

E Toru Ngā Mea

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ABSTRACT

It is widely recognized that a capable and competent Māori health workforce is central to improving health outcomes for Māori. However, little attention has been paid to the development of indigenous health practitioners as specialists in their own right. Huarahi Whakatū is the only Nursing Council accredited Professional Development Recognition Program focused specifically on the needs of Māori Registered Nurses (RNs). Outcomes which have resulted from Huarahi Whakatū include recognition and affirmation of the distinctive elements Māori RNs bring to their practice, and Māori RNs being assisted to identify and articulate evidence based on those elements. Issues for consideration in the ongoing development of Huarahi Whakatū include recognition that individual journeys towards the development of a body of knowledge and practice which underpins indigenous nursing are unique and lifelong; and the critical importance of wider systemic support which both recognizes the validity and legitimacy of the distinctive elements Māori RNs bring to their nursing practice, and actively supports Māori RNs to access professional development pathways which support their development as specialized indigenous health practitioners.

Keywords: Māori health, Māori nurses, indigenous health practice, indigenous workforce development.

INTRODUCTION

Whaia te pae kia tata
Mau tono te tumanako, whakapono, aroha
Pursue your goals to become a reality
No matter what, Maori nurses will apply their values into practice
“It is our Māori way, our Māori things, our Māori world.”

OUR CONTEXT

In 2006, Māori, the Indigenous people of Aotearoa/New Zealand, comprised 14.6% of the total population. Māori are a relatively young population; the median age is 22.7 years, with 35.4% being under the age of 15 years. A slowly increasing older population is also evident, with the proportion of Māori aged 65 years increasing from 3.4% in 2001, to 4.1% in 2006 (Statistics New Zealand, 2007).

Te Tiriti o Waitangi is an agreement between the British Crown and the Māori people of Aotearoa. Signed in 1840, the Te Tiriti characterizes a relationship between the Crown and iwi Māori which, through a mutually beneficial partnership, intended to ensure the wellbeing of all people in Aotearoa, both individually and collectively. Te Tiriti o Waitangi remains a key instrument to guide national development, affirming the unique status of Māori as the Indigenous population, while simultaneously conferring, through government, the rights of citizenship upon all New Zealanders (Taskforce on Whanau-Centred Initiatives, 2009).

MĀORI DEVELOPMENT

Māori communities, as with other Indigenous peoples, have always conceptualized health and wellbeing in a much broader context than the narrow focus on physical health and illness. In the 1980s, against a backdrop of widespread Māori resistance to ongoing assimilative policies and practices, key developments in Māori education, and the wider dissemination of holistic Māori models of health and wellbeing, Māori aspirations for health and
wellbeing started to actively assert a greater emphasis on self-determination, economic self-sufficiency, social equity, and cultural reaffirmation (Durie, 2008). Informed by the principle of adding value, as opposed to deficit focused frameworks based solely on disparity reduction, Durie (2003) identifies the ultimate aim of Māori development as adding value to Māori lives, Māori knowledge, and Māori society. Unlike disparity reduction, Māori development is not a finite process and has no end point (Durie, 2003).

Māori development agendas also exist with in the broader context of kaupapa Māori theory, a theoretical framework which evolved from a base of being Māori, asserting recognition, affirmation, and validation of Māori cultural world views (Pihama, 2001; Smith, 1999). Kaupapa Māori theory is intrinsically connected to, and situated within, the wider historical, social, economic, and cultural context of an overt form of resistance to Western dominance (Bishop and Glynn, 1999; Henry and Aotearoa, 2001; Smith, 1999).

Māori cultural world views (Pihama, 2005). Although in many respects Māori individuals share similar aspirations to those of other New Zealanders, there are specific outcomes desired by Māori on the basis of aspirations, values, and affiliations that align Māori with each other; aspirations which stem directly from being Māori (Durie, 2005).

The principle of indigeneity does not preclude the recognition of other cultural groups, however such recognition is within the context of the unique positioning of Indigenous peoples in the life of the nation (Durie, 2008).

**Māori Health**

Persistent health inequities for Māori have long been recognized. Māori continue to be negatively represented across a range of health indicators, as well as being more likely to have unmet health needs (Ministry of Health, 2017). Differential access to the quality of health services received, alongside the impacts of colonization and the cumulative effects of historical socioeconomic disadvantage experienced by earlier generations are widely acknowledged as contributing to inequities in health outcomes for Māori (Ministry of Health and University of Otago, 2006).

In 1988, the Standing Committee on Māori Health, in their submission to the Minister of Health, recommended that the Te Tiriti a Waitangi be regarded as the foundation for good health in New Zealand (Standing Committee on Māori Health, 1988). The Standing Committee (1988) also identified that Māori health issues could only be addressed by the involvement of a greater number of Māori in both the setting of priorities and the delivery of health care; health services must have the support of the Māori community; and health care delivery must include both western trained health professionals and people trained in Māori schools of learning.

Successive health reforms since the mid-1980s have identified Māori health as a priority area, with the 1990s seeing rapid expansion in the development of Māori health service providers whose services were characterized by distinctively Māori delivery frameworks (Minister of Health and Associate Minister of Health, 2006c). Reflective of increasing acknowledgement of Māori health and wellbeing aspirations, the New Zealand Public Health and Disability Act 2000 makes it clear that District Health Boards (DHBs) must address Māori health and must recognize the Treaty of Waitangi in decision making and priority setting, with a view to improving health outcomes for Māori. In particular, DHBs are charged with establishing and maintaining processes to enable Māori to participate in and contribute to strategies for Māori health improvement; and to foster the development of Māori capacity for participating in the health sector in order to meet the needs of Māori (New Zealand Public Health and Disability Act, 2000).

**He Korowai Oranga: The Māori Health Strategy** (Ministry of Health, 2002) articulates how Māori health objectives are to be achieved. With the overall aim of whānau ora: Māori families supported to achieve their maximum health and wellbeing. He Korowai Oranga asks the health and disability sectors to recognize the interdependence of people; that health and wellbeing are influenced and affected by the “collective” as well as the individual; and the importance of working with people in their social contexts, not just with their physical symptoms. He Korowai Oranga is explicit in recognizing that Māori wish to be able to express themselves as Māori in Aotearoa, affirming Māori approaches, and strongly supporting Māori models of health and wellness alongside Māori led initiatives to improve the health of whānau, hapū, and iwi.

Extending opportunities for health services and the workforce within those services to practice Māori views of health and healing is identified as necessary to realizing whānau oreshole outcomes (Ministry of Health, 2003). A capable and competent Māori health workforce, both clinically and culturally, is pivotal to providing appropriate care to Māori and their whānau (Ministry of Health and Associate Minister of Health, 2006c). This workforce is not intended to simply provide a more culturally diverse workforce. It is explicitly intended to, through contributing to Māori aspirations, result in better outcomes for Māori, whānau, hapū, and iwi. Given this, increasing the Māori health workforce must focus on participation as Māori, not simply by Māori.

**Dual Competency**

The concept of dual competency as it relates to the Māori health workforce has come to be commonly understood as acknowledging the importance of both clinical and cultural expertise. However, dual competency encompasses much more than this. It explicitly recognizes Indigenous health as a specialized area of practice (Sones et al., 2010). Dual competency visibly communicates that Māori have a body of knowledge and skills drawn from Te Ao Māori which are relevant for the provision of effective health service delivery for Māori. Specialization occurs because dual competency requires the bridging of two knowledge bases and value systems, with clinical and cultural dimensions positioned not as contradictory or in competition, but as complementary and able to add strength to each other (Maxwell-Crawford and Ihimaera, 2012). However, it is also recognized that these gains are not enough to create a high quality health workforce, well equipped and supported to meet the growing health needs and expectations of Māori whānau (Maxwell-Crawford and Ihimaera, 2012). From a Māori development perspective, increasing the number of Māori in the health workforce is not intended to simply provide a more culturally diverse workforce. It is explicitly intended to, through contributing to Māori aspirations, result in better outcomes for Māori, whānau, hapū, and iwi. Given this, increasing the Māori health workforce must focus on participation as Māori, not simply by Māori.

**Wellbeing Development**

Wellbeing development exists within the broader context of puhorua, and the workforce within those services to practice Māori views of health and healing is identified as necessary to realizing whānau oreshole outcomes (Ministry of Health, 2003). A capable and competent Māori health workforce, both clinically and culturally, is pivotal to providing appropriate care to Māori and their whānau (Ministry of Health and Associate Minister of Health, 2006c). This workforce is not intended to simply provide a more culturally diverse workforce. It is explicitly intended to, through contributing to Māori aspirations, result in better outcomes for Māori, whānau, hapū, and iwi. Given this, increasing the Māori health workforce must focus on participation as Māori, not simply by Māori.

**Workforce Development**

Workforce development strategies have focused primarily on the recruitment and retention of the Māori health workforce. Substantial gains have been made in increasing the Māori health workforce. For example, the proportion of Māori registered nurses doubled from 1991–2001 (Ministry of Health, 2006). However, it is also recognized that these gains are not enough to create a high quality health workforce, well equipped and supported to meet the growing health needs and expectations of Māori whānau (Maxwell-Crawford and Ihimaera, 2012). From a Māori development perspective, increasing the number of Māori in the health workforce is not intended to simply provide a more culturally diverse workforce. It is explicitly intended to, through contributing to Māori aspirations, result in better outcomes for Māori, whānau, hapū, and iwi. Given this, increasing the Māori health workforce must focus on participation as Māori, not simply by Māori.
important to note that the term “Indigenous prac-
tice and practitioners” as it is used and understood in
this paper: that is, the bridging of two knowl-
edge and value systems (Baker, 2008) differs from
Indigenous practitioners for whom the practice base
comes entirely from Te Ao Māori, for example, tradi-
tional Māori healers.

**INDIGENOUS HEALTH PRACTITIONERS: SPECIALIZED, UNIQUE, AND DISTINCTIVE PRACTICE**

As noted above, the complementary interface be-
tween Indigenous and western knowledge bases is at
the centre of unique and distinctive Indigenous
health practice. However, it can be argued that the
support required for this interface to be fully ex-
plored and developed has yet to occur across
health disciplines. Despite it being widely recognized
that a capable and competent Māori health workforce
is central to improving health outcomes for Māori,
little attention has been paid to the development of
Indigenous health practitioners as specialists in their
own right. Of critical importance is that Indigenous
practitioners need to be supported to incorporate
dual world views into their practice, develop best
practice models, and have more tools to draw on
from Māori world views (Raxter, 2008; Baker, 2008;
Hopkirk, 2010). Facilitating Indigenous health
leadership for this is essential (Sones et al., 2010).

Current health training programs have little, if
any, focus on Indigenous health as a unique and dis-
tinctive specialized area of practice. On the contrary,
training programs can produce the exact opposite
outcome. For example, some have commented on
the mismatch between dominant health training
paradigms and the extent to which Māori come
under pressure to compromise cultural values and
identity in order to succeed within training pro-
grams, in the process losing confidence in the valid-
ity of kaupapa Māori processes and models, and
undergoing processes of acculturation (Elder, 2008;
Levy, 2007; Melne, 2005; Wilson et al., 2011).

It has been recognized that opportunities to
strengthen and maintain one’s identity as Māori is a
key workforce strategy and crucial for the develop-
ment of a Māori health workforce able to partici-
pate as Māori (Levy, 2007; Robertson et al., 2006;
Wilson et al., 2011). Previous research has found that
Māori practitioners sense they “do the work differ-
ently,” with this stemming from their own sense of
identity as Māori (Elder, 2008; Melne, 2005). Our
own experiences within the health sector are con-
sistent with this; knowing there is a difference in the
way we practice as Māori, but sometimes being un-
able to clearly articulate how or what these differ-
ences are.

Supporting ongoing developments in relation to
exploring the interface between Indigenous and
western knowledge bases requires an understanding
of the various influences on cultural identity. Māori
are not limited to traditional or stereotypical group-
ings, drawing influence from many different Māori
and non-Māori social, cultural, and political organi-
tations, with multilayered markers of identity and
connection (Moewaka Barnes, 2010; Tipene-Clarke,
2005; Ware and Walsh-Tiapata, 2010). A history of
colonization is regarded as the most significant ex-
perience that Indigenous peoples share, with com-
mon patterns of loss of culture, land, voice, popula-
tion, health, and traditional methodologies (Durie,
2004). It is also recognized that cultural identity is
heavily affected by colonial imposed social and judg-
ment, integral to such programs is embracing the
notion that explorations of identity and being com-
fortable with one’s own identity are often challen-
ging and lengthy processes (Elder, 2008). The process
of learning is as important as the content. Central
to the provision of opportunities to strengthen cul-
tural identity are culturally based environments and
processes which are acutely aware of participants
wellbeing (Hopkirk, 2010). Culturally safe learning
environments such as wānanga, Murae roa, and
hui, and teaching practices which support the de-
velopment of best practice will encourage access to
Māori world views, language, and ways of know-

The other salient point to make is that de-
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Indigenous health practice development. Not only

**PRIORITYING INDIGENOUS AGENDAS**

Alongside the emphasis on greater participation by
Māori in the health workforce, there is also recogni-
tion that all health practitioners and services must
be responsive to the needs of Māori. With the Health
Professionals Competency Assurance Act 2003 (HPCA)
as a direct catalyst, there has, over the past decade,
been significantly increased emphasis on the cultur-
al safety and competency of the non-Māori health
workforce.

It is beyond the scope of this paper to critique the
cultural competency frameworks currently util-
ized. However, it is important to highlight that
frameworks for cultural competency have tended to
be positioned in the same way as the acquisition of
other technically oriented competencies. Such an
approach fails to recognize the often intensely person-
ally challenging nature of cultural competency jour-
nys, as underlying values and knowledge bases are
reflected on, challenged, and redefined. Cultural com-
petency encompasses significantly more than the in-
dividual acquisition of technical competencies.

It has also been argued that the cultural com-
petency framework is deliberately utilized because
it is perceived as a less politicized mechanism for
addressing the needs of diverse groups. This is evi-
denced by cultural competency being predominant-
lly constructed and taught within a skill acquisition
paradigm, far removed from a social justice para-
digm which seeks societal transformation (DeSouza,
2008). That organizations and systems are also re-
quired to be culturally competent to realize effective
individual practice tends to be obscured by the cur-
rent approach to cultural competency. Others have
argued that inconsistent definitions, understand-
ing, and implementation of cultural competency in
health practice makes it difficult to implement care
using these frameworks (Grant et al., 2013). The
other salient point to make is that despite clear policy directives which affirm Māori
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has resulted in significantly fewer resources being devoted to the development needs of a specialized Indigenous Māori health workforce, but has also required Māori to divert attention away from their own cultural needs and aspirations in order to assist in the cultural competency development of their non-Māori colleagues.

These comments are not intended to diminish the critical importance of a genuinely culturally safe and competent non-Māori health workforce. Rather, they aim to highlight the imbalance which exists in relation to meeting the differing and unique professional development needs of the Māori and non-Māori health workforces. Facilitating opportunities which affirm cultural identity and indigenous practices for the Māori health workforce are very different to those aimed at enhancing the cultural competency of the non-Māori health workforce.

It can be argued that significantly more attention and resources need to be prioritized for the development of indigenous health practitioners as specialists in their own right across the spectrum of health related professions. This paper explores one programme which has specifically focused on the professional development needs of Māori Registered Nurses (RNs). Successes, key learnings, and areas for ongoing exploration and development are explored, particularly in relation to the contributions made by this programme to the development of Māori RNs as specialist indigenous health practitioners.

**Huarahi Whakatū: Professional Development Recognition Program (PDRP)**

The introduction of the Health Practitioners Competence Assurance Act 2003 requires the Nursing Council of New Zealand to ensure the ongoing competence of its practitioners. Competencies were introduced for three scopes of practice; Registered Nurses (RNs) utilize nursing knowledge and complex nursing judgment to assess health needs, provide care, and advise and support people to manage their health. Practicing independently and in collaboration with other health professionals, RNs practice in a variety of contexts, working with individuals, whānau and communities, and, depending on educational preparation and practice experience, may also be involved in the management, education, policy development, and research of nursing practice (Te Kaunihera Tapuhī o Aotea, 2012).

Competencies for the RN scope of practice encompass four competency domains. The ‘professional responsibility’ domain requires RNs demonstrate ability to apply the principles of the Te Tiriti o Waitangi to nursing practice; and practice nursing in a manner that the client determines as being culturally safe (Te Kaunihera Tapuhī o Aotea, 2008).

Compliance with the HPCA Act 2003 also resulted in the development of frameworks for continuing competence, the recertification of practice certificates, and the reviewing of competence (Te Kaunihera Tapuhī o Aotea, 2005). In 2004, the Nursing Council began approving professional development recognition programs (PDRPs) as a mechanism for recertification. PDRPs allow nurses who are already demonstrating continuing competence through PDRPs to be exempt from a recertification audit. Recertification focuses specifically on competency to practice, whereas PDRPs are focused on providing support for nurses to develop their practice, recognize additional contributions made to workplaces, and inform career planning and ongoing professional development (Te Kaunihera Tapuhī o Aotea, 2011).

In general, PDRPs are developed and/or delivered by employers and professional organizations. Nursing Council approval is given to PDRP programs that have met specified standards, including the recognizing of RN’s 60 hours of professional development in the past three years, and two assessments against the Council’s competencies for scopes of practice. Three yearly assessments of competence, based on the PDRP submission, are also required. The criteria for advancement through PDRP programs are determined by the delivery organization, not the Nursing Council (Te Kaunihera Tapuhī o Aotea, 2008).

**Huarahi Whakatū: Professional Development Recognition Program (PDRP)**

As at 31 March 2011, there were a total of 45,518 RNs on the New Zealand Nursing Register. Of these, 7% identified as New Zealand Māori. District Health Boards, then Māori health service providers, showed a high proportion of Māori RNs, with mental health and primary health care receiving the higher practice areas for Māori RNs (Te Kaunihera Tapuhī o Aotea, 2012).

Huarahi Whakatū is a practice based PDRP for Māori registered nurses. It is the only Nursing Council accredited PDRP that is focused specifically on the needs of Māori RNs. Fully understanding the distinctiveness and value of Huarahi Whakatū requires a brief description of its history. Huarahi Whakatū has its origins in a Te Rau Matatini project focused on developing and retaining Māori nurses expertise in mental health through the identification of Māori mental health core competencies and career pathways. The initial stages of the project involved, in consultation with a reference group, identifying Māori mental health core competencies and specialist Māori mental health nursing competencies. The program, completed in 2005, was called Huarahi Whakatū: Māori Mental Health Nursing Career Pathway (Maxwell, 2004). Although a professional development program was recommended to support the implementation of this career pathway, a lack of effective systems at the time prevented the embedding of the pathway within practice.

In 2006, Huarahi Whakatū was revised to align with the changes made by the Nursing Council to the RN nursing competencies. In 2007-08 Te Rau Matatini, in partnership with the Māori Caucus of Te Ao Māramaotanga (New Zealand College of Mental Health Nurses), and Ngā Ngāru Haunui o Aotearoa (National Māori Health Providers Association) piloted the program to 20 Māori RNs, primarily from the mental health sector. Building on the pilot process and evaluation findings, Huarahi Whakatū was further revised and submitted to the Nursing Council for accreditation as a PDRP. Accreditation critical to ensuring Huarahi Whakatū and the specific needs of Māori RNs were accorded equal status and validity with other accredited PDRPs, was achieved in 2009.

Since its accreditation, a total of 200 Māori RNs from DHBs, nongovernment organizations (NGO), haunui Māori providers, mental health and addiction services, primary healthcare, older adult, child and youth health, public health and whānau are providers have participated in Huarahi Whakatū. In the two years following accreditation, Huarahi Whakatū focused on reaching Māori RNs situated in isolated rural areas across New Zealand. This resulted in established relationships with Māori RNs from Northland to Invercargill.

Unlike other PDRPs, Huarahi Whakatū is not directly provided by an employer or union. It is hosted and delivered by a national Māori health workforce development organization, Te Rau Matatini. Huarahi Whakatū is coordinated by a Māori registered nurse, supported by a network of Māori and non-Māori RNs nationally, and guided by a cultural and clinical governance board with access to Māori RN mentors and Māori assessors.

**Program Description**

Māori nursing is a specialised expression of nursing that deliberately integrates traditional and contemporary Māori health frameworks and western bodies of knowledge across the caring, illness health and recovery domains (Te Rau Matatini, 2007)

The specific aims of the Huarahi Whakatū PDRP program are to:

1. enhance responsiveness to clients and whānau health needs;
2. recognize and reward cultural and clinical excellence;
3. strengthen best practice standards of Māori nursing care;
4. provide a framework for professional growth and development;
5. identify skill levels of Māori nurses;
6. improve job satisfaction, recruitment and retention of Māori nurses; and
7. raise the professional profile of Māori nursing practice.

Huarahi Whakatū promotes the philosophy of dual competency, with this portrayed as two sep-
and the
clude clients, colleagues and senior staff,
ori in
and for Māori. The framework encompass-
es four domains within Pukenga Haumanu and six
domains identified as being integral to practice by
and for Māori in Pukenga Haumanu. There are
four practice levels (puna) which ascend in recogni-
tion of the mastery of nursing practice, reflecting
competency stages in each of the puna. Recognizing
the diversity among nurses and the need to provide
tailored approaches to the clinical and cultural pro-
essional goals and career pathways of individual
urses, the framework is flexible in that it enables
nurses to exist at different levels in each puna. This
framework seeks to maintain the integrity of each
knowledge base in its own right, but provides nurses,
with a structure, language, and tools by which to
begin to consider, describe, and articulate their spe-
cialized practice as Māori RNs.

A heavily self-directed program, Huarahi Whakatū
comprises regional wānanga which are
tailed for each group of Māori RNs, encouraging
clinical and cultural reflective practice, and provid-
ing support to gather necessary portfolio evidence.
It also includes resources, self-paced learning,
the compilation of a professional portfolio, mentors,
and links with other Māori RNs, and Māori assess-
sors. Program participants are supported by a pro-
gram coordinator, who is a Māori RN, as well as a
governance group. Participants are expected to com-
pile a written portfolio of evidence which includes
self-assessment, peer review, performance appraisal,
practice narrative, curriculum vitae, professional de-
velopment and practice hours, and evidence related
specifically to their chosen practice level.

The program assessment process con-
sists of two stages: mahi tuhituhi (written), which
has a primary focus on the submitted portfolio, and
a kanohi ki te kanohi hui (face to face hui). The hui
stage enables direct contact between the Māori RN,
their roopu tautoko (support group) which may in-
clude clients, whānau, colleagues and senior staff,
and the whānakaratingatanga panel. The assessment pan-
el consists of two Māori RNs, a Kaumatua and/or
Kaia with relevant experience in Māori health, and
client and/or whānau representatives, all of whom
are trained for the assessment role.

Program Learnings
There were 17 Māori RNs who completed the pilot
program in 2007–08. Levels of nursing experience
ranged from new graduate level to nurses with over
20 years of experience. Employers included both
DHBs and NGOs. In 2012 a random sample of Māori
RN who had participated in Huarahi Whakatū were
sent a short online survey to complete. Of the 60
participants, 50% had over 20 years nursing experi-
ence, 25% had 10 years or more nursing experience,
and the remaining 25% having under 10 years of nursing experience.

Drawing on evaluative material from the initial
program, the 2012 survey, and reflections of the
lead author’s involvement in both the development
and delivery of the program, this section details the
key learnings which have emerged from Huarahi Whakatū.

Program outcomes
Participants identified a range of outcomes which
they attributed to involvement in Huarahi Whakatū.
In the pilot evaluation, the highest areas of confi-
dence for nurses were greater acceptance of a range
of evidence to demonstrate competency; enhanced
critical thinking in relation to practice; professional
development being supported and facilitated; and
Māori nursing being respected and recognized. In
the 2012 survey, over 70% of participants felt that
Huarahi Whakatū helped with identifying and
enhanced their value as a Māori RN. For 90%, the
program was useful in aiding their description of
clinical nursing practice; 95% considered Huarahi Whakatū
had aided them in describing their cul-
nmental practice; 84% felt the program had encouraged
them to incorporate tikanga into their practice; and
70% felt Huarahi Whakatū helped with identifying and
clarifying their professional development needs
as Māori RNs.

Program participants also commented on out-
comes observed as a result of their RNs participat-
ing in Huarahi Whakatū. These included a growth
in confidence and practice, the professional develop-
ment of their nurses, critical thinking in relation
to practice, and evidence based practice. Huarahi Whakatū
was also considered to reflect contemporary
practice, and engender respect and recognition for
Māori nursing practice.

Building Indigenous health specialists
The evaluation findings identified perceptions of
what characterized a Māori nurse. These charac-
teristics included: confidence; motivation to initiate
change; innovation in service delivery; the ability to
comprehend kaua, tikanga, wider Māori values, and
basic te reo; respect and utilization of Māori owned
and operated models of care; being connected to
and trusted by the community; and having a clear
focus on the needs of the people. Māori RNs were
also viewed as having the capacity to take the best
from both clinical and kaupapa Māori world views,
incorporate whanaungatanga into practice, and par-
ticipate in ongoing knowledge and training.

All pilot program participant employers be-
lieved it was important to have a Māori body of
knowledge incorporated in a professional develop-
ment and recognition program for Māori nurses.
For some, Huarahi Whakatū was of benefit because of
its explicit focus on Māori knowledge bases and
processes.

The nurses who participated in Huarahi Whakatū
were diverse. This was in relation to both their ex-
perience, access to Māori world views and resour-
ces, and the extent to which their training within
Western paradigms resulted in challenges for them
when asked to specifically think within the context
of Māori world views.

Engagement with Huarahi Whakatū was affected
by one’s personal readiness to engage in what could
be a significantly challenging process, both person-
ally and in terms of additional workload. For some,
particularly those for whom there had been limited
opportunities for active engagement with, and ex-
posure to, Te Ao Māori, it was important to progress
slowly and gently; facilitating moments of connec-
tion with “being Māori” which could provide a safe
foundation for participants to move forward in their
own personal journey. The journey for each partici-

RNs to nursing practice are perceived as valid, valued, and appreciated. There was a view that Māori RNs needed to be recognized for their professionalism and leadership, and Huarahi Whakatū is an important mechanism to facilitate this. It was recognized that achieving this required wider systemic support across the workplace, with such support reflected in broader issues such as employment conditions, remuneration, reward, value and appreciation, and opportunities for ongoing development. The existence of this support was directly related to the recruitment and retention of Māori RNs in workplaces. It was found that employee participation in Huarahi Whakatū resulted in some organizations reflecting on their own internal systems to ensure their Māori RNs were appropriately supported within their workplace.

Future development
It is important to consider the ongoing development of Huarahi Whakatū. Feedback from the pilot program suggested that a key challenge, particularly for NGOs, was the significant resources needed to operationalize Huarahi Whakatū in their organizations. Issues needing to be resolved included equitable remuneration with mainstream PDRP providers, human resources to support RNs on the program, and access to professional development funds to support Māori RNs training and time away. Huarahi Whakatū, with its accreditation status as a PDRP, has equal status with other accredited RN PDRPs. However, as has been noted previously, unlike other PDRPs, Huarahi Whakatū is not directly provided by an employer or professional body. Because of this, it is heavily dependent on the building of relationships with professional groups and RNs to promote the importance and value of Huarahi Whakatū for RNs, with the aim of encouraging employers to provide access to the program for their Māori RN workforce. This approach has had mixed results, with variable levels of acceptance of Huarahi Whakatū as an important Indigenous workforce development program for Māori RNs, even in organizations with large Māori RN workforces. Further development is required to firmly embed Huarahi Whakatū as a viable and accessible professional development pathway option for all Māori RNs.

The issue of program extension was also raised, specifically in relation to catering for the needs of more advanced Māori RNs and those not in clinically focused roles, but for whom Huarahi Whakatū would be extremely valuable. Some considered that the Māori RNs who had already participated in Huarahi Whakatū were emerging leaders; however ongoing planning and resources were needed to actualize this leadership potential for future development. Technical and administrative improvements were also identified, such as improving program marketing and promotion, and streamlining the administrative requirements for participants where possible. Plans are currently being made for enhanced online delivery which reduce administrative burdens. The development of an online mentoring program with e-portfolios is also being planned.

Concluding Comments
Despite widespread recognition that a capable and competent Māori health workforce is central to improving health outcomes for Māori, little attention has been paid to the development of Indigenous health practitioners as specialists in their own right. Huarahi Whakatū is the only New Zealand Nursing Council accredited PDRP that is focused specifically on the needs of Māori RNs to explore a complementary interface between Indigenous and Western knowledge bases and build a unique and distinctive Indigenous nursing practice. The findings described in this paper are evidence of the important initial contributions being made by Huarahi Whakatū to the development of specialized Indigenous nursing practice. It is important to recognize that the development of a body of knowledge and practice underpinning Indigenous nursing specialists is a unique and lifelong journey. Flexible processes, which take into account differing points of readiness to engage in what can be a challenging and lengthy process, are critical. So too are the provision of guidance, support, and resources to assist Māori RNs to not only reach and internalize moments of illumination in relation to identifying the specific elements they bring as Māori to their nursing practice, but also to articulate an evidence base around them. Ongoing mentorship opportunities for Māori RNs are central to the development of Indigenous nursing practice. The explicit embedding of Huarahi Whakatū within a Māori world view, both in terms of content and process is also vital, recognizing that the actual process of learning is core to positive outcomes. Huarahi Whakatū does not exist in a vacuum. Wider systemic support which recognizes the validity and legitimacy of the distinctive elements Māori RNs bring to their nursing practice is critical. Successful engagement by Māori RNs in Huarahi Whakatū requires active and genuine workplace support which facilitates access to necessary professional development resources for Māori RNs. Huarahi Whakatū is a significant step in the right direction but requires much greater buy-in from key stakeholders to realize its full potential of an Indigenous nursing practice, able to influence positive health outcomes for whānau Māori in Aotearoa.

It is essential that more attention and resources are prioritized for the development of Indigenous health practitioners as specialists in their own right across the spectrum of health disciplines. The legislative and policy mandate for this is clear, with DHBS explicitly required to establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement. From a Māori development perspective, increasing the number of Māori in the health workforce is not intended to simply provide a more culturally diverse workforce. It is explicitly intended to, through contributing to Māori aspirations, result in better outcomes for Māori, whānau, hapū, and iwi. Increasing the Māori nursing workforce must focus on participation as Māori, not simply by Māori.

References