2017

Audit Report: Tapuhi Tū Toa Intervention Study

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ACKNOWLEDGEMENTS

Ehara taku toa i te toa takitahi, engari he toa takitini, takimano

Strength comes not from ourselves alone but from the support of thousands

Thank you to all of you who contributed your time, energy and thoughts to the audit of Tapuhi Tū Toa.

LIST OF INITIALISMS

AUT	Auckland University of Technology
EIT	Eastern Institution of Technology
NZNO	New Zealand Nurses' Organisation
RAG	Research Advisory Group
TEC	Tertiary Education Commission
TTT	Tapuhi Tū Toa
WRMHD	Whakauae Research for Māori Health and Development

GLOSSARY

Kaimahi	Worker
Kanohi ki te kanohi	Face to face
Pānui	Public notice, announcement
Rangahau	Research
Tauira	Student
Tautoko	Support
Te ao Māori	A Māori worldview
Tika	Moral, right, correct
Wānanga	Learning event
Whakawhanaungatanga	Relationships, kinship, connection
Whānau	Family, kinship group sharing a common line of descent

EXECUTIVE SUMMARY

The Tapuhi Tū Toa (TTT) Māori Nurses Smoking Cessation Intervention, developed by Whakauae Research for Māori Health and Development[1] (WRMHD) and its research partners in 2014 - 2015, is based on previous research results and on cessation evidence. The Intervention model was feasibility tested with student nurses, during Te Rūnanga New Zealand Nurses' Organisation (NZNO) hui, who strongly supported implementation of the intervention.

In 2015, Intervention pilot study research was initiated and funded by WRMHD with a research advisory group being established to guide the Intervention research. Research advisory group (RAG) members included both education tertiary institution staff and Te Rūnanga (NZNO) representatives in addition to research team members.

Several targeted tertiary institutions agreed to participate in the Intervention research. However, after twelve months of intensive activity the Intervention remained undelivered. Following an extended period of unsuccessfully attempting to recruit Māori student nurse smokers, in sufficient numbers, on the targeted sites the TTT Intervention study was terminated by the lead researchers in October 2016.

Soon after termination of the Intervention study, WRMHD commissioned an audit of TTT to identify factors which contributed to the intervention gaining less traction than had been expected given the results of earlier feasibility testing. The audit was carried out by WRMHD with all audit information being collected prior to the close of 2016. Information was collated and analysed early in 2017 with the audit report then being compiled during February and March 2017.

AUDIT OBJECTIVES

The objectives of the TTT audit were to:

- Identify and describe what happened when implementation of the Intervention was attempted;
- Identify and explain what the barriers were to implementation - was it the Intervention model, or other factors e.g. institutional barriers? student motivation? and,
- Determine what may need to happen in the future if tertiary institution schools of nursing are to successfully facilitate TTT delivery.

[1] Whakauae Research for Māori Health and Development is a Ngāti Hauiti owned research centre. Established in 2005, Whakauae has a successful record of delivering investigator led health and social services research as well as research and evaluation commissioned by agencies which include several North Island district health boards along with Te Puni Kōkiri and the Ministry of Health.

METHODS

A range of methods was used to collect audit information including interviews with tertiary institution staff and RAG members, a tauira online survey and document review.

RESULTS & DISCUSSION

Documentary evidence details intensive interaction among key players in the study. In addition to extensive email communications, the Coordinator documented tertiary institution site visits, telephone discussions with tertiary institutions and communications with research team members to 'problem solve' the various challenges encountered in attempting to implement TTT.

The Coordinator worked with six tertiary institutions at various points. The primary focus of her engagement with each Institution shifted as the study progressed from securing site 'buy in' through to satisfying individual site ethics and other related requirements then finally the recruitment of tauira. Securing site 'buy in' was achieved reasonably quickly however, satisfying site pre-delivery requirements took much longer than anticipated. Institutions initially recruited as study control sites later became intervention sites when the quasi experimental design of the study was discontinued due to insufficient sites being engaged to accommodate the original design[2]. Facilitating the transition from control to intervention sites required both local and overarching ethics amendment approvals which took some time to secure.

To support the recruitment of tauira, the Coordinator met kanohi ki te kanohi with both tauira and staff at tertiary institutions. A total of ten presentations were made with 103 tauira and 20 staff in attendance. Due to various delays and low numbers of tauira registrations, TTT delivery dates needed to be changed seven times. In addition, the initial TTT key staff contact on each site changed at least once during the year, in most cases due to staff resignations.

Tauira who responded to an audit online survey (n=8) each recalled receiving information about TTT through their nursing programme with most indicating that that information had been clearly relayed. Most had considered taking part in the Intervention and indicated a continuing interest in participating in the future. In one instance, a respondent reported having since quit smoking because of the learning she had been exposed to through the promotion of TTT at her Institution.

Interview and document review data highlighted the pervasive 'busyness' of the tertiary institution setting with the final weeks of the academic year being particularly frenetic. Compounding the 'busyness' of this environment were the complexities of tertiary institution structures, processes and accountabilities. Introducing an additional demand, in the form of the TTT Intervention research, into the already fraught tertiary institution context was inevitably going to be a challenge. The research team, it was suggested, may have had an insufficient understanding of the tertiary institution context to readily negotiate these complexities. Carrying out some of the work necessary to establish a solid

[2] The proposed change in research design was submitted to the AUT Ethics Committee and was approved on 06 September 2016.

foundation for the delivery of the Intervention in the tertiary institution setting could therefore have usefully been done prior to attempting implementation.

The 'busyness' of the tertiary institution context, combined with the reality that TTT was not necessarily a priority for already stretched staff nor for 'time poor' tauira juggling a host of competing responsibilities in their lives, contributed to the inability to get traction with the Intervention. In the main, it appeared that the primary priority for tauira was to complete their assessments and pass their course of study. The fact that Intervention delivery was finally not timed to occur until late in the academic year was the likely tipping point for tauira who were by then fully focussed on satisfying formal requirements of study despite indicating earlier interest in participating in the Intervention.

Whether schools of nursing in tertiary institutions were the best sites for targeting Māori nursing tauira is in question in the view of some informants. The schools, it was suggested, may not necessarily be fertile grounds for supporting either the learning of tauira generally nor the work of Māori members of staff. Furthermore, staff themselves are likely to lack the knowledge and skill-based competencies to effectively support tauira cessation.

Complicating the context for TTT implementation still further was the history of the development of the Intervention and the relationships amongst some of the key players. The TTT Intervention model was the outcome of a collaboration between several partners including Whakauae Research and Te Rūnanga (NZNO). The second phase of the research however, that involved the piloting of TTT, was independently funded and led by Whakauae Research. The interests of Te Rūnanga (NZNO) in the phase two research were intended to be represented through the RAG. That representation did not however, fully satisfy the needs of Te Rūnanga (NZNO) contributing to the organisation and its constituency being less invested in phase two than they had been in phase one. That lesser investment may have impacted on the TTT uptake of both tertiary institutions and tauira.

The audit evidence highlights the robust and intensive work undertaken by the Intervention Coordinator to get TTT 'off the ground'. In the face of the myriad of challenges to the smooth rollout of the Intervention, which emerged over time, the Coordinator demonstrated flexibility, resourcefulness and the willingness to seek and take the advice of the research team where appropriate. Indeed, the universal view among informants was that the work that the Coordinator had carried out, in difficult circumstances, could not be faulted.

Primary barriers to TTT implementation appear to be institutional, being associated with both the complexity of the tertiary institutions context and with the demands on both tauira and staff engaged in programmes. The timing of TTT delivery, in the final months of the academic year, most certainly did not 'work' in the tertiary institution setting. Additionally, the short notice of opportunities to participate in TTT proved altogether impractical in a context within which a significant degree of forward planning was critical to successfully 'surviving' the academic year.

Strategies informants believed necessary to support successful facilitation of TTT focused on future delivery in schools of nursing settings. Better integration of the Intervention was considered critical and could be achieved through improved timing of delivery and linking tauira participation to the gaining of credits towards completion of a formal assessment. Putting the Intervention 'on the map'

for tertiary institutions and their tauira well in advance was also critical and could be achieved through presenting at the annual heads of school meeting.

Having a well-grounded working knowledge of how tertiary institutions operate, and of their operational contexts, was identified as being particularly important for the successful implementation of interventions such as TTT that are driven by external agents. That knowledge would, it was suggested, increase the likelihood that 'all the ducks would be lined up' in readiness for an intervention to begin rather than needing to be 'lined up' before delivery could be progressed as had eventuated with TTT.

CONCLUSION

The TTT Intervention model was endorsed at the close of the first phase of the Māori Nurses and Smoking research when it was feasibility tested. The second phase of the research involved the attempt to pilot the Intervention model. Audit findings highlight that the model itself was widely supported by a range of stakeholders. The model incorporated components considered integral to effectively support nursing tauira on a cessation journey. Despite the strengths of the Intervention model however, including its broad acceptability, implementation in schools of nursing during 2016 has been less than successful. The audit evidence identifies that the primary barriers to implementation lie not within the model itself but in the realities of the schools of nursing delivery context. Whilst institutional barriers present as the primary impediment to the successful implementation of TTT, the research team's need to conclude the study by the end of 2016 also figures.

RECOMMENDATIONS

If TTT is to be delivered in tertiary institution schools of nursing in the future the following actions are recommended:

- Encourage Te Rūnanga (NZNO) to lead the TTT Intervention as the organisation is strategically well-placed to take up that role;

- Encourage a wide range of professional organisations, such as the College of Nurses Māori Caucus, Te Ao Māramatanga Māori Mental Health Nurses, Te Kaunihera and Wharangi Ruamano to endorse the TTT Intervention promoting it across their respective memberships;

- Ensure that TTT is presented and promoted at heads of school level, in the lead up to the academic year, through forums such as the annual heads of school meeting. Notice in advance will increase the likelihood of schools of nursing being well placed to offer the TTT Intervention;

- Identify and recruit priority tertiary institution sites focussing on those with the highest proportion of Māori student nurses enrolled, with the mechanisms already in place to support the broader learning of tauira and where existing relationships and related networks can best be leveraged;

- Ensure all the necessary tertiary institution requirements, such as ethics approval and relationship agreements, are satisfied **prior to** attempting the delivery of TTT on sites;

- Emphasis that tertiary institution delivery sites need to 'own' the intervention if implementation is to be effective; their commitment is essential;

- Identify and recruit key staff as TTT 'champions' on each delivery site;

- Build in contingencies for accommodating the likelihood that key staff, integral to successful delivery on each site, may change for reasons beyond the control of TTT Intervention personnel. Such contingencies could include identifying more than one key staff as TTT 'champions' on each delivery site;

- Ensure 'champions' are fully conversant with the TTT Intervention approach and have access to ongoing coaching with respect to efficaciously promoting TTT amongst tauira;

- Ensure tauira are made aware at enrolment, as well as early in the academic year, of when the TTT Intervention will be timetabled for delivery;

- Determine, negotiate and finalise how tauira participation in the TTT Intervention will contribute to meeting nursing programme assessment requirements on each delivery site;

- Put in place supports to facilitate tauira wānanga participation including childcare funding;

- Ensure that tauira have the opportunity to identify what additional supports they may need to facilitate both participation in the wānanga and in other components of the TTT Intervention; and,

- As part of the Intervention consider developing a tuākana/tēina type model, such as that currently operating at the Eastern Institution of Technology (EIT) with NZNO, to facilitate support for tauira who smoke being provided by Māori nurses who have themselves quit smoking.

If TTT is to be delivered outside tertiary institution schools of nursing in the future the following actions are recommended:

- Encourage Te Rūnanga (NZNO) to lead the TTT Intervention as the organisation is strategically well-placed to assume that role;

- Consider Te Rūnanga (NZNO) regional structure as the mechanism for delivery of the TTT Intervention;

- Consider Te Rūnanga (NZNO) regional tauira hui as the settings for the wānanga component of the Intervention fostering whanaungatanga amongst tauira within and across neighbouring rohe; and,

- Equip Māori nurse leaders regionally to work closely with the tauira engaged with TTT by providing those leaders with the training necessary to provide support. A facilitator with the expertise and mana of the TTT Coordinator could ideally be engaged to offer that type of training.

1. OVERVIEW: TAPUHI TŪ TOA INTERVENTION AND AUDIT

The background to the development of the TTT Intervention is outlined below along with a description of the Intervention model, a chronological summary of the attempt to implement TTT and an overview of the aims of the subsequent TTT implementation audit.

BACKGROUND TO THE DEVELOPMENT OF TAPUHI TŪ TOA

In 2013, a research collaboration was formed between the New Zealand Nurses' Organisation (NZNO), WRMHD and Taupua Waiora at Auckland University of Technology (AUT). That collaboration focussed its research interest on developing an indepth understanding of the smoking behaviours, and attitudes to smoking cessation, of Māori registered nurses and student nurses. Māori nurses had been identified, through earlier research, as being well positioned to influence smoking prevention and cessation among whānau and Māori communities. A role for Māori nurses, in contributing to health gains by reducing smoking prevalence, had therefore previously been clearly established.

During 2013, the research collaboration conducted a national web-based survey of 410 Māori nurses, student nurses and other health workers belonging to NZNO. That survey determined an overall smoking prevalence of 21.5%. The prevalence for Māori student nurses however, was 32% in contrast to a rate of 20% among Māori registered nurses (Gifford, Wilson, Boulton, Walker & Shepherd-Sinclair, 2013).

Whilst the overall prevalence rate of Māori nurses smoking was lower than that identified through previous research, it remains significantly higher than that of nurses and midwives overall (13.6%) (Ponniah & Blomfield, 2008). Māori nurses indicated that smoking cessation has positive benefits for their own and others' health. Nevertheless, most who smoked did not see themselves as being particularly effective in being helpful for Māori in relation to smoking prevention and cessation (Gifford et al., 2013).

The research collaborative's national survey was followed by in-depth qualitative interviews with 43 participants to better understand Māori nurses who smoked and the impact their smoking had on their role as nurses including in the delivery of smoking cessation advice. Commonly, Māori nurses had taken up smoking in environments where smoking was normalised. However, it was clear that being Māori, a nurse and a smoker was professionally marginalising as well as creating conflicted identities and a dissonance when carrying out their nursing role. Despite being empathic and non-judgmental about patients who smoked, dissonance influenced the efficacy of Māori nurses who smoked in supporting Māori, whānau and other patients through the provision of smoking cessation advice. They ended up giving minimal, or ineffective, smoking cessation advice (Gifford, Walker, Clendon, Wilson, & Boulton, 2013; Gifford, Wilson, & Boulton, 2014).

Māori nursing students' experiences differed from those of registered nurses as they reported more notable conflicts around being both a smoker and a health professional, possibly because their knowledge of tobacco-related health issues heightened their awareness of the discrepancy between smoking and nursing. The association between tobacco use and ill health sat uncomfortably with

nursing and its association with caring for health. Most of the nurses in this study conveyed a clear motivation, along with reasons, to quit smoking, such as health gain, pregnancy and being better role models. Clearly evident however, was their lack of familiarity with, or practical application of, best evidence. Moreover, there appeared to be a general lack of understanding about addiction and the bodily effects associated with smoking.

Māori student nurses were identified as being an optimal target group for participation in smoking cessation activities using tailored, culturally-based smoking cessation interventions. Such interventions can leverage off the dissonance student nurses experience influenced by their awareness of being a smoking health professional (Gifford et al., 2014). The intention of developing and trialling an intervention targeted at Māori student nurses was to provide protected time for students to come together to develop an understanding about the various facets associated with smoking and why they continue to smoke despite the dissonance they experience. It was about 'planting the seeds' necessary for successful smoking cessation in the medium to long-term. The aim of the follow up intervention research was to pilot and evaluate TTT, a culturally-based smoking cessation approach developed by the research team specifically targeting Māori nursing students.

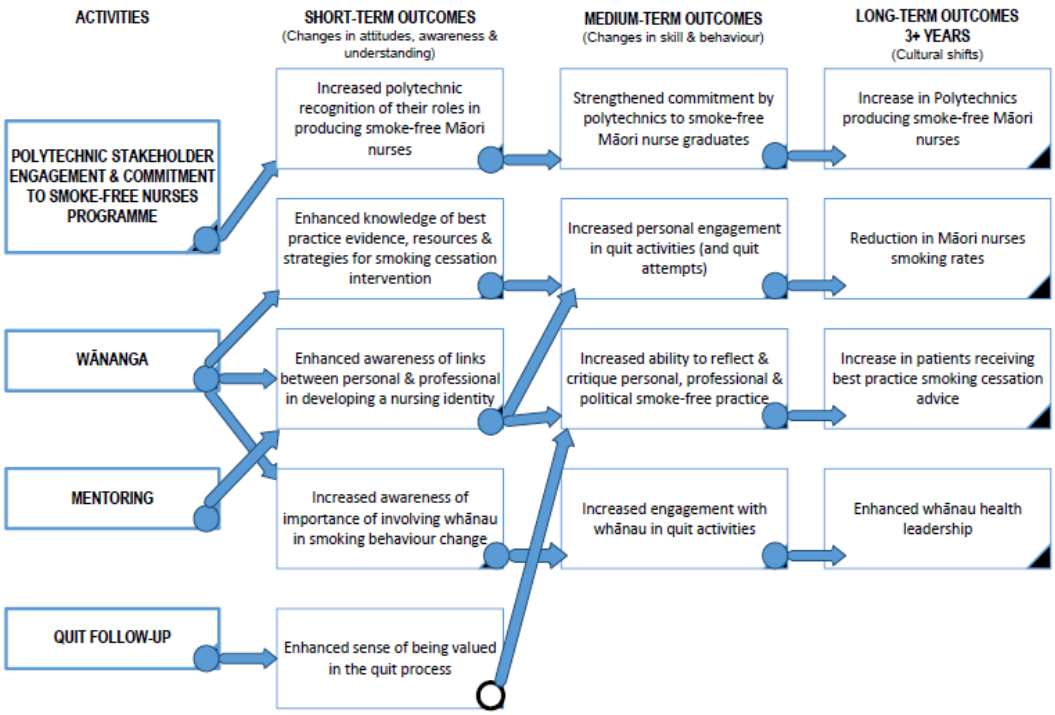
DESCRIPTION OF THE TTT INTERVENTION MODEL

TTT feasibility testing was carried out in the closing phase of the WRMHD, NZNO and Taupua Waiora research collaboration's research. NZNO members were consulted, with presentations being made by research team members at both the NZNO Indigenous Hui-a-Tau held in Auckland and in the Eastern Bay of Plenty during 2014 (Gifford, 2014). At the Auckland Hui, 157 NZNO members completed a feasibility survey with results indicating overwhelmingly strong support for TTT implementation. Tertiary institution schools of nursing, where it was envisaged TTT intervention participants would be recruited, were also consulted.

The TTT Intervention pilot study was later initiated, funded and led by WRMHD, with the intention of drawing on a mixed methods quasi-experimental design. The study aimed to recruit control and intervention groups, drawn from amongst Māori tauira who smoked and were currently enrolled on a nursing degree programme in one of four targeted polytechnics. Two - three tertiary institutionsites were to be recruited to act as the control group with two sites additionally being recruited to act as the intervention group. Evaluation research was to be used to determine the effectiveness of TTT.

A TTT Intervention summary was presented during the consultation period with NZNO members and target tertiary institutions. That summary, including activities and expected short, medium and longer-term outcomes captured in a TTT logic model (refer Figure 1), is reproduced below.

Figure 1. TTT Logic Model



Tapuhi Tū Toa – The Intervention: The TTT Interventon is located within te ao Māori (a Māori worldview) and is informed by Māori cultural values in order to better assist Māori nursing students to develop robust professional identities. Underpinning the intervention is a theory of change focussed at three levels; the personal, the professional and the political. The intervention's purpose is to equip Māori nursing students with the necessary knowledge, skills and attitudes to embark on a smoking cessation journey, with the aim that they will be smoke-free at the time of their nursing registration.

TTT draws on three key areas of change:

1. **Personal – Te Tupu Tangata**: PRIME (plans, responses, impulses, motives, evaluation) theory will build on a positive and growing sense of identity as a health professional. This will create rules about behaviours, which can in turn generate quit attempts;
2. **Professional – Te Tupu Mahi**: Nurses will be better positioned professionally through enhanced evidence-based knowledge, which will translate directly into practice; and,
3. **Political – Te Tupu Motu**: Kaupapa Māori theory, the Treaty of Waitangi and the Framework Convention on Tobacco Control provide frameworks for wider advocacy on behalf of Māori.

The three core components of the intervention are**:**

1. **Wānanga**: The aims of the wānanga are to (a) connect smokers and provide opportunities for discussion (b) stimulate thinking about smoking and other personal behaviour that may create tensions for health professionals and (c) link participants with a range of options for behaviour change;

2. **Whanaungatanga**: In recognition of the culturally pivot role of collective support and connection, we intend to put in place strategies for ongoing follow-up for those who want this. Whanaungatanga could be in the form of a buddy system, cessation providers working directly with quitters, a partner, or wider whānau or other supports; and,
3. **Rangahau**: Demonstrating the effectiveness of the intervention is a crucial component, therefore, running alongside of the intervention is a rangahau component. This component involves participants connecting with evaluation researchers at four key points during the intervention research; at recruitment, during the wānanga, at three months post-wānanga and at six months post-wānanga. A range of data is to be collected including participant feedback on the intervention and outcome measures, at each of these stages.

TTT includes a one and a half day wānanga on marae where local marae tikanga will be observed. We recognise that not all Māori identify, or are comfortable negotiating their way, as Māori. To increase participation and the attractiveness of the wānanga, they may or may not include noho depending on the site. Wānanga includes a variety of components (refer Table 1 below). Throughout the wānanga there will be spot prizes to incentivise participation. Additionally, smoking cessation milestone incentives (e.g. spa vouchers) will be available to those students who formally indicate their intention to make a quit attempt. Formal quitting will be verified by participants' registration with a local smoking cessation provider, or the Quit Line, and by quit status using a smokerlyzer.

Table 1. Intervention Group – Components of the Wānanga

Wānanga Day 1: 9am – 5pm	**Wānanga Day 2: 10am - 2pm**
Participants: Māori nursing students only	**Participants:** Participants bring member(s) of their whānau and non-smoking Māori students
Content: • Whakawhanaungatanga • Introduction – includes a brief history of Māori and tobacco as well as an overview of the intervention • Exploration of the context of smoking for participants and its impacts • Addiction and cessation aspects of smoking • Ex-smoker Māori nurse leader(s) and potential mentors during the intervention and ideally until participant graduation • What can non-smoking and smoking peers, whānau, and the institution do to help? • Local Māori smoking cessation kaimahi • Alternative supports within the community • Where to from here? Planning for graduation	**Content:** • Mihi whakatau (in consultation with marae) • Whakawhanaungatanga • Overview of the intervention • What's in a cigarette – interactive activity • What can non-smoking and smoking peers, whānau, and institutions do to help? • Where to from here? Planning for graduation

Control Group (TTT Intervention): The control group are to receive the current standard smoking cessation intervention according to the *New Zealand Guidelines for Helping People to Stop Smoking*. Those guidelines include a structured approach and the offer of nicotine replacement therapy. TTT participants are to be recruited from the nursing degree programmes offered by two tertiary institutions. Participants responding to recruitment calls in each of the two control groups will have the opportunity to go into a random prize draw for a $30 voucher (a Warehouse, Warehouse Stationery, Countdown Supermarket or petrol voucher). At the conclusion of the recruitment period, if the outcomes are promising in terms of numbers, participants will be offered the opportunity to participate in the TTT intervention.

Participants

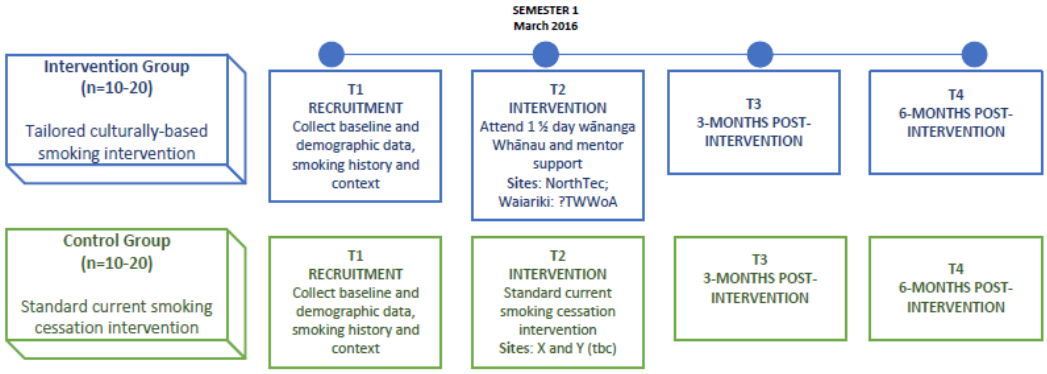
We intend to recruit 10-20 participants to each of the intervention and control groups (N=20-40) with those numbers expected to reasonably accommodate the inevitable incidence of participant 'drop-out'. Education Performance Indicator data for 2011, issued by the Tertiary Education Commission (TEC) in 2014, will be used to select TTT intervention and control sites based on their numbers of Māori nursing students. Target tertiary institution sites are those with a probable 24-48 enrolled Māori students who smoke (based on our findings that 32% of Māori nursing students are current smokers). It is anticipated that TTT wānanga will need a minimum of five participants to function effectively. Whanaungatanga, along with regular email and/or phone contact with participants, will be used to minimise the rates of attrition between recruitment and the various stages of TTT implementation

Potential participants will (a) identify as Māori, and (b) be currently enrolled in a nursing degree programme at a tertiary institution. Those not meeting these criteria will be excluded. The Intervention Coordinator will visit the tertiary institution sites and talk to the students during orientation week and invite those interested to take part in a wānanga to be held during March 2016. In addition, a smoking and level of addiction questionnaire will be placed on the sites' intranets which will include an opt-in question so that other potential participants can be recruited.

Data Collection and Analysis

Quantitative (smoking and addiction questionnaire) and qualitative (small group and individual interviews; verbal group feedback) data will be collected at four points; at recruitment, during the wānanga, at three months post-wānanga and at six months post- wānanga (refer Figure 2 below). Data will be statistically analysed for means and confidence intervals and a comparison made between the intervention and control groups. Qualitative data will be thematically analysed.

Figure 2. Overview of research design



Ethical Considerations

Ethical approval will be sought from AUT's Ethics Committee (refer http://www. aut. ac.nz / research ethics). All potential participants will receive an information sheet outlining the research, the expectations associated with participating, participant rights and any strategies to mitigate potential risks associated with the research (expected to be minimal). Participation is entirely voluntary with participants able to withdraw at any time without consequences. Confidentiality is assured with the identity of participants to be kept anonymous in any publications and presentations arising from the research. Following clarification, and answering of any questions arising, participants will be required to provide their written consent to participate. All data will be stored separately from consent forms in a secure cabinet by WRMHD, and destroyed after a period of six years.

Research Advisory Group

A Research Advisory Group (RAG) will be established by the principal investigators to guide the implemenation research.

IMPLEMENTING THE TTT INTERVENTION

Coordinator activity

In August 2015, an Intervention Coordinator, with extensive experience in Māori smoking cessation and project management, was contracted by Whakauae Research to lead the implementation of the TTT Intervention pilot study. The Coordinator initially contributed to the development of the research team's application to the AUT Ethics Committee[3] for ethics approval and began actively engaging with the priority tertiary institutions with a view to securing their commitment, by early in 2016, to participate in the implementation study. She worked with the Institutions identified by the research team as being the priority[4] before 'throwing the net wider', in October 2015, to involve a next layer of

[3] The ethics application, number 15/433, was subsequently approved by the Ethics Committee.

[4] The priority tertiary institutions were those with the highest numbers of Māori students enrolled in their schools of nursing referencing data cited in, *The performance of New Zealand Schools of Nursing: Responsiveness to Māori nursing students – Scorecard 2014.* Schools of nursing are currently located in several different types

'medium' priority Institutions (ranked in line with the 2011 tauira data issued by TEC in 2014) when uptake of those initially engaged appeared to be less than certain.

Among the Coordinator's initial tasks were engaging RAG members, preparing a draft RAG terms of reference and servicing the inaugural RAG meeting held in Auckland in February 2016. Members of the RAG were the TTT lead researchers, the Intervention Coordinator, two representatives of Te Rūnanga NZNO, two representatives from tertiary institutions, two experts in the field of smoking cessation, including one with particular expertise in Māori smoking cessation, and a representative of Smokefree Nurses Aotearoa New Zealand (refer Appendix One). Hui were to be chaired by one of the two Intervention research leads. The agreed role of the RAG was to provide:

- Open, frank, expert and constructive views and advice throughout the duration of the project;
- Technical, clinical and cultural knowledge throughout the duration of the project; and,
- Insight into issues raised, and if applicable, provide solution based feedback to assist the project to move forward.

It was expected that the RAG would meet, face to face or via teleconference, on three occasions during the term of the Intervention pilot study. In total however, two meetings were convened mirroring the delays in the Intervention roll out that later occurred. Implementation and evaluation matters were however, considered and reviewed by the RAG through email communications at different points during the year.

At its February 2016 hui, the RAG determined that non-smokers wanting to support colleagues to quit should be included in the Intervention and evaluation components of the research. A primary reason for the inclusion of non-smokers was the need to ensure sufficient numbers of registrations for the Intervention to proceed. At this point in the study, it was already becoming apparent that successful recruitment of sufficient numbers to proceed with the Intervention would present a challenge.

Later, in mid-2016, the multi-method quasi-experimental study design was withdrawn to better accommodate the realities of trying to implement the Intervention. The two control group sites already participating in the study then joined the one already existing intervention site to also become intervention sites. A control group was no longer included in the study design.

Evaluation activity

Alongside Coordinator activity, the TTT evaluation component of the research design was also in motion. The evaluation was to be externally planned and led by an expert Māori programme evaluator contracted for that specific purpose. Beginning in mid-2015, the evaluator worked closely with a Whakauae evaluator to develop a TTT evaluation plan which was subsequently completed early in 2016. The evaluation plan did not include a comparative design, utilising both intervention and control

of tertiary education provider settings across the country; wānanga (2), technical institutes (14) and universities (3).

groups, for reasons including that the evaluators did not believe that the scale of the Intervention would justify the use of such a design.

The evaluation plan was reviewed at the inaugural RAG meeting in February 2016. RAG members agreed with the evaluators that a comparison design would not yield findings of any statistical relevance. However, they believed retention of such a design would nevertheless generate useful contextual information. The RAG determined that the evaluation plan should be revised, with the inclusion of a comparison study design, and resubmitted for their approval. A revised evaluation plan was then prepared and circulated among RAG members on 08 April 2016 for review. Minimal changes were required with the revised evaluation plan being approved by the RAG later in April 2016.

Termination of the implementation study

After 12 months of intensive activity, the wānanga component of the Intervention had yet to be delivered. In total wānanga dates were changed seven times over the course of the study to better accommodate the needs of the tertiary institutions and ensure the Intervention would go ahead. Given the changes made to the study design to increase participation, along with the extended period of unsuccessfully attempting to recruit Māori student nurse smokers in sufficient numbers, the TTT Intervention research was finally terminated, by the two lead researchers in October 2016.

TTT AUDIT

Soon after termination of the research project, WRMHD determined that an audit of TTT was necessary to identify factors which may have contributed to the intervention gaining less traction than had been reasonably expected given the results of the initial research which had included feasibility testing. The audit was carried out by WRMHD, the TTT research funder. All audit information was collected late in 2016. The information was then collated and analysed early in 2017 with the audit report being drafted during February and March 2017.

AUDIT OBJECTIVES

In October 2016, WRMHD planned and begun implementation of a TTT Intervention audit. The objectives of the TTT audit were to:

- Identify and describe what happened when the Intervention Coordinator, and the research team, attempted to implement the Intervention;
- Identify and explain what the barriers were to implementation - was it the Intervention model, or other factors e.g. institutional barriers, student motivation, etc; and to,
- Determine what may need to happen in the future if tertiary institution nursing education providers are to successfully facilitate the delivery of Tapuhi Tū Toa.

2. METHODS

TTT audit information was collected from several sources using methods including interviews, an online survey of Māori nursing students and a document review. These audit information components are each described below.

AUDIT INTERVIEWS

A pivotal component of the audit design was a set of one-off telephone interviews with three categories of informant; namely tertiary institution staff, on the sites where the Intervention was to be delivered in the latter half of 2016, RAG members and the Implementation Coordinator. Table 2 below identifies the number of informants in each of these categories.

Table 2: Audit interview participants by category and number

Audit interview participant category	**Number of participants**
Tertiary institutions staff	3
Research Advisory Group (RAG) members	4
Intervention Coordinator	1
TOTAL	**8**

Audit interviews were carried out during November - December 2016. All interviews were conducted one-on-one via telephone. Telephone interviewing was used to collect audit information due to issues of geographical distance as well as limitations on the time available both on the part of informants to participate in interviews and on the part of the auditor to complete data collection.

Audit information (refer Appendix Two) was sent electronically to all interview participants, and content discussed, prior to interviews being carried out. Participants were also asked to sign a consent form prior to interview (refer Appendix Three). Three separate interview guides (refer Appendix Four) were designed to collect audit information; these were tailored for use with each of the three categories of informants.

ONLINE SURVEY

An online student survey tool was designed, reviewed and refined by the auditor (refer Appendix Five). The online survey was constructed and administered using Survey Monkey[5]. Three separate online survey web links were generated; one for each of the three tertiary institution schools of nursing targeted. Online survey web link information (refer Appendix Six) was emailed to the key TTT contact staff at each of the three tertiary institutions still involved in the study as at October 2016. Contact staff were asked to upload the information to the relevant student intranet to facilitate student access. After a series of reminders to key contact persons, all three surveys were eventually posted.

In two instances, a very low survey response meant that the respective tertiary institution key contacts were twice asked to bring the intranet posted survey information to the attention of students. In all three instances, the survey was open for a minimum of nine days with the highest level of response being recorded for the survey that was posted for the briefest period (nine days). A total of eight valid survey responses were received from tauira across the three tertiary institution sites.

Contingencies for accommodating potentially low survey participation rates were considered by Whakauae prior to survey design. Use of an online survey tool was selected as being likely to be the optimum survey administration mechanism because of ease of tauira access, minimal completion requirements in terms of time and ease of survey return. To further incentivise participation those who took part in the survey were also eligible to be entered in a random draw to win a $100 Warehouse voucher. A separate random draw was made for each of the three sites with a $100 Warehouse voucher being allocated on each of the sites. All online survey respondents were offered the opportunity to opt in to the random draw and almost all chose to do so.

DOCUMENT REVIEW

Document review included email communications between the Intervention Coordinator and the other key players in the Intervention. The Coordinator was asked to provide access to the emails between herself, the six tertiary institutions she had worked with at various points during 2015 – 2016, the RAG and WRMHD. She was additionally tasked with providing a written summary of the interaction she had had with each of the six Institutions matching key dates with email communications. All email information was requested from the Coordinator in early November 2016 and provided later that month. Tertiary institution engagement summaries were also compiled by the Coordinator and sent to the auditor in late November - early December 2016 as requested.

ANALYSIS

Telephone interviews were audio-recorded, with the consent of participants, and transcribed. Notes were also made during interviews. These notes, along with interview transcripts, were reviewed and

[5] Survey Monkey is a provider of independent, third party, web-based survey tools combining survey methodology with web technology (Survey Monkey, 2015).

thematically analysed. Online survey results were largely statistically analysed using Survey Monkey. The limited amount of qualitative data collected via the online survey was thematically analysed alongside key informant interview data. Documentary evidence was both quantitatively and thematically analysed. The analyses of each audit information component were synthesised and the results of that synthesis are presented in the next chapter of the report.

AUDIT LIMITATIONS

The audit was a small-scale operation completed over a brief period. The audit design was impacted by time and resource restrictions with findings, to some degree, reflecting those restrictions. In addition to the compressed timeframe and limited resource for the conduct of the audit, low level input from one key player group constituted a further limitation; that group was the tauira themselves. Whilst input from this key group was secured, a higher rate of participation may have increased the likelihood that the issues identified were those of greatest significance in relation to the low uptake of TTT among tauira.

Unfortunately, the timing of audit information collection, very late in the academic year, meant that tauira were no longer able to be easily accessed through their learning institutions. Delaying the collection of audit information until the new academic year began, in 2017, was not feasible given the requirement for prompt audit completion. Even if it had been feasible however, there was no guarantee that the cohort of 2016 students would be returning to their former schools of nursing facilitating access for audit data collection. These logistical factors impacted on the rate of audit participation of tauira.

3. RESULTS AND DISCUSSION

TTT audit results are presented and discussed here under each of the three audit objectives previously identified in the Overview: Tapuhi Tū Toa Intervention and Audit. These objectives were to:

- Identify and describe what happened when implementation of the Intervention was attempted;
- Identify and explain what the barriers were to implementation - was it the Intervention model, or other factors i.e. institutional barriers, student motivation, etc; and,
- Determine what may need to happen in the future if tertiary institution schools of nursing are to successfully facilitate the delivery of Tapuhi Tū Toa.

WHAT HAPPENED & WHAT WERE THE BARRIERS?

The results of document review, the tauira online survey and interviews with tertiary institution staff and RAG members are each presented and discussed below.

Document review

Documentary evidence details intensive interaction among key players in the study including between the TTT Coordinator and the priority tertiary institutions. TTT related email communications between the Coordinator and key players including a) tertiary institutions and tertiary institution networks b) AUT c) the RAG and d) WRMHD were analysed for audit purposes. Table 3 below quantifies Coordinator email communications by group.

Table 3: TTT Coordinator email communications summary

Email communications group	**Number**
Tertiary institutions and tertiary institution networks	394
AUT	68
RAG	178
WRMHD	474
TOTAL COORDINATOR EMAILS	**1114**

The focus of email communication content shifted as engagement with the tertiary institutions moved from phase one through to phases two and three. These phases are illustrated below in Figure 3: Tertiary institution engagement phases.

In addition to email communications, the Coordinator documented tertiary institution site visits, telephone discussions with tertiary institution staff and communications with TTT research team members to 'problem solve' the various challenges presented at different stages in the implementation of the study. Table 4 below quantifies these Coordinator engagement activities**.**

Table 4: Coordinator engagement activity summary

Type of engagement activity	**Number**
Telephone discussion with tertiary institution staff	77
Tertiary institution site visit	15
Meetings with TTT research team to 'problem solve'	21
Total primary engagement activities	**113**

In total, the Coordinator worked with four top priority and two medium priority tertiary institutions, at various points, during the term of the research study. As has previously been noted, the Intervention pilot study design assumed the successful recruitment of 10-20 participants to the Intervention groups (n=2 tertiary institutions) and control groups (n= 2 tertiary institutions) equating to 20 – 40 participants in total (refer 1: Overview: Tapuhi Tū Toa Intervention and Methods Audit section above).

Table 5 below summarises the period of Coordinator engagement, in relation to each of the six Institutions, the study's priority ranking of these Institutions and the outcomes of engagement.

Table 5: Priority ranking of Institutions by period of engagement

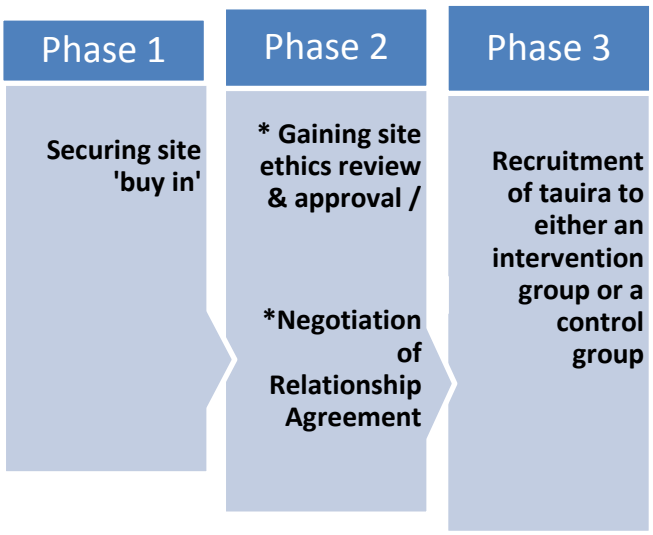
Period of engagement	**Institution and institution priority ranking**	**Engagement outcome**
August – November 2015	Institution 1: Top priority	Agreed to participate as an **Intervention site**. **Withdrew** citing staff capacity issues.
August 2015 – October 2016	Institution 2: Top priority	Agreed to participate as an **Intervention site. Insufficient student registrations** meant that the Intervention was not delivered.
November 2015 – October 2016	Institution 3: Top priority	Agreed to participate as a **control site**. Became an **Intervention site** when Institution 4 withdrew from the study. **Insufficient student registrations** meant that the Intervention was not however, delivered.
November 2015 – July 2016	Institution 4: Top priority	Agreed to participate as an **Intervention site. Withdrew** citing staff capacity issues.

November 2015 – February 2016	Institution 5: Medium priority	Subsequent to email and telephone communications and a site visit, Institution 5 advised being **unavailable** to participate**.**
March – October 2016	Institution 6: Medium priority	Agreed to participate as a **control site**. Became an **Intervention site** after Institution 4 withdrew. **Insufficient student registrations** meant that the Intervention was not delivered.

As Table 5 highlights, Coordinator engagement with the priority tertiary institutions spanned a period of over a year, from August 2015 – October 2016. Following termination of the Intervention study, in October 2016, the Coordinator liaised with Māori smoking cessation services in the regions of tertiary institutions 2,3,4 and 6 and with the institutions themselves. The purpose of that liaison was to help ensure that standard Māori smoking cessation services would be readily available to tauira in the respective schools of nursing to, at least in part, fill the gap left by the withdraw of the TTT Intervention.

The primary focus of the Coordinator's engagement with each tertiary institution shifted as the study progressed. Documentary evidence identifies that the focus of the engagement generally moved through the phases illustrated in Figure 3 below.

Figure 3: Tertiary institution engagement phases



Phase 1 was concluded reasonably quickly in the cases of all five tertiary institutions and primarily involved communication via email and telephone. Phase 2 however, was much more protracted for several reasons. Primarily, Phase 2 protraction may be attributed to the researchers unexpectedly encountering an additional layer of research ethics review and approval requirement at individual tertiary institution level.

In the first instance, study ethics review had been sought from the AUT Ethics Committee by the researchers, in consultation with the Coordinator, with ethics approval being granted prior to engaging the tertiary institutions. The expectation that AUT ethics review and approval would clear the study for implementation across the tertiary institutions proved to be erroneous. Consequently, the Coordinator was then required to invest considerable time and energy in working with sites, in association with the research team, to secure local level ethics approval in Phase 2.

Tertiary institutions 3 and 6 were recruited initially as control sites but were later invited to become intervention sites when the quasi experimental design of the study was discontinued due to insufficient sites being engaged in the study to accommodate the original design[6]. Amendments to both local level and AUT ethics approvals were required to facilitate transition from control site to intervention site status. Once again considerable Coordinator and research team time and energy was invested in working through the required changes to gain final ethics approval.

The other key activity component of Phase 2 was negotiation of formal relationship agreements[7] between each of the tertiary institutions and the TTT study. Delays were additionally encountered in signing off these agreements. The delays were, in part, attributable to the research team with respect to finalising the relationship agreement document and securing approval for amendment from the AUT Research and Innovation Office. Those delays were however, then further exacerbated by slow responses to sign off from some of the tertiary institutions.

In Phase 3 of engagement, the Coordinator worked with the tertiary institutions to support tauira recruitment to the study. In the cases of all four of the tertiary institutions which remained engaged with the study for any length of time, the work of the Coordinator in Phase 3 included meeting kanohi ki te kanohi with tauira. The purpose of these hui was to present and discuss the TTT intervention along with what tauira might expect from participating. In all four cases, staff of the Institutions were also present at hui. Table 6 below summarises the number of Coordinator presentations to groups of tauira and staff by date and Institution.

Table 6: Coordinator presentations at tertiary institutions

Date	**Institution**	**Number of tauira attending**
06 September 2016	Institution 2: Top priority	4 tauira (+ 2 staff): session 1 11 tauira (+ 1 staff): session 2
22 August 2016	Institution 3: Top priority	15 tauira (+ 2 staff)
February 2016	Institution 4: Top priority	40 tauira (+ 3 staff): session 1 4 staff: session 2

[6] The proposed change in research design was submitted to the AUT Ethics Committee and was approved on 06 September 2016.

[7] The relationship agreement document recorded how the collaboration between each tertiary institution and the TTT study would be conducted regarding establishing and maintaining a working relationship.

31 March 2016 13 May 2016 18 May 2016 20 May 2016	Institution 6: Medium priority	1 staff: session 1 4 Faculty staff: session 2 15 tauira (+1 staff): session 3 10 tauira (+1 staff): session 4 8 tauira (+ 1 staff): session 5
		Total presentations = 10 **Total participants = 123 (103 tauira + 20 staff)**

Up until mid-2016 recruitment was into intervention or control groups. When the research team reviewed the research design, subsequently moving away from a quasi-experimental approach, recruitment was confined to the intervention group. The proposed date for delivery of the wānanga component of the Intervention, which was to have been broadly chronologically aligned across the intervention sites, was changed seven times over the year in line with delays in earlier phases of Intervention rollout.

With the support of the TTT study leads the TTT Coordinator carried out a final concerted drive, during August - September 2016, to recruit tauira to the intervention. The goal of the drive was to recruit a total of at least five smokers on each of two of the three intervention sites by 13 September 2016 and at least a further five smokers on the remaining site by 21 September 2016. As has previously been noted, non-smoking tauira were also invited to take part in wānanga. The final numbers of tauira recruited on each site are recorded below in Table 7.

Table 7: Final numbers of smoking and non-smoking tauira recruited by tertiary institution

Tertiary institution	**Number of smoking tauira recruited**	**Number of non-smoking tauira recruited**
Institution 2	2	4
Institution 3	1	0
Institution 6	2	8

Other data highlighted, through the audit of Coordinator documents, included concerns with changes in tertiary institution staffing assigned to the TTT Intervention study. Table 8 below summarises those changes with respect to each of the five sites which agreed, at some point, to take part in the study.

Table 8: Changes in key staff members assigned to the TTT Intervention study

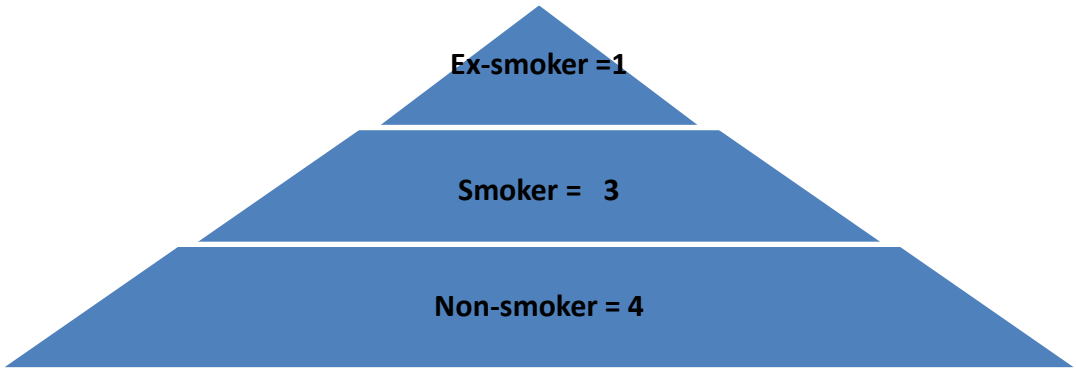
Tertiary institution number & priority rating	Change in staffing
1 Top priority	**YES:** Key staff member left
2 Top priority	**YES:** Key staff member left
3 Top priority	**YES:** Key staff member changed
4 Top priority	**YES:** Key staff member left
6 Medium priority	**YES:** Key staff member left

Table 7. identifies that, in the cases of all five of the tertiary institutions which agreed to participate in the pilot study, changes occurred with respect to who the key contact staff member/s was who would work with the Intervention Coordinator. In two instances, the loss of a key contact staff member was linked to the withdrawal of the tertiary institution from the study (Institutions 1 and 4), both cited lack of staff capacity to subsequently take part in the study. In the remaining three instances of staff change, responsibility was shifted to other members of staff.

Online survey

The online survey was completed by a cross section of eight tauira including both current smokers and non-smokers. Figure 4 below highlights the smoking status of respondent tauira.

Figure 4: Tauira smoking status (n=8)

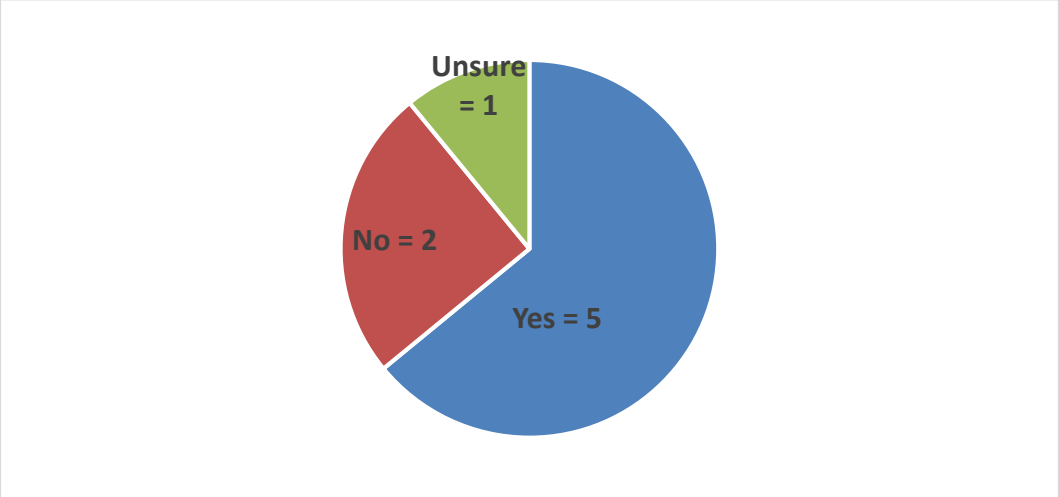


All eight survey respondents indicated that they could recall receiving information about the TTT Intervention, through their nursing programme, at some point during 2016. Information had been

provided to tauira at all tertiary institutions by the Intervention Coordinator, who had made presentations on TTT to tauira groups (refer Table 6 above). In some instances, that information was complemented by that provided by tertiary institution staff and / or via the respective student intranet on each site.

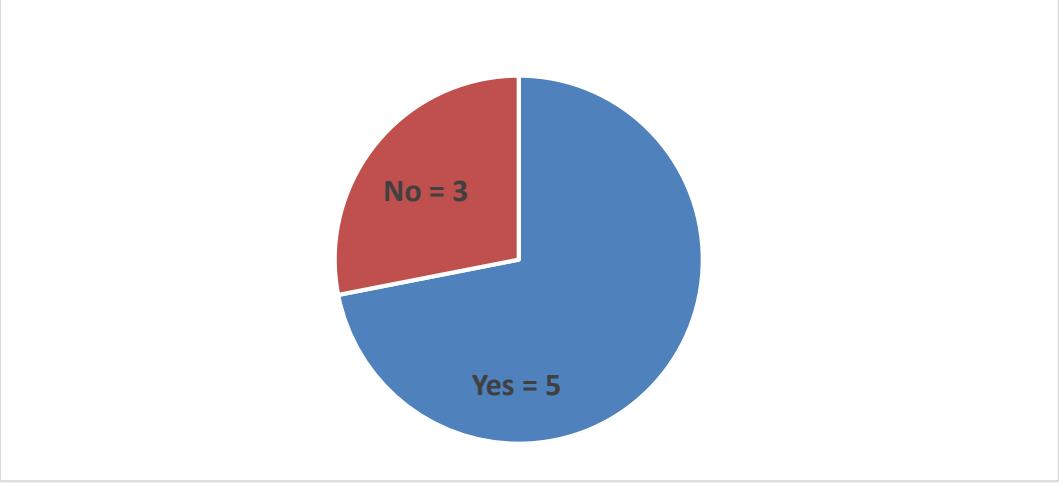
The tauira were asked to assess whether they believed they had been provided with clear information about TTT; Figure 5 below charts responses.

Figure 5: Clear information about TTT was provided (n=8)



Tauira were also asked whether they had considered taking part in the TTT Intervention. Responses are illustrated below in Figure 6.

Figure 6: Did you consider taking part in the TTT intervention (n=8)?



The five tauira who had considered taking part in the TTT intervention included all three smokers who responded to the online survey along with the ex-smoker and one of the four non-smokers. The smoking tauira explained that they had been interested in taking part in TTT for a variety of reasons.

One of these tauira believed TTT would offer her "another opportunity to quit" as well as allowing her to contribute to quit research. Another observed that quitting was important recognising that "becoming a registered nurse smoking is not good".

For the ex-smoker who had been interested in participating in TTT, that interest had been sparked by having had the experience herself of being a smoker and of successfully quitting. The non-smoker who had indicated an interest in TTT participation explained that that interest was due to her seeing a need "to tautoko our other students who are wanting to become smokefree".

The three tauira who had not considered taking part in the TTT intervention were all non-smokers. One of these three tauira explained, she "…didn't feel that it [TTT] was relevant to me" and therefore did not consider taking part. The two remaining tauira shared a similar view.

Survey respondents were offered the opportunity to make any additional comments they wished to make regarding the TTT intervention. Most respondents (n = 6) availed themselves of the opportunity to comment further including all three smokers. One of these smokers stated she was "ashamed that nobody wanted to take part. I would love to try the programme and see where it takes me". Another "wished it had still taken place" whilst the third asked "what is the plan for next year since the numbers for holding a wānanga were not met [in 2016]?"

The three remaining respondents offered a range of comments. A non-smoker explained that, though she had been interested in taking part in the Intervention, she "was unable to attend the wānanga as [she] was on [her] transition placement" at the time that the wānanga was scheduled to take place. The one respondent who was an ex-smoker shared the following: "I would have liked to be more involved as [I] was a smoker at the time. However, talking about it and thinking about it through learning about the program[me] helped me to make the decision to successfully quit".

Interviews

The setting for TTT implementation was, as has previously been noted, schools of nursing located within tertiary institutions. Interview informants commonly alluded to the pervasive 'busyness' of the tertiary institution setting. A tertiary institution staff member, for example, observed "…there's hundreds of things that go on in institutions like this". She summed up just how busy life in a tertiary institution could be when, only partly in jest, she exclaimed: "I usually say to my family, oh, in February, you know, "don't expect me to be available until November!" (I07). In the view of several informants, the final weeks of the academic year in tertiary institution schools of nursing were particularly frenetic. At that time of year "I can't even speak to a lot of my colleagues, they're a bit drowned" (I02) an informant explained.

The pace of the academic year impacted not only on staff but on tauira too. Tauira were:

> …incredibly busy just trying to get to their lectures, get to their clinical … learn how to do things in the clinical [setting] out there, and to get all these assessments done (I02).

The interplay between the 'busyness' inherent in the tertiary institution environment and the often hectic lives of tauira, themselves balancing a host of competing demands on their time and energy, was highlighted by informants. As an informant noted, tauira were typically "racing between tech and work and kids and all sorts" (I07) whilst others observed that, for tauira, "there's no sort of down time" (I04) resulting in "a huge amount of pressure on them" (I02).

In the case of the TTT Intervention, even though tauira indicated an initial interest early in the year in taking part, by the time the Intervention was finally being rolled out on tertiary institution sites tauira were in quite a different space. As one informant observed, in relation to the eventual roll out:

> …timing for the students was a bit difficult…. smoking students couldn't probably - wouldn't necessarily be interested - in engaging during a stressful semester and giving up…. [It] could have felt like just one more thing and "I'd like to do that but I don't have the energy to do that right now" (I04).

For staff, TTT unsurprisingly presented challenges. An informant confided "they wanted someone to champion the programme [TTT]…but…we just didn't have the time to do it" (I01). Another informant further explained these constraints on time:

> The main problem with doing anything in a school of nursing is the semesters are very short. So the semesters are only like maybe 12 or 13 weeks teaching and then there's like exam weeks and there's a break in the middle for a couple of weeks where they all study…. there's an enormous amount of content that they need to learn in order to come out and be able to pass that nurses' exam (I02).

The 'busyness' of the tertiary institution context, combined with the reality that TTT was not necessarily a priority for already stretched staff, likely contributed to the often-lengthy delays in the Coordinator getting responses to emails and telephone calls. At times, she needed to send repeated emails and make repeated calls to elicit necessary responses from tertiary institution staff. On the part of the research team there were also sometimes delays, one example being in the finalising of amendments to the relationship agreement which was necessary before that document could in turn be signed off by the participating tertiary institutions. Together all these delays contributed to the shrinking of the window of opportunity available to deliver the intervention within the 2016 academic year.

The complexities of the structure, processes and accountabilities, both internal and external, of tertiary institutions were noted by informants compounding the 'busyness' of the operating environment. As an informant observed "it's so complex … it's the whole thing. I think it's always about structure and how to get through all that maze" (I07). When the 'captains of the ship' themselves struggled to 'wade through the maze' however, life in a tertiary institution could present even more challenges. An informant, for example, described the frustrations of 'trying to make things' happen when:

> …we've just got a new [senior manager] who is trying to work out "what are the correct procedures that work around this place"? And… wanting to make sure that she [keeps] everything …tika (I01).

Introducing an additional demand, in the form of the TTT Intervention research, into the already fraught tertiary institution context described above was something widely believed to be "difficult to get traction on" (I08). Indeed, the research team had not really "anticipate[d] …all the 'red tape' with the institution[s]" (I03) that needed to be dealt with before the Intervention could be rolled out in the view of several key informants. That 'red tape' included the requirement to secure local level ethics approval, in the case of each tertiary institution involved in the Intervention research in addition to the overarching ethics approval already secured through AUT. The preparation and negotiation of multiple site relationship agreements and, in at least one instance, production of a research project plan were also requirements. Faced with all these unexpected additional demands it became increasing clear, in the view of one informant, that the research team ideally "should have started [TTT Intervention work] way earlier" (I03) to successfully negotiate these convoluted and time consuming requirements.

Complicating the context for TTT implementation still further was the history of the development of the Intervention and the relationships amongst some of the key players. As has been previously noted, the TTT Intervention model was the outcome of a Health Research Council funded phase one research collaboration between several partners including Whakauae Research and Te Rūnanga (NZNO). The second phase of the research however, that involved the piloting of TTT, was independently funded and led by Whakauae Research. The interests of Te Rūnanga (NZNO) in the phase two research were represented through the RAG.

The shift in Te Rūnanga's (NZNO) relationship with the research between phase one and phase two contributed to Te Rūnanga's (NZNO) representatives and constituency feeling less committed to the phase two research. As an informant explained "it didn't feel like nursing owned [TTT] anymore…. Te Rūnanga didn't seem to have a presence … and people couldn't connect with it" (I06).

Several informants queried how closely the wider research team had worked with Te Rūnanga to support the interface with the tertiary institutions and the tauira themselves. In the words of one of these informants a strong alliance with Te Rūnanga was necessary because "Te Rūnanga guarantees you access …like the middle man or the middle person to the students and I think that that you need that partnership to access the students" (I05). Te Rūnanga has "relationships with the schools of nursing… the staff, and probably the students too because they come along to [Te Rūnanga] hui. And some of them are on the student body of Te Rūnanga" (I02). Better use of those connections may perhaps have been made too through the research team "… talking at [Te Rūnanga] hui and keeping people connected to the second phase" (I06). The lesser level of Te Rūnanga (NZNO) constituency engagement with phase two of the research, it was felt, contributed to the challenges faced around the bedding in of TTT in the tertiary institutions including with respect to recruiting participants.

As several informants concurred, the potential for Te Rūnanga (NZNO) to strongly support the TTT Intervention through, for example, encouraging the participation of their members was not fully

realised in 2016. Clearly the TTT model itself was not at issue here but rather the roles of the RAG members in providing advice to the Coordinator around promoting uptake and themselves contributing to that promotion.

A further point raised by several informants concerned whether in fact the schools of nursing in tertiary institutions were the best site for targeting Māori nursing tauira in the first place. One informant questioned whether the schools were well attuned to the needs of either Māori staff or tauira, both of whom were represented in very low numbers. Another supported that view adding:

> …there's lots of things happening because of, I guess, government policy and the [fewer]workforce opportunities at the end of things. What I've felt coming through is a lot more [ethnic] tension, less Māori kaiako in those kura. So perhaps the environment wasn't the best to start with? (I06).

Another informant observed that schools of nursing staff did not always demonstrate the requisite empathy with tauira who smoked taking an approach which was not at all helpful. She provided an example of hearing a staff member talk with tauira about their smoking:

> …the words [the staff member used] weren't appropriate …you can't make people - you can't bully people - into not smoking. You can't say "you know as a health professional you shouldn't be smoking". Of course they know that (I03).

When staff themselves were not conversant either with TTT or with cessation best practice generally they were not necessarily the best people to be championing TTT uptake. It had proven to be challenging for the Coordinator to ensure staff were well positioned to champion the Intervention for several reasons including time constraints as well as staff turnover. The extent of the turnover of staff associated with TTT had been significant as has been previously highlighted by Table 7 above.

Informants concurred that the Intervention Coordinator had faced formidable challenges driving TTT in the frenetic and complex tertiary institutions environment. As one informant noted "she did a wonderful job engaging like she did" (I02). Another commented "she was the ideal person. She's got a lot of mana [among] a lot of rōpū members" (I06). Indeed, the universal view among informants was that the work that the Coordinator had carried out, in difficult circumstances, could not be faulted.

There was consensus that the timing of the TTT rollout was not well matched with either the needs of tauira nor of the tertiary institutions. The incompatible timing of the rollout was greatly exacerbated by the late but unavoidable research team decision to include the control sites as Intervention sites. The limited lead in time to this shift in the research design impacted on the opportunities tertiary institutions had to support recruitment. In one instance, for example, the local ethics committee approval necessary to accommodate the change in research design meant having to:

> …wait for the approval from the chief executive …the days were ticking down ….and then the icing on the cake was… we'd been given sort of a clear message that we weren't to do any promotion or, you know, recruiting until we'd had that approval (I01).

The same informant added that "if there'd been more time [and] …maybe not just one engagement with the potential participants…. Creating the relationship with the participants may have meant they had more commitment to it" (I01).

The audit evidence discussed above highlights the robust and intensive work undertaken by the Intervention Coordinator to get TTT 'off the ground'. In the face of the myriad of challenges to the smooth rollout of the Intervention which emerged over time, the Coordinator demonstrated flexibility, resourcefulness and the willingness to seek and take the advice of the research team where appropriate.

Primary barriers to TTT implementation appear to be institutional, being associated with both the complexity of the tertiary institutions context and with the demands on both tauira and staff engaged in schools of nursing programmes. Where tauira may have embraced TTT in principle, in the early phases, the realities of participation were a major issue when balanced against a host of competing demands in terms of study along with paid and unpaid work responsibilities as the year unfolded. Staff, who had shown support for TTT in the early phases, were very often no longer in place when the Intervention was ready to roll out. Staff changes contributed to additional demands on the Coordinator such as bringing new staff 'up to speed' with TTT and attempting to secure their 'buy in' where they may have been assigned to take over the TTT support role on their site without necessarily having a strong commitment to the kaupapa.

The timing of TTT participation opportunities, in the final months of the academic year, most certainly did not 'work' in the tertiary institution setting. Additionally, the short notice of these opportunities for participation proved altogether impractical in a context within which a significant degree of forward planning was critical to successfully 'surviving' the academic year.

Whilst institutional barriers present as the primary impediments to the successful implementation of TTT, the research team's need to conclude the study by the end of 2016 combined with uncertainty around who is best placed to drive and deliver TTT also figure.

WHAT NEEDS TO HAPPEN TO SUPPORT FUTURE DELIVERY?

In the main, suggestions for supporting successful facilitation of TTT focused on future delivery within the tertiary institution schools of nursing setting rather than in any alternative setting. The improved integration of the Intervention with schools of nursing programmes was considered necessary. That integration could in part be achieved through addressing issues such as timing and maximising of the benefits of TTT participation for students.

Regarding improved timing, an informant suggested it would be advantageous for "…researchers and schools [to] get the information in front of the potential participants at the beginning of the year" (I01). This would avoid adding the pressure of a last-minute rush to the already frenetic learning and teaching environment. Forward planning would increase the likelihood that TTT tauira recruitment requirements would be adequately met.

In a similar vein, another informant promoted getting the schools of nursing on-board with the TTT Intervention research well ahead of time by taking the research proposal to:

> …the heads of school meetings that are run through the NZNO. So all of the schools agree to participate and … because of the wider organisation, you get the buy in…. if we were looking in hindsight and we were doing it again then that meeting would be the crucial point that you would have to get buy in from all the schools before you actually undertook the project maybe the following year (I06).

The NZNO heads of school meeting referred to by the above informant is generally held annually around mid-year.

Better accommodating the reality that, for students, meeting the requirements of course completion is the priority was important. As one informant explained "**…**students really find it difficult to do anything for their…study apart from what is actually counted as assessment somewhere" (I02). Exploring ways of linking participation in the TTT Intervention with achieving credits toward completion of specific course requirements was raised by several informants as a mechanism for increasing tauira participation. Thus:

> …there might be some way for people who are doing research …and the school to think "does participation in this in any way contribute to achievement of an outcome …or a learning assessment or something"?... how it might contribute to the assessment work they're already doing (KI01).

Assigning credits for participation would signal commitment to the smokefree nurses agenda as well as better addressing the' time poor' situation of nursing tauira. It was recognised however, that linking TTT participation with the achievement of credits would be a challenging avenue to pursue given factors including the unique curriculum offered by each school of nursing.

Having a well-grounded working knowledge of how tertiary institutions operate and of their operational contexts was also identified as being critical to the successful implementation of interventions such as TTT that are driven by external agents. That knowledge would, it was suggested, increase the likelihood that 'all the ducks would be lined up' in readiness for an intervention to begin rather than needing to be 'lined up' before rollout could be progressed as had eventuated with TTT.

Challenges to the successful implementation of TTT in the tertiary institution setting are clearly significant. The following section of the Report draws together audit conclusions and provides recommendations for any future implementation of TTT both in tertiary institutions and outside that setting. Many of these TTT challenges, and the adjustments considered necessary to facilitate future successful implementation, are additionally documented in an invitational seminar presentation, and webinar broadcast (refer Appendix Seven), delivered at the University of Otago at the close of 2016 (Gifford, 2016). That presentation was well received highlighting the value to the public health community of sharing knowledge around what 'does not work' as well as the successes interventions may achieve.

4. CONCLUSION & RECOMMENDATIONS

The audit sought to provide Whakauae Research and the TTT RAG with information in relation to why TTT implementation was unsuccessful. The Intervention model is evidence-based and had been stakeholder endorsed at the close of the first phase of the Māori Nurses and Smoking research following feasibility testing. The second phase of the research involved the attempt to pilot the Intervention model.

Despite the strengths of the Intervention model, including its broad acceptability, implementation in schools of nursing during 2016 has been less than successful. The audit evidence identifies that the primary barriers to implementation lie not within the model itself but in the realities of the schools of nursing delivery context. Whilst institutional barriers present as the primary impediment to the successful implementation of TTT, the research team's need to conclude the study by the end of 2016 also figures.

In the light of the audit results and discussion, several recommendations are made with respect to the possible future implementation of the TTT Intervention. These recommendations address the final audit objective; determine what may need to happen in the future if tertiary institution schools of nursing are to successfully facilitate the delivery of TTT. In the event, however, that TTT is instead delivered under the umbrella of Te Rūnanga NZNO, and outside the schools of nursing, recommendations are provided in relation to that alternative delivery scenario.

RECOMMENDATIONS

If TTT is to be delivered in tertiary institution schools of nursing in the future the following actions are recommended:

- Encourage Te Rūnanga (NZNO) to lead the TTT Intervention as the organisation is strategically well-placed to take up that role;

- Encourage a wide range of professional organisations, such as the College of Nurses Māori Caucus, Te Ao Māramatanga Māori Mental Health Nurses, Te Kaunihera and Wharangi Ruamano to endorse the TTT Intervention promoting it across their respective memberships;

- Ensure that TTT is presented and promoted at heads of school level, in the lead up to the academic year, through forums such as the annual heads of school meeting. Notice in advance will increase the likelihood of schools of nursing being well placed to offer the TTT Intervention;

- Identify and recruit priority tertiary institution sites focussing on those with the highest proportion of Māori student nurses enrolled, with the mechanisms already in place to support the broader learning of tauira and where existing relationships and related networks can best be leveraged;

- Ensure all the necessary tertiary institution requirements, such as relationship agreements, are satisfied **prior to** attempting the delivery of TTT on sites;

- Emphasis that tertiary institution delivery sites need to 'own' the intervention if implementation is to be effective; their commitment is essential;

- Identify and recruit key staff as TTT 'champions' on each delivery site;

- Build in contingencies for accommodating the likelihood that key staff, integral to successful delivery on each site, may change for reasons beyond the control of TTT Intervention personnel. Such contingencies could include identifying more than one key staff as TTT 'champions' on each delivery site;

- Ensure 'champions' are fully conversant with the TTT Intervention approach and have access to ongoing coaching with respect to efficaciously promoting TTT amongst tauira;

- Ensure tauira are made aware at enrolment, as well as early in the academic year, of when the TTT Intervention will be timetabled;

- Determine, negotiate and finalise how tauira participation in the TTT Intervention will contribute to meeting nursing programme assessment requirements on each delivery site;

- Put in place supports to facilitate tauira wānanga participation including childcare funding;

- Ensure that tauira have the opportunity to identify what additional supports they may need to facilitate both participation in the wānanga and in any ongoing components of the TTT Intervention; and,

- As part of the Intervention consider developing a tuākana/tēina type model, such as that currently operating at EIT with NZNO, to facilitate support for tauira who smoke being provided by Māori nurses who have themselves quit smoking.

If TTT is to be delivered outside tertiary institution schools of nursing in the future the following actions are recommended:

- Encourage Te Rūnanga (NZNO) to lead the TTT Intervention as the organisation is strategically well-placed to assume that role;

- Consider Te Rūnanga (NZNO) regional structure as the mechanism for delivery of the TTT Intervention;

- Consider Te Rūnanga (NZNO) regional tauira hui as the setting for the wānanga component of the Intervention fostering whanaungatanga amongst tauira within and across neighbouring rohe; and,

- Equip Māori nurse leaders regionally to work closely with the tauira engaged with TTT by providing those leaders with the training necessary to provide support. A facilitator with the expertise and mana of the TTT Coordinator could ideally be engaged to offer that type of training.

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6. APPENDICES

APPENDIX ONE: RESEARCH ADVISORY GROUP (RAG) MEMBERS

Denise Wilson – Co Academic Lead: Dr Denise Wilson is of Ngāti Tahinga (Tainui) descent. Denise is Professor of Māori Health, Co-Director of Taupua Waiora Centre for Māori Health Research, and Associate Dean Māori Health at Auckland University of Technology. Denise is a Fellow of the College of Nurses Aotearoa (NZ) and Te Mata o te Tau (Academy of Māori Research & Scholarship), on the Editorial Board of the Journal of Clinical Nursing and the Indigenous Journal of Wellbeing - Te Mauri Pimatisiwin. Denise is also the Chair of the Family Violence Prevention Investment Advisory Board and Deputy Chair of the Family Violence Death Review Committee.

Grace Wong: Dr Grace Wong is Director of Smokefree Nurses Aotearoa/New Zealand and a Senior Lecturer in Nursing at Auckland University of Technology. Dr Wong has a background in public health nursing, tobacco control, and research about nurses and smoking, and Asian people and smoking.

Hayden McRobbie MB ChB (Otago), PhD (London): Hayden McRobbie is Professor of Public Health Interventions at Barts and The London School of Medicine and Dentistry, Queen Mary University of London (UK) and Director of the Dragon Institute for Innovation (NZ). After completing his medical degree, he went on to study in London and gained a PhD in medical psychology. He now has over 16 years' experience in the provision of behaviour change interventions in the fields of smoking cessation and weight management. Hayden provides advice to a range of international organisations and expert bodies, committees, working groups and conferences. He is Assistant Editor of Nicotine and Tobacco Research and Addiction, Deputy Editor of the Journal of Smoking Cessation, and a member of the Society for Research of Nicotine and Tobacco (SRNT).

Heather Gifford – Co Academic Lead: He uri au nō ngā awa e rere nei, ko Rangitīkei, ko Whanganui. Nō reira, e tau tāku manu ki te pae maunga e tū mai rā, ko Ruahine, kia poia rā e ngā haumiri o tāku tupuna, o Hauiti. Whakatau atu ki te whakaruruhau o Rātā, e tau, e tau rā.

Heather began her professional career as a nurse working in the field of child and family health. She has since taught at a tertiary level in health services, worked as a manager with a Māori Development Organisation and in Māori primary health care. In 1996, she returned to tertiary study completing a Post Graduate Diploma in Public Health at Otago University and a Master's in Public Health soon after. She then completed her PhD, and later held a postdoctoral

fellowship, with Te Pūmanawa Hauora, the Research Centre for Māori Health and Development, Massey University. In 2005, in collaboration with Ngāti Hauiti, she established Whakauae Research for Māori Health and Development, an iwi based research centre. In 2016, after ten years as Director, she stepped down to take up a role within Whakauae as Senior Advisor Business and Research. Heather's research interests to date have concentrated on health service delivery and intervention, and the development of whānau, hapū and iwi based models to address Māori health issues, in particular, tobacco control research with a focus on prevention and policy work.

Kerri Nuku Ngāti Kahungunu, Ngā Tai: Kerri has extensive health sector experience that includes nursing, midwifery, policy development, and international and national advocacy roles. With her auditing, management and governance background Kerri has been involved in many Ministry and health project groups. Kerri is currently the Kaiwhakahaere o Te Rūnanga o Aotearoa, Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation. She also continues her contribution in the health sector as a Director for the New Zealand Nurses Organisation and a member of the Māori Relationship Board Member, HBDHB, Trustee Maungaharuru Tangitu Trust, Board of Trustee for Te Aute College.

Leanne Manson Ngāti Tama Ki Te Tau Ihu, Te Ātiawa: Leanne works as the Policy Analyst Māori with the New Zealand Nurses Organisation. Leanne has an extensive nursing background having worked both overseas and in the New Zealand health sector in a range of areas in Paediatrics, Medical, Hospice, Renal and Haemodialysis Unit and as a Policy Analyst at the Ministry of Health. Leanne has an Honours degree in Māori studies and Te Reo Māori and a Post Graduate Diploma in Public Health and currently studying towards her Masters. Leanne is committed to her iwi Moemoeā and is a trustee on the Ngāti Tama ki Te Waipounamu Trust.

Sue Taylor, Ngāti Kahungunu (ki Wairarapa), Ngāti Raukawa (ki te Tonga)

Sue has many years' experience in the field of hauora particularly tobacco control, health promotion, social services and AoD. She is a Director of T&T Consulting Limited which specialises in training, education, research and evaluation. Before forming T&T, Sue was the National Smoking Cessation Manager/Trainer, for Te Hotu Manawa Māori, and prior to that worked as an AoD counsellor and Iwi Social Worker for Te Rūnanga o Raukawa ki te Tonga. She is actively involved with Iwi, hapū and marae development. She is the mother of two, grandmother of six and great-grandmother of one.

Teresa Taylor – Intervention Coordinator

Ka mihi ōku iwi ko Ngāti Raukawa ki te Tonga, koutou ko Ngāti Tūkorehe, Ngāti Kahungunu ki Wairarapa, Ngāti Kuia, Ngāti Apa ki te Rā Tō, Rangitāne ki Wairau me Ngāti Pākehā ki a koutou katoa. Teresa is a Director of T & T Consulting Limited, and has worked on a variety of projects within the Māori tobacco control sector over a period of sixteen years.

Participants in the first RAG hui, convened on 22 February 2016 in Auckland, also included:

Orana Harris and Reena Kainamu

APPENDIX TWO: AUDIT INFORMATION FOR INTERVIEW PARTICIPANTS

Tapuhi Tū Toa Smoking Cessation Intervention: Implementation Audit

AUDIT INFORMATION

Whakauae Research is carrying out an audit of the implementation of the Tapuhi Tū Toa (TTT) Smoking Cessation Intervention. The intervention was funded by Whakauae in three schools of nursing during 2016. The audit is being carried out to identify the factors which may have contributed to the low levels of TTT uptake among Māori students in the targeted schools of nursing.

Before you decide whether to contribute to the audit process please read this sheet. If you decide not to contribute there will be no disadvantage to you of any kind.

We are interested in talking with you about:

- Why you believe tauira uptake was too low to support TTT delivery in 2016;
- What you think could have been done differently to increase the level of uptake in 2016;
- What you think may need to be done in the future to increase uptake among Māori student nurses in tertiary education settings (specifically polytechnics and wānanga).

If you are willing to contribute to the audit:

- we will meet with you, at a time and place that suits you, for a period of 30 – 40 minutes;
- you will only need to answer the questions you want to answer;
- you can end the meeting at any time if you want to; and,
- we will ask you for your written consent to take part and to audio record discussion.

What will happen to the audit information you give us?

- Audit information you give us will be analysed and reported in such a way that you will not be able to be identified. Your name and any information which could identify you will not be linked in any reporting to the things you talk about;
- Audit information collected will be securely stored and accessible only to the auditors;
- Results of the audit may be published. Information included in any published material will in no way be linked to you without your prior express permission.

Questions

If you have any questions about the audit, either now or in the future, please contact us:

Ms Lynley Cvitanovic
Whakauae Research for Māori Health and Development, Whanganui
Ph (06) 347 6772
Email: lynley@whakauae.co.nz

Dr Heather Gifford
Whakauae Research for Māori Health and Development, Whanganui
Ph (06) 347 6772
Email: heather@whakauae.co.nz

APPENDIX THREE: CONSENT FORM

Tapuhi Tū Toa Smoking Cessation Intervention: Implementation Audit

November 2016 AUDIT CONSENT FORM

I have read the Audit Information Sheet and understand what the audit is about. My questions have been answered to my satisfaction. I know that I can ask for more information about the audit at any time and that:

- My participation in this audit is entirely voluntary;
- I can withdraw the audit information I provide, up to and including 31 January 2017, without disadvantage of any kind;
- My audit interview will be recorded with my consent. If audio-recording is used, I can choose to have the recorder stopped at any time during my interview;
- Any record of my name and address will be destroyed at the conclusion of the audit. An anonymous transcript of my audit interview will however, be retained in secure storage for three years by Whakauae Research after which it will be destroyed;
- I may decline to answer any question(s) and/or may decide to end the interview without disadvantage to me of any kind;
- The results of the audit may be published, but my anonymity will be preserved. No information which could reasonably lead to the identification of informants will be included in any report or published material resulting from this audit without the express prior consent of the participant concerned.

I (name).....agree to take part in this interview as part of an audit being carried out by Whakauae Research for Māori Health and Development.

Date: Signature of informant:

APPENDIX FOUR: INTERVIEW GUIDES

Host Institution Staff Perspectives

1. **Please outline what you know about the Tapuhi Tū Toa Māori Nursing Students Smoking Cessation Project**

2. **Please tell me what you know about how your institution became involved with the Tapuhi Tū Toa Māori Nursing Students Smoking Cessation Project**

(**Prompts:** What did you think the TTT Project involved? What contact did you have with the TTT Co-ordinator? In what ways did you think your institution was being asked to contribute? In your view was your institution adequately placed to contribute as requested i.e. as a control/intervention site?)

3. **Please describe what happened after your institution was invited to take part in Tapuhi Tū Toa, as a delivery site, and had agreed to participate.**

(**Prompts:** In what ways did you think your institution was being asked to contribute? Who was assigned to 'look after' TTT in your institution, how and why? Who was involved in deciding how to bring tauira on board? In your view was your institution adequately placed to contribute as requested i.e. as a delivery site?)

4. **What involvement did you have with Tapuhi Tū Toa?**

(**Prompts:** What role did you think that you would have in the promotion and delivery of TTT at your institution? What role did you end up having (if different to what you had initially thought**)**? How clear were you about what was expected of you in relation to TTT? What contact did you have with the TTT Co-ordinator?

5. **Please tell me about how tauira were introduced to Tapuhi Tū Toa**

(**Prompts:** Who told tauira about Tapuhi Tū Toa and how they could take part? What medium was used to share this information with tauira? What opportunities were there for tauira to find out more about Tapuhi Tū Toa?)

6. **In your view, what things made it difficult to get Tapuhi Tū Toa 'off the ground' in your institution?**

(**Prompts:** Why was there a low level of interest among smoking tauira in taking part in TTT? What roles did timing / adequate promotion / relevance of the model to the target group / staff support/ target group motivation etc play in the level of uptake and why?)

7. **What, if anything, do you think could have been done differently by the Tapuhi Tū Toa Co-coordinator to support a higher level of Tapuhi Tū Toa uptake among your smoking tauira?**

(**Prompts:** Could timing / promotion of TTT / securing staff support/ motivating of target group etc have been improved to support tauira uptake? If so how?)

8. **What do you think could have been done differently by your institution to support a higher level of Tapuhi Tū Toa uptake among smoking tauira?**

(**Prompts:** Could timing / promotion / staff support/ target group motivation etc have been improved to support tauira uptake? If so how?)

9. **What do you think needs to happen in the future if nursing education polytechnic providers are to successfully facilitate the delivery of Tapuhi Tū Toa?**

10. **What else would you like to tell me about your experience with Tapuhi Tū Toa this year?**

Research Advisory Group (RAG) Perspectives

Using the material sent out to Research Advisory Group members about the close off of the intervention as an introduction to the interview ask:

(1) What do you think, from your experience, might have been the factors that contributed to the TTT intervention gaining little traction in the targeted schools of nursing?

(**Prompts:** What roles do you think timing / adequate promotion / relevance of the model to the target group / staff support/ target group motivation etc may have played in the level of uptake and why?)

(2) What else do you think could have been done to deal with issues faced in attempting the rollout of TTT in the targeted schools of nursing? E.g. the repeated delays resulting from the need to satisfy the requirements of tertiary institution ethics committees etc, low levels of student interest in participation)

(Prompts: What do you think could have been done differently by institutions to support a higher level of Tapuhi Tū Toa uptake among smoking tauira? Could wider institutional commitment / timing / promotion / staff support/ target group motivation etc have been improved to support tauira uptake? If so how?). What, if anything, do you think could have been done differently by the Tapuhi Tū Toa Co-ordinator to support a higher level of Tapuhi Tū Toa uptake among smoking tauira? Could timing / promotion of TTT / securing staff support/ motivating of target group etc have been improved to support tauira uptake? If so how?)

(3) What suggestions do you have about what should be done in the future if we want to support smoking cessation among Māori student nurses in school of nursing settings?

(4) What else would you like to say about the challenges in implementing Tapuhi Tū Toa during 2016?

Coordinator's Perspective (Tapuhi Tū Toa Audit)

1. **Please briefly outline how you expected Tapuhi Tū Toa to roll out**

(**Prompts:** Who did you think was going to do what? What was to be your role? What was to be the role of the institutions themselves?)

2. **What worked well with respect to recruiting the institutions?**

(**Prompts:** What kinds of approaches were most successful for you? Why do you think these kinds of approaches were the most successful?)

3. **What challenges did you face around successfully recruiting the institutions?**

(**Prompts:** How common were the challenges you faced across the sites and why? What challenges were unique to particular sites and why?)

4. **Please tell me about the steps you took to deal with the challenges you faced in recruiting the institutions**

(**Prompts:** In what ways were the steps you took with each institution similar or different? How effective do you think the steps you took were?)

5. **What do you think you would do differently, if anything, around recruitment if you were attempting to roll out TTT in the future?**

(**Prompts:** In what ways were the steps you took with each institution similar or different? How effective do you think the steps you took were?)

6. **What worked well with respect to the promotion of TTT among tauira?**

(**Prompts:** What kinds of promotional approaches were the most successful? Why do you think these kinds of approaches were the most successful? What level of input did the institutions appear to commit to promotion and support?)

7. **What were the challenges around promoting TTT among tauira?**

(**Prompts:** How common were the promotional challenges across the sites and why? What challenges were unique to particular sites and why?)

8. **In your view what things may have made it difficult to get Tapuhi Tū Toa 'off the ground' in the targeted institutions?**

(**Prompts:** What roles do you think timing / adequate promotion / relevance of the model to the target group / staff support/ target group motivation etc may have played in the level of uptake and why?)

9. **What do you think could have been done differently by institutions to support a higher level of Tapuhi Tū Toa uptake among smoking tauira?**

(**Prompts:** Could wider institutional commitment / timing / staff support/ target group motivation etc have been improved to support tauira uptake? If so how?)

10. **What, if anything, do you think you could have been done differently to support a higher level of Tapuhi Tū Toa uptake among smoking tauira?**

(**Prompts:** Could timing / promotion of TTT / securing staff support/ motivating of target group etc have been improved to support tauira uptake? If so how?)

11. **What do you think needs to happen in the future if nursing education polytechnic providers are to successfully facilitate the delivery of Tapuhi Tū Toa?**

12. **What else would you like to say about the challenges in implementing Tapuhi Tū Toa during 2016?**

APPENDIX FIVE: ONLINE SURVEY TOOL

1. **Please tick the statement below that describes your smoking status**

   I am a current smoker

   I am a non-smoker

2. **I recall getting information about the Tapuhi Tū Toa Māori tauira smoking cessation intervention through my nursing programme in 2016:**

   Yes, I do recall getting information about Tapuhi Tū Toa Māori

   No, I do not recall getting information about Tapuhi Tū Toa Māori

   I'm not sure

3. **If you do recall getting information about Tapuhi Tū Toa did you think about taking part?**

   Yes No I'm not sure

4. **If you answered Yes to Q3 above, please explain briefly <u>why you did</u> consider taking part in Tapuhi Tū Toa:**

5. **If you answered No to Q3 above, please explain briefly <u>why you did not</u> consider taking part in Tapuhi Tū Toa:**

6. **If you answered No to Q3 above, please tell us what might have made taking part in Tapuhi Tū Toa more likely for you:**

7. **The Tapuhi Tū Toa intervention was clearly explained to me in a way that I could understand:**

   Yes No I'm not sure

   Please comment:

8. **What else would you like to say about the planned Tapuhi Tū Toa intervention?**

9. **If you would like to be entered in a random prize draw for a $100 Warehouse voucher, please enter your contact email address or telephone number below (this personal information will be used only for the purpose of contacting you if you are the prize draw winner).**

Thank you for taking part in this audit survey.

APPENDIX SIX: ONLINE SURVEY INVITATION PANUI

Tēnā koutou

Earlier in 2016, tauira in your programme were invited by (name of Intervention Coordinator) to take part in Tapuhi Tū Toa, a smoking cessation intervention specifically tailored for Māori nursing tauira. Tapuhi Tū Toa was not delivered however, because there were not enough tauira interested in taking part. Now, Whakauae Research for Māori Health & Development (Whanganui) is carrying out an audit to try and find out what might have needed to happen to increase tauira interest in taking part in Tapuhi Tū Toa.

We would appreciate hearing your views as part of the audit process. Please complete our brief online survey. The survey link is https://www.surveymonkey.com/r/SGC6HJ6. The audit survey will close on Friday November 18 2016 at 11pm.

Your survey input will be confidential (whatever you have to say will not be linked to your identity in any audit reporting). You do not need to give us your contact information unless you want to be included in the (name of polytechnic) random prize draw for a $100 Warehouse voucher. We will use your contact information (email or telephone number) only for contacting you if you are the random prize winner.

Completion of the survey will be taken as your consent to take part in the Tapuhi Tū Toa audit. If you have any questions about the Tapuhi Tū Toa audit, please contact Lynley Cvitanovic (06) 347 6772 lynley@whakauae.co.nz

Thank you

APPENDIX SEVEN: PUBLIC HEALTH SEMINAR PĀNUI

When good interventions go bad: Learning from failure. Dr Heather Gifford, Whakauae Research

Failure is something we seldom talk about publically but there is great potential for learning when interventions fail. In this seminar Heather will describe an intervention study aimed at supporting Māori student nurses to quit smoking before graduation. Despite careful planning, kaupapa Māori theoretical grounding, and much hard work in six tertiary settings, the intervention failed to even get off the ground. Heather will discuss possible reasons, and ask: what does this teach us? What are the implications for other projects and settings?

Dr Heather Gifford is a member of the ASPIRE 2025 collaboration, and founder of Whakauae Research for Māori Health and Development, an iwi-based research centre, which was established in collaboration with Ngāti Hauiti, in 2005. After 10 years as Director of Whakauae, she now works in a senior advisory role.

Friday 9 December, 12.30 to 1.15

Small Lecture Theatre, Level D, University of Otago Wellington
To join by web-conference go to: https://otago.ac.nz/zoom/ph_seminars
For more information, see http://otago.ac.nz/UOWevents