complex information posed challenges. We noted that written resources were difficult for patients and their families to understand due to their complex format and information.

'Not all health-care settings had available, up-to-date or culturally appropriate materials.' Photo: AdobeStock

Ensuring that handouts were appropriate for individuals across all health literacy levels was a significant challenge.

Complex layouts, dense text, and excessive information increased the potential for information overload and hindered patient comprehension, particularly for those with cognitive impairments or anxiety.

These points highlight the importance of simple, clear, and visually accessible written materials.[1,10]

We also observed how limited resources impacted equitable access to information.

Not all health-care settings had available, up-to-date or culturally appropriate materials, which constrained patient access.

“Ensuring that handouts were appropriate for individuals across all health literacy levels was a significant challenge.”

Availability was further complicated by the current strict budget constraints within New Zealand’s health system, resulting in an inconsistent distribution of patient education resources nationwide.[11],[12]

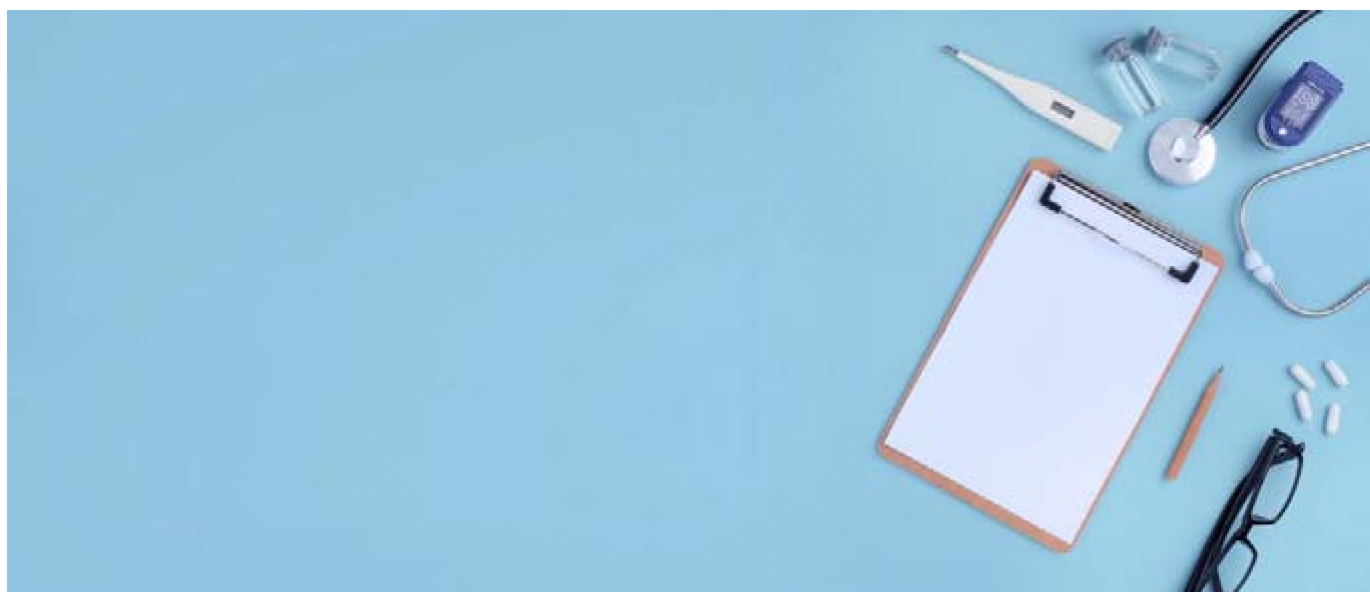
Furthermore, it has been noted[5] that in many cases, written information was only provided at the patient’s request or at the discretion of the nurse, worsening inequities in information access.

These factors reflect the influence of the FoC framework’s context of care, specifically highlighting barriers in policy and systems in place.[3]

In the context of disability and diverse communication needs, written materials alone can be limiting if not adjusted appropriately to the patient’s preferences, accessibility and health literacy levels.

People with disabilities often experience barriers to health communication due to a lack of accessible formats and communication strategies.[13]

It can be harder to retain verbal instructions alone or to process written information without support.[14] A recent study highlighted the importance of multiple approaches to enhance comprehension, demonstrating that relying solely on one mode of instruction significantly reduces recall among individuals with intellectual disabilities.[15]



Written information is not just a ‘nice to give’ to patients on discharge. Photo: AdobeStock

For example, adults with mild intellectual disability recalled more information when learning involved vocal production, speaking or reading aloud, compared to when they only listened or read silently.[15]

Moreover, it has been demonstrated[5] that a combination of written and standard verbal information also improved patients’ medication knowledge compared to providing verbal information alone.

The authors concluded that combining verbal and written communication significantly enhances patient understanding and self-management after discharge.

Despite these limitations, we identified some key strategies to improve the quality of the written information provided.

Simplified information pages

Researchers[1] have evaluated the effectiveness of a more accessible simplified information page (SIP) in discharge instructions, which include the most crucial and often overlooked discharge information for patients, such as primary diagnosis, prescribed medications, potential adverse side effects, and important follow-up appointment dates.

Patient Name: ______________________ Date: ______________

Today, you were treated at the Clements Emergency Department for ______________
(Diagnosis)

After you leave the Emergency Department, get these medicines from your pharmacy:

- Medicine Name:
  - Dose:
  - How long to take:
  - Purpose:
- Medicine Name:
  - Dose:
  - How long to take:
  - Purpose:
- Medicine Name:
  - Dose:
  - How long to take:
  - Purpose:

You also need to visit your other doctors so they can check on you.

- Doctor Name ______________, Specialty ______________
  - Date, Time

EMERGENCY

If you have these symptoms, visit the Emergency Department:

-
-

Figure 2. Simplified information page layout used in discharge instructions.

The SIP's digestible information resulted in improved patient recall and understanding of critical discharge instructions, which reduced chances of readmission.1 An example is provided above in Figure 2.

Combining accessible and inclusive information modes

Multiple researchers2,5 have found that both verbal and written discharge instructions offer higher rates of accurate recall compared with those receiving only one form of communication — improving self-management.

We argue that utilising both verbal and written methods to educate patients, with or without disabilities, improves knowledge, understanding, and confidence in self-management, all of which are critical for effective post-discharge care.5

Recommendations for nursing practice and policy

Written content should use minimal medical jargon and be available in multiple languages to support understanding across all health literacy levels, especially for individuals whose English is not their first language.6

Organisational support is needed to provide discharge materials in multiple languages, especially for common non-English languages in the local community.

Researchers have found that both verbal and written instructions offer higher rates of accurate discharge. Photo: AdobeStock

We also recommend policies that ensure timely access to interpreters to enhance verbal communication alongside written translations during the discharge process. This will enable nurses to deliver safer education, reduce communication barriers, and improve patient understanding and safety.9

Meeting patients' education and information needs through accessible language, improving understanding and increasing satisfaction with the education provided addresses psychosocial needs in

line with the FoC framework.[3,16]

Additionally, enhancing financial support through system-level policies would enable all healthcare settings to afford the production and distribution of high-quality written information promoting consistent and equitable access to patient education nationwide.[3]

We recommend that nurses advocate for the routine use of written materials as a standard part of their discharge education routine to help patients receive accurate information.

Personalised educational approach

Greater patient engagement and confidence were observed in our clinical placements when nurses took time to review discharge information, simplifying the language and using drawings and annotations to aid patients' understanding.

The SIP's digestible information resulted in improved patient recall and understanding of critical discharge instructions. Photo: AdobeStock

We encourage nurses to use plain, everyday language when providing verbal and written education, avoiding medical jargon.

We also recommend annotating handouts to highlight key information and encouraging patients to ask questions to confirm their understanding.

Local and government organisations, such as Healthify NZ[17], Medsafe[18], MIMS (Monthly Index of Medical Specialities) New Zealand[19], and resources available within Health Information Platform for Practitioners Online already offer accessible, patient-friendly health information.

Nurses should utilise these reliable resources to reduce the time spent simplifying complex handout information.

In the spirit of the integration of the care domain in the FoC framework, engaging patients in the design of handouts can further enhance their effectiveness by seeking patient feedback on language, layout and

illustrations to ensure materials are understandable and aligned with patient priorities.[21], [3]

A personalised, patient-centred approach to education may improve patient satisfaction, understanding, and treatment adherence, highlighting the importance of tailoring resources to individual needs rather than relying solely on standardised formats.[22]

> **'We encourage nurses to use plain, everyday language when providing verbal and written education, avoiding medical jargon.'**

Multidisciplinary team collaboration

We recommend that nurses actively engage in multidisciplinary team (MDT) collaboration to ensure accurate, timely and accessible information is provided on discharge, working alongside the likes of pharmacists, interpreters, cultural support, and social workers.

Collaboration helps ensure that patients receive clear, culturally appropriate and understandable information about their care, medications and support.

This should also include proactively referring patients with disabilities to appropriate support services to ensure a safe and informed discharge process.

Research[23] has found that effective discharge information and planning are facilitated by communication among patients, families, and MDT members, leading to shared expectations and improved patient outcomes.

Collaboration supports effective communication, continuity of care across different disciplines and improves patient outcomes.

Effective communication and therapeutic partnerships help boost patient health. Photo: AdobeStock

Conclusion

Obstacles to using written information effectively include language barriers, poor pamphlet design, and limited resources.

These factors can lead to inadequate patient education, resulting in low health literacy, poor treatment adherence, and ineffective management of the condition.

Therefore, nurses need to integrate patient-centred education at discharge, using clear verbal and written information to enhance understanding, particularly for individuals with intellectual disabilities.

Organisational support is vital to ensure discharge materials are available in multiple languages and that policies facilitate timely access to interpreters, promoting equitable and effective patient education.

These approaches align with the FoC framework by strengthening both the relational domain, through effective communication and therapeutic partnerships, and the contextual domain, through supportive systems and policies that enable consistent, equitable care.[3]

Overall, these bedside and system-level recommendations provide a practical pathway to safer, more person-centred transitions from hospital to home.

Claire Samuel, **Sieun Kim**, **Francine Llanillo**, **Lorenzo Marcelo**, **Kiran Karaka** and **Chenhao Yang** are final-year bachelor of nursing students at the University of Auckland. They began working on this article during their second year of study and are due to graduate this year. **Kim Ward** is a senior lecturer at the School of Nursing at the University of Auckland.

References

1. DeSai, C., Janowiak, K., Secheli, B., Phelps, E., McDonald, S., Reed, G., & Blomkalns, A. (2021). Empowering patients: Simplifying discharge instructions (https://bmjopenquality.bmj.com/content/10/3/e001419). *BMJ Open Quality.*
2. Hoek, A. E., Anker, S. C. P., van Beeck, E. F., Burdorf, A., Rood, P. P. M., & Haagsma, J. A. (2020). Patient discharge instructions in the emergency department and their effects on comprehension and recall of discharge instructions: A systematic review and meta-analysis (https://pubmed.ncbi.nlm.nih.gov/31439363/). *Annals of Emergency Medicine, 75*(3), 435–444.
3. Kitson, A., Conroy, T., Kuluski, K., Locock, L & Lyons, R. (2013). *Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs (https://digital.library.adelaide.edu.au/server/api/core/bitstreams/584b1213-5d1f-44c5-ae5a-f723ff819349/content),* School of Nursing, the University of Adelaide.
4. Perri, S., Argo, L., Kuang, J., Bui, D., Hill, B., Bray, B., Treitler-Zeng, Q. (2016). A picture's meaning: The design and evaluation of pictographs illustrating patient discharge instructions (https://doi.org/10.1080/17538068.2016.1145877). *Journal of Communication in Healthcare*, 8(4), 335–349.
5. Johnson, A., Sandford, J., & Tyndall, J. (2003). Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home (https://doi.org/10.1002/14651858.CD003716). *Cochrane Database of Systematic Reviews, 2003*(4).
6. Rameshkumar, T., Haputhanthrige, I. U., Misbahunnisa, M. Y., & Galappatthy, P. (2022). Patients' knowledge about medicines improves when provided with written compared to verbal information in their native language (https://doi.org/10.1002/14651858.CD003716). *17*(10).
7. Kemp, K. A., Quan, H., & Santana, M. J. (2017). Lack of patient involvement in care decisions and not receiving written discharge instructions are associated with unplanned readmissions up to one year

(https://doi.org/10.35680/2372-0247.1205). *Patient Experience Journal*, *4*(2), 4.

8. Infometrics New Zealand. (2023). *Regional Economic Profile | Auckland | Census | Languages spoken (https://doi.org/10.35680/2372-0247.1205)*. Infometrics. Retrieved May 14, 2025.
9. Shamsi, H. A., Almutairi, A. G., Mashrafi, S. A., & Kalbani, T. A. (2020). Implications of Language Barriers for Healthcare: A Systematic Review (https://doi.org/10.5001/omj.2020.40). *Oman Medical Journal*, *35*(2).
10. Khaleel, I., Wimmer, B. C., Peterson, G. M., Zaidi, S. T. R., Roehrer, E., Cummings, E., & Lee, K. (2020). Health information overload among health consumers: A scoping review (https://doi.org/10.1016/j.pec.2019.08.008). *Patient Education and Counselling*, *103*(1), 15-32.
11. Goodyear-Smith, F., & Ashton, T. (2019). New Zealand health system: universalism struggles with persisting inequities (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31238-3/abstract). *Lancet* (London, England), 394(10196), 432–442.
12. Ministry of Health. (2024, November 13). An overview of Vote Health funding for the health system in Budget 2024 (https://www.health.govt.nz/about-us/new-zealands-health-system/vote-health/budget-2024).
13. Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons with disabilities as an unrecognised health disparity population (https://doi.org/10.2105/AJPH.2014.302182). *American journal of public health*.
14. Barrington, M., Fisher, K. R., Harris-Roxas, B., Spooner, C., Trollor, J. N., & Weise, J. (2025). Access to healthcare for people with intellectual disability: a scoping review (https://doi.org/10.1177/14034948251317243). *Scandinavian Journal of Public Health*.
15. Icht, M., Ben-David, N., & Mama, Y. (2021). Using Vocal Production to Improve Long-Term Verbal Memory in Adults with Intellectual Disability (https://doi.org/10.1177/0145445520906583). *Behavior Modification*, 45(5), 715–739.
16. Oliveira, V. C., Refshauge, K. M., Ferreira, M. L., Pinto, R. Z., Beckenkamp, P. R., Negrao Filho, R. F., & Ferreira, P. H. (2012). Communication that values patient autonomy is associated with satisfaction with care: a systematic review (https://doi.org/10.1177/0145445520906583). *Journal of physiotherapy*, *58*(4), 215-229.
17. Healthify NZ (https://doi.org/10.1177/0145445520906583).
18. Medsafe (https://doi.org/10.1177/0145445520906583). *New Zealand Medicines and Medical Devices Safety Authority.*
19. MIMS New Zealand (https://www.mims.co.nz/).
20. Pratt, M., & Searles, G. E. (2017). Using Visual Aids to Enhance Physician-Patient Discussions and Increase Health Literacy (https://doi.org/10.1177/1203475417715208). *Journal of Cutaneous Medicine and Surgery*, *21*(6), 497–501.
21. Fong, S., Tan, A., Czupryn, J., & Oswald, A. (2019). Patient-centred education: How do learners' perceptions change as they experience clinical training? (https://doi.org/10.1007/s10459-018-9845-y) *Advances in Health Sciences Education*, *24*, 15-32.
22. Gledhill, K., Bucknall, T. K., Lannin, N. A., & Hanna, L. (2023). The role of collaborative decision-making in discharge planning: Perspectives from patients, family members and health professionals (https://doi.org/10.1111/jocn.16820). *Journal of Clinical Nursing*, *32*(19-20), 7519–7529.

FEATURES

Presence and absence in aged residential care: The quiet reality of loneliness and isolation

By Adetoun Oyekunle

April 13, 2026

Nurse and researcher Adetoun Oyekunle reflects on the daily loneliness she's witnessed among aged-care residents.

Christmas can be the loneliest time for some aged-care residents. Photo: AdobeStock.

In the week leading up to Christmas, and in the days after, aged-residential care (ARC) facilities often feel warmer and more alive. Decorations go up, special menus appear, music plays softly in the lounges and staff work deliberately to create moments of celebration, comfort, and dignity.

But what stays with me long after Christmas is not the carols or the lunch, but the contrast.

Adetoun Oyekunle

Some residents are collected by family, taken out for a meal, while some are surrounded by familiar voices and laughter. Others sit nearby, watching those reunions unfold. Not because they have no children or relatives, but because no one comes. For a few, there is not even a phone call.

In these moments, the distress was not about missing gifts or outings, but about the quiet realisation of being forgotten.

This reflection is drawn from my nursing practice in aged-residential care over the past few years.

What I have observed was not an isolated experience, nor was it unique to the festive season. Christmas did not create this isolation; it simply made it more visible.

The heightened activity, increased family presence, and celebrations made social differences more apparent. Even residents who usually appeared to cope well became more withdrawn as the days passed and visitors failed to arrive. In these moments, the distress was not about missing gifts or outings, but about the quiet realisation of being forgotten.

While Christmas magnifies the issue, loneliness and social isolation in aged residential care are not seasonal. They persist on ordinary weekdays, on birthdays that pass quietly, and on long afternoons when absence becomes routine. Over time, absence can become normalised by families, by the system and even by residents themselves. Residents may stop asking. Staff may stop expecting visitors.

Loneliness is not only a feeling – it is a risk

What I observed during this period reflects a wider, well-documented issue in aged care: loneliness and social isolation among older people.

In ARC, they can be present even when care needs are met, because care is not the same as connection. Evidence from national and international health authorities consistently shows that loneliness and social isolation have significant consequences for older people's health.[1]

Meaningful connection, however, does not require perfection, long visits or

significant expense.

Te Whatu Ora-Health New Zealand (HNZ) identifies impacts on both mental and physical wellbeing,[2] while the World Health Organization links social isolation and loneliness to poorer health outcomes, reduced quality of life and increased mortality risk[3] .

In everyday practice, the effects of loneliness often appear in subtle ways that can easily be misunderstood or overlooked. Residents may become more anxious and repeatedly ask questions. Others may show changes in behaviour, including restlessness, irritability, agitation or a gradual withdrawal from activities they once enjoyed. Low mood and tearfulness are also common, particularly after other residents have received visits. Physical changes may follow, such as reduced appetite or poor sleep.

'They're being looked after' is not the whole story.

It is easy to assume that once a loved one enters aged residential care, their need for family decreases because they are being looked after. This assumption is understandable. Facilities are structured, staffed, and designed to provide safety, continuity of care and clinical oversight. Nurses and care staff deliver care with professionalism and compassion, often going beyond their formal roles to provide comfort and reassurance.

A short phone call at the same time each week provides reassurance and something to look forward to.

'A short phone call at the same time each week provides reassurance and something to look forward to.' Photo:AdobeStock.

However, family contact fulfils a different function from formal care. It provides emotional reassurance, reinforces identity and belonging, and affirms to residents that they remain valued within their family network. This type of connection cannot be substituted by even the highest standard of professional support.

One of the most difficult aspects to witness in practice is the emotional shift some residents experience throughout the day. There may be early hope as the facility becomes busier, followed by quiet disappointment as visiting hours pass and no one arrives. In these moments, residents may feel unseen and disconnected, even while their care needs are fully met.

How families can support connection without needing to do 'big things'

Many families want to do better but feel overwhelmed by practical constraints or emotional complexity. Distance, financial pressures, caregiving fatigue, strained relationships and the difficulty of witnessing aging and decline all play a role. Sometimes guilt becomes heavy enough to turn into avoidance.

Meaningful connection, however, does not require perfection, long visits or significant expense. It requires intentionality and consistency.

Predictable contact can significantly reduce anxiety for older people. A short phone call at the same time each week provides reassurance and something to look forward to. Knowing when contact will occur is often more important than how long it lasts, particularly for residents living with uncertainty or cognitive decline.

When visits are not possible, acknowledging meaningful days still matters. A brief phone call, voice message, or video greeting on a birthday or holiday can transform how a resident experience that day. Even a few minutes of contact communicates a powerful message: you were remembered.

Sharing responsibility across the family can also improve consistency. When contact falls to one person alone, it may become irregular or stop altogether during busy periods. A simple plan, agreeing who will call or visit on which days, can help maintain regular connection without placing the burden on a single family member.

A respectful reflection

For families with a loved one living in aged residential care, it may be worth reflecting on what presence continues to mean beyond the provision of care. Care meets essential needs, but connection meets the human need to be seen, remembered, and valued.

Christmas will come again. So will birthdays, anniversaries, and ordinary Tuesdays when loneliness can feel even heavier than it does on significant days. The question is whether older people will experience those moments as still connected to family, or as quietly left behind.

Often, it is not grand gestures that matter most, but small, consistent acts of presence. A short, predictable phone call made regularly and at the right time can be enough to remind an older person that they are still remembered, and that they still matter.

Adetoun Oyekunle RN, MNSc, FCNA(NZ), is a care manager at Capital & Coast Care Coordination Centre in Wellington, which provides home help assessments. She is currently completing a professional doctorate on shift choice and flexible scheduling at Victoria University of Wellington's School of Nursing, Midwifery and Practice.

She is also seeking nurses to take part in a short, anonymous survey on the impact of shift choice and flexible scheduling on fatigue, *here*.

- *NZNO is advocating for safer staffing in aged care, through its Age Safe (https://maranga-mai.nzno.org.nz/age-safe) campaign.*

References

1. White, J., Falcioni, D., Thomacos, N., Mackenzie, L., Noble, N., & Boyes, A. (2025). Social Connection, Loneliness, and Solutions: Perceptions of Older Adults (https://www.tandfonline.com/doi/full/10.1080/01924788.2025.2492991). *Activities, Adaptation & Aging*, 1-25.
2. Te Whatu Ora-Health New Zealand. *Loneliness and isolation – mental wellbeing information (https://info.health.nz/health-topics/conditions-treatments/older-peoples-health/mental-wellbeing-loneliness)*.
3. World Health Organization. *Social isolation and loneliness among older people.* (https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/social-isolation-and-loneliness)

FEATURES

‘Not a birthday I expected to see’ – nurse, patient and professor Jacquie Kidd on stage-four cancer and racism

By Mary Longmore

April 9, 2026

When poet, nurse and Māori health professor Jacquie Kidd, Ngāpuhi, talks to me, it is her 63rd birthday.

Jacquie Kidd and Penny. Photo by John Cowpland of Alphapix.

"It's not a birthday I expected to see. Because in July it'll be four years since my colonoscopy, which was my first diagnosis. So I'm now on the far end of the bell curve."

We first talked in 2023, after Kidd went public with her terminal bowel cancer diagnosis. She wasn't angry — as a wahine Māori she said it felt "inevitable — why should I be any different?" given the statistics.

Yet, had the free bowel screening threshold been lowered to 50 for Māori, as the evidence supported — research she had contributed to — she may not be now facing an early death.

Kidd explores this in her confronting new book, *Ngākaurua,* a reflection on her cancer diagnosis, identity as a wahine Ngāpuhi and the brutal realities of racism in Aotearoa she's witnessed in her work — and is now experiencing herself.

As she writes, in the book:

My reality is this. Had free screening been introduced for Māori at 50, when it should have been, I would probably have been caught with a polyp and would not now have terminal cancer. It means I can look at some people who are in power today and say that their decision-making has contributed to my death.

Despite being an introverted and private person, Kidd says she decided to share her story to show how racist and stacked the health system is against Māori — and offer an alternative; a vision of how it might be better, not just for Māori but for everyone. A "reimagining" of a world where primary health is funded enough to provide wraparound, safe and accessible care for whānau; care which is led by whānau, tikanga and mana motuhake — autonomy.

She hopes it will inspire students, new academics or clinicians to find their own approaches to solve health inequities.

But there are other reasons, too.

"The inequities was one thing, but the other reason I was okay putting so much of my history in there is that I wanted to show that it doesn't matter if you have a rocky start. You can still go on and do stuff that's really important."

> **'The whakapapa connection is what made it viable to actually dream about doing something different, because I was never able to just settle.'**

The book reveals her early failed struggle to become a nurse, in an effort to please her father after a tumultuous childhood, as well as her own severe mental health problems. It tracks her winding and rocky path from mental health nursing into nurse education then academia, which led to her becoming a professor in her 50s — and a determination to go against the grain as a deeply-empathetic researcher willing to share her own vulnerabilities and stories, alongside others'.

"Maybe I've given them that little bit of encouragement which says you don't have to have been groomed into academic success in order to make it in academia. Or that its okay to be a vulnerable researcher who leads with their heart and isn't all about numbers. There are so many things I hope for this book because my work is not enough to turn around this racist train that we're on."

It's also about her whakapapa — a connection that has been live for her since childhood when she could communicate with her tūpuna — some of whom had also been nurses.

Being so derailed by a chaotic home life, Kidd said, meant school was hard.

“There was no way I was ever going to make it, based on my early and teen years. It had to come from somewhere else. And that somewhere else was my whakapapa,” she says.

Some of Kidd's nursing tūpuna, known as the Ngāpuhi nursing sisters, in 1901 Whangārei during the Boer War which New Zealand troops fought in. Left to right: Alcyone Calkin, M Kaire, Constance Calkin, Louisa Kingi, Kohu Gertrude. Photo:.Auckland War Memorial Museum Tāmaki Paenga Hira.

“But the whakapapa connection is what made it viable to actually dream about doing something different, because I was never able to just settle.”

‘Rangatahi have got this’

These days, despite cutting back on projects after getting her one to three year diagnosis in 2022, Kidd is still feeling okay. She is somewhat surprised to be still here. She recently started low-dose chemotherapy to shrink, or slow, the secondary tumours in her lungs.

“I've been incredibly lucky these tumours are slow-growing and giving me time.”

Workwise, she is still fulltime at Auckland University of Technology, supervising students and colleagues, advising research groups — and supporting the next generation of researchers as best she can.

“I think it comes back to the new people coming through – the rangatahi and the young adults who are coming through in health across the board, but also particularly Māori youth coming through,” she says.

“They've got this — we actually need to get out of their way.”

Jacquie Kidd at Waitangi in 2024.

Too many long-time leaders are "clinging on" to positions of power, instead of stepping aside and supporting fresh young leaders to flourish.

In the last six months, she reckons she has been supervised about eight or nine Māori nursing doctoral students, doing "incredible" work.

"I'm not in a position where I can commit myself to the important research projects that need to be done – but I can commit myself to the people who are putting themselves forward to do those research projects."

As well as working fulltime, she is also keynote speaker at this month's world indigenous cancer conference (https://www.heiahurumowai.org.nz/wicc2026) in Manukau, where she is talking about the importance of whānau voice.

> **'There are so many things I hope for this book because my work is not enough to turn around this racist train that we're on.'**

She is also co-chair of Māori cancer leadership network, Hei Āhuru Mōwai, which works to tackle racism in cancer care, policies and outcomes.

Fear of 'white backlash'

And at the end of last year, she and colleagues finally published a damning article in the New Zealand Medical Journal, *Tūtakarerewa — (https://nzmj.org.nz/journal/vol-138-no-1627/tutakarerewa-indigenous-advocacy-and-structural-racism-in-bowel-cancer-screening-in-aotearoa-new-zealand) Indigenous advocacy and structural racism in bowel cancer screening in Aoteroa New Zealand (https://nzmj.org.nz/journal/vol-138-no-1627/tutakarerewa-indigenous-advocacy-and-structural-racism-in-bowel-cancer-screening-in-aotearoa-new-zealand).*

It proves, says Kidd, that in 2020 the Government — via the Ministry of Health — turned its back on expert advice that dropping the free bowel screening age for Māori from 60 to 50 would save thousands of lives. Including, possibly, hers.

"It really highlights how hard people worked in that space and how much evidence was ignored. It shows how these inequities are perpetuated."

Ignoring evidence that Māori got bowel cancer younger, died faster and things were only getting worse — the Government (led by Labour at the time) decided not to extend the programme.

> **‘It doesn’t matter if you have a rocky start. You can still go on and do stuff that’s really important.’**

Key reasons were “fear of white backlash” — as well as the cost of providing enough colonoscopies to meet the true need that would have been revealed, the study found.

In 2022, the Government agreed to pilot a 50-year-old Māori and Pacific threshold in Tairāwhiti, Midcentral and Waikato, for three years.

But those pilots have now ended, and last year, a new threshold was set by Minister of Health Simeon Brown of 58 for everyone — the same age Kidd was diagnosed with stage four cancer. It meant more than 100,000 Māori and Pacific people who would have been eligible, were at risk.

He iti, he pounamu

Outside work, Kidd these days is focusing on the small but precious things — he iti, he pounamu. Her whānau — she has three daughters, a son and several moko — “dogs, sunshine, ice cream and lots of laughing”.

Ngākaurua is published by Cuba Press (https://thecubapress.nz/shop/ngakaurua-my-experience-of-cancer-identity-and-racism-in-aotearoa/) was launched at The Women’s Bookshop in Auckland on April 9

- *Disclosure: Kaitiaki coeditor Mary Longmore worked with Jacquie Kidd on the editing of Ngākaurua.*

COLLEGES & SECTIONS

Women’s health college: Continuing to break barriers in nurse-led care

By Jill Lamb

April 27, 2026

More nurses than ever are expanding into advanced practice such as colposcopy and hysteroscopy, which can prevent gynaelogical cancers — but more are urgently needed, says departing college chair Jill Lamb.

NZNO's women's health college committee, left to right: Professional nurse advisor Julia Anderson, Jackie Gartell, Sarah Marshall, Jill Lamb (chair), Sandy Hamilton, Josie Lambert and Nadine Riwai. Absent: Vanessa May.

Speaking at a colposcopy and gynaecology nursing study day in Wellington recently, I saw about 50 nurses there — many already working in or looking to expand into this field. I felt their enthusiasm was a reflection of the growing momentum in nurse-led women's health services.

Colposcopy is a procedure where a lighted microscope is used to examine the cervix, vagina and vulva for abnormal cells. A hysteroscopy is where a thin camera (hysteroscope) is used to examine the inside of the uterus.

Currently, around 10 nurse colposcopists are either qualified or in training — an encouraging step forward. In 2023, the college reviewed and updated its colposcopy training standards (https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Womens%20Health/Presentations/2023-03-28%20Colposcopy%20Standards%20Final.pdf), creating a clearer pathway for nurses to enter the field. A further update is planned to align with the latest HPV (human papillomavirus — a sexually-transmitted infection that can lead to cancer) screening pathway.

Nurses are well-placed to be part of the solution in both primary and hospital settings.

Evidence shows that increasing the number of nurse colposcopists is cost-effective, reduces waiting times, improves attendance and gives women more choice in their care. Reducing barriers is critical — many women feel nervous or whakamā about cervical examinations.

The introduction of the cervical self-test has also been a significant step forward, with 80 per cent of eligible women choosing this option. The college continues to advocate for it to be free for all.

Equity remains a major concern. Wāhine Māori and Pacific peoples experience higher rates of cervical cancer, with Māori women more than twice as likely to die from the disease compared with non-Māori women. Early detection and timely referral are essential to improving outcomes.

Following reduced funding for cervical screening training, the college is stepping in to provide financial assistance specifically for nurse training in this area.

New Zealand's first nurse hysteroscopist, Lauren Moore

Expanding into hysteroscopy

We have also been advancing nurse-led hysteroscopy. After a successful pilot in 2018, training standards (https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Womens%20Health/2025-05-16%20WHC_hysteroscopist_training_standards%20review%202025%20(formatted).pdf?ver=JTBvWmOBylRRwRGAFBlg7Q%3d%3d) were developed in line with the United Kingdom model.

Endometrial cancer is a growing health burden in New Zealand, particularly for Pacific women and increasingly for those under 50.

Expanding the number of nurses trained in hysteroscopy will help ensure more timely diagnosis and treatment. Since Waikato nurse practitioner Lauren Moore became New Zealand's first nurse hysteroscopist in 2022, three more nurses have qualified.

Photo: AdobeStock.

However, the withdrawal of Te Pūkenga's postgraduate course in 2025 has created a gap. The college is now exploring online training options and working with universities and Te Whatu Ora-Health New Zealand to secure future support.

Advocacy and growth

College membership has grown to nearly 700 members, supported by strong engagement through social media and an active committee.

We recently wrote to Minister of Health Simeon Brown outlining concerns about barriers to timely gynaecological and cervical screening care. HNZ's chief nurse has responded to acknowledge these concerns and signalled openness to future engagement.

With nurses making up the country's largest regulated workforce, we are calling for greater nursing and midwifery representation in national discussions on women's access to care.

Long wait times for gynaecology outpatient appointments remain a significant issue, and nurses are well-placed to be part of the solution in both primary and hospital settings.

A time for transition

After four years as chair, I am stepping down. Christchurch Women's Hospital colleague Sarah Marshall will take over later this year.

I will continue contributing to the profession through the NZNO nursing leadership section and am helping prepare for the women's health college conference, *Many journeys, one purpose (https://web.cvent.com/event/cc02f472-4cae-4cc8-93a5-47dfee06bfdd/summary): Honouring all voices in health*, to be held in Wellington in May.

A lifelong passion

After beginning my career in 1978 as an enrolled nurse, I have spent more than 40 years in women's health, most of that time at Christchurch Women's Hospital.

Drawn to outpatient care and colposcopy early on, I became a nurse practitioner in 2012 and have helped pioneer nurse-led hysteroscopy in New Zealand.

We have a really collegial atmosphere here at Christchurch Women's Hospital. I support the gynaecologists by picking up a lot of the work and they support me by picking up more of the complex patients.

I love women's health. It's often preventative work — helping detect and treat issues early—and that makes such a difference.

— Jill Lamb is outgoing chair of NZNO's women's health college and an NP women's health at Christchurch Women's Hospital.

COLLEGES & SECTIONS

Pasifika nurses urged to join CENNZ as annual conference wraps up in Auckland

By Sione 'Ulufonua

April 23, 2026

NZNO's college of emergency nurses NZ (CENNZ) held its 30th annual conference in Auckland in March.

NZNO emergency nurses Sandra Richardson (left) and Eillish Satchell (right) with emergency physician Mike Nicholls, who all spoke at the conference.

Emergency nurses from all over the country gathered for two days of whakawhanaungatanga (relationship building), learning and celebrating their dedication to emergency nursing.

This year's theme, te pae tawhiti – pursue distant horizons, highlighted the resilience and adaptability of emergency nurses amid ongoing social and political changes, underscoring their unwavering pursuit of clinical and cultural excellence.

'I strongly encourage Pasifika emergency nurses to join CENNZ and make use of this valuable platform for their own professional development.'

I recently came across CENNZ online and saw this event as an excellent opportunity for professional development.

As a new emergency nurse, it makes sense for me to register and become a member of CENNZ.

Membership would offer access to valuable networking opportunities, educational resources, and the collective knowledge of experienced colleagues, all of which are essential for my professional growth and confidence in the field.

Being part of this community would also help me stay updated with best practices and ongoing developments in emergency nursing, ensuring I provide a high standard of care.

The event was very rewarding, and it was the hard mahi of CENNZ's national and conference committee that made it happen.

I'd like to give a shout out to the sponsors and exhibitors who showcased the latest technology and clinical products. Hopefully, we will see some of these innovations in our emergency departments in the near future.

A heartfelt thank you also goes to the scholars and speakers who generously shared their research and insights, contributing to our collective growth.

Their ongoing support for CENNZ is invaluable, and together, we continue to strengthen the emergency nursing community.

Regretfully, I did not make it to the glitter and grit cocktail evening, but I am sure everyone had

NZNO emergency nurse Natasha Hemopo-Kemp (right) and professional nurse advisor Suzanne Rolls at the conference.

a great time. I'll blame it on aging, though it's probably more about needing an early night after such an inspiring and full-on day.

I strongly encourage Pasifika emergency nurses to join CENNZ (https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/) and make use of this valuable platform for their own professional development.

I look forward to reconnecting with everyone at future events — see you all in 2028.

Until then, may we continue to support each other and advance emergency nursing together.

Sione 'Ulufonua

Registered nurse

Auckland

LETTERS

Out-of-date laws, red flags and STI home-testing – NZ regulations too lax

By Janine Falkiner

April 20, 2026

Registered nurse Janine Falkiner offers a tongue-in-cheek home-testing case study in her letter that reveals how Australia's medical regulations are better than ours.

Not all STI home-testing kits are created equal -- here's a tip to find the best ones. Photo: AdobeStock

Accessing treatment for an sexually transmitted infection in New Zealand can be an expensive secret-squirrel mission.

The handy at-home-test-kit sold in New Zealand pharmacies for under $20 almost seems a generous public service.

Unfortunately, the therapeutic products regulation in New Zealand is weak on requiring evidence that products are reliable and effective.

Janine Falkiner.

Australian law, aligned to European Union regulations, demands stronger evidence of product reliability and effectiveness.

Questionable products can currently be legally sold across New Zealand.

Anything you put on or in your body to improve your blemish or itch, strength or focus are therapeutic products.

Luckily, there is a large chain of pharmacies across both New Zealand and Australia, subject to quite different laws. You know, the big yellow one that looks like a supermarket.

Search for the product you want reassurance about – on both the New Zealand and Australian websites. If it's sold in New Zealand but not Australia, treat that as a red flag, not a bargain.

This is a handy little work-around until New Zealand law can stand up to the industry of snake-oil peddlers here.

You're very welcome.

Janine Falkiner

Registered nurse in primary health

Auckland

The previous government's Therapeutic Products Act, modernising regulation of medicines, medical devices, and natural health products, was repealed by the Coalition Government in 2024. Regulation is currently reliant on laws from the 1980s.

LETTERS

Join our nationwide survey on Tiriti-based organisational journeys

By Heather Came, Clive Aspin and Julio Pereira

April 13, 2026

Has your organisation been, or is on, a Te Tiriti o Waitangi journey? Researchers exploring how kāwanatanga — authority to govern — can be exercised in a truly ethical and te Tiriti-led way, want to hear from you.

Waitangi Day, 2026. Photo by Mary Longmore.

We are inviting leaders, staff, and members from organisations across Aotearoa to take part in an important nationwide online survey exploring Tiriti-based organisational journeys. Your insights and

experience are vital for building a national picture of how organisations are engaging with Te Tiriti o Waitangi.

> **If you have insights into your organisation, you are the right person to respond.**

Our Honourable Kāwanatanga study, led by Heather Came and Clive Aspin, is examining organisational governance, power-sharing and the practical application of Te Tiriti. We aim to survey 1000 organisations and interview around 50 leaders, to identify practical steps for organisational Te Tiriti journeys and create a unique repository of knowledge about Tiriti-based governance and practice.

Clive Aspin and Heather Came.

The online questionnaire is suitable for formal and semi-formal organisations as well as community groups. It takes approximately 30-45 minutes to complete and focuses on: Structural power-sharing, relational practice, policy and systemic integration, monitoring and accountability.

If you have insights into your organisation, you are the right person to respond. You do not need permission from others in your organisation, and we value your personal perspective. You do not need to identify your organisation when completing the survey.

The study has received ethics approval from Te Herenga Waka Human Ethics Committee (approval number 2025/HEO40157).

The survey will close on 31 May 2026, so please take a few moments to share your experiences and help shape a national understanding of Tiriti-based organisational practice.

Julio Pereira

Your contribution is greatly appreciated and will help us identify meaningful, practical ways for organisations to honour Te Tiriti.

Please complete the questionnaire online by clicking the link: Take the Survey Now (https://docs.google.com/forms/d/e/1FAIpQLSe9E6eKabmXMSi502JKydW7I-zp1ti59N_X9YXiapoOU21m1w/viewform?pli=1). Or scan the QR code below.

— *Heather Came is founder of Stop Institutional Racism (STIR), Clive Aspin is associate professor of health at Te Herenga Waka-Victoria University of Wellington and Julio Pereira is associate professor and senior tutor in statistics at Massey University.*