E Toru Ngā Mea

Maria Baker
Michelle Levy

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 within 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; an overt form of resistance to Western dominance and policies of assimilation and integration in the *Aotearoa* context (Bishop and Glynn, 1999; Henry and Pene, 2001). It also recognizes that the designation of Indigenous world views and knowledge as inferior is central to the deliberate and ongoing process of colonization (Reid and Robson, 2007). The self determined aspirations of Māori to participate *as Māori* lie at the heart of Māori development agendas.

Indigeneity

Durie (2008) discusses "the principle of indigeneity" which is underpinned by the determination of Indigenous peoples to retain their own distinctive cultural identity, avoid assimilation, and exercise a degree of autonomy. Fundamental to the principle of indigeneity is that wellbeing depends on many factors, but among Indigenous peoples the world over, cultural identity is considered to be a critical prerequisite (Durie, 1999, 2008).

Contemporary Māori aspirations can be broadly described as resting on Māori values, the realities of Māori experience and world views, and the need to retain the distinct identity that comes from a unique heritage, common journeys, familiar environment, and a set of shared aspirations (Durie, 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, 2013). Differential access and 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 o Waitangi* be regarded as the foundation for good health in New Zealand (Standing Committee on Maori 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, 2006). 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 ora* outcomes (Ministry of Health, 2002). A capable and competent Māori health workforce, both clinically and culturally, is pivotal to providing appropriate care to Māori and their *whānau* (Minister of Health and Associate Minister of Health, 2006; Ministry of Health, 2006, 2008). *He Korowai Oranga* recognizes that the Māori health workforce is necessary if the health and disability sectors are to deliver effective and appropriate services to *whānau*. With the underrepresentation of Māori across the health workforce, extending workforce development initiatives are seen as vital. Of importance is that Māori health workforce development exists within the broader context of Māori development aspirations.

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 (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.

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). Durie (2004) asserts that this interface is largely about the search for balance between scientific advancement, human spirituality, and world views shaped by long standing associations with the natural environment. It is this complementary interface and weaving together of dual practice which will result in the development of a unique and distinctive Indigenous practice (Hopkirk, 2010; Sones et al., 2010). It is im-

portant to note that the term "Indigenous practice and practitioners" as it is used and understood in this paper: that is, the bridging of two knowledge and value systems (Baker, 2008) differs from Indigenous practitioners for whom the practice base comes entirely from *Te Ao Māori*, for example, traditional Māori healers.

Indigenous Health Practitioners: Specialized, Unique, and Distinctive Practice

As noted above, the complementary interface between 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 explored 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 (Baxter, 2000; 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 distinctive 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 programs, in the process losing confidence in the validity of *kaupapa* Māori processes and models, and undergoing processes of acculturation (Elder, 2008; Levy, 2007; Milne, 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 development of a Māori health workforce able to participate as Māori (Levy, 2007; Robertson et al., 2006; Wilson et al., 2011). Previous research has found that Māori practitioners sense they "do the work differently," with this stemming from their own sense of identity as Māori (Elder, 2008; Milne, 2005). Our own experiences within the health sector are consistent with this; knowing there is a difference in the way we practice as Māori, but sometimes being unable to clearly articulate how or what those differences 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 groupings, drawing influence from many different Māori and non-Māori social, cultural, and political organizations, with multilayered markers of identity and connection (Moewaka Barnes, 2010; Tipene-Clarke, 2005; Ware and Walsh-Tapiata, 2010). A history of colonization is regarded as the most significant experience that Indigenous peoples share, with common patterns of loss of culture, land, voice, population, health, and traditional methodologies (Durie, 2004). It is also recognized that cultural identity is heavily affected by the colonial by-products of both marginalization from mainstream society and cultural alienation from, and differential access to, the resources of *Te Ao Māori* (Durie, 2008; Rata, 2012; Reid and Robson, 2007). The notion of internalized racism becomes relevant, with historical and contemporary impacts of colonization including the conscious or subconscious acceptance of the dominant society's attitudes, beliefs or ideologies about the inferiority of one's own ethnic group (Jones, 2000; Paradies, 2005). The outcomes of internalized racism can be patterns of thinking, feeling, and behaving that result in discriminating and invalidating oneself, whilst simultaneously privileging and valuing the dominant culture (Paradies, 2005).

Rata (2012) describes a range of models that endeavour to classify and describe Māori identity. Those of most benefit understand cultural identity as a fluid construct, affected by the nature of relationships with the external world. This is as opposed to cultural identity being a primarily inner personal

experience. Also recognized are: the multiple factors which Māori may consider central to their identity; Māori culture is not essentialized; the impact that dominant culture has on one's cultural identity as Māori; and the affirmation of diverse Māori identity positions (Rata, 2012).

Discussions regarding cultural identity are important as they emphasize that Māori health practitioners will occupy diverse and shifting positions in relation to their own cultural identity. Given this, such positions need to be accounted for in any program aimed at strengthening cultural identity and supporting the ongoing development of the interface between Indigenous and western knowledge bases which is required for a unique and distinctive Indigenous health practice. Utilizing *kaupapa* Māori theory and its central positioning as a form of resistance to the dominance of western paradigms, via asserting recognition, affirmation, and validation of cultural world views as Māori, we can see how programs focused on the ongoing development of Māori health practitioners and specialized Indigenous practice are not simply about the technical acquisition of skills, but form part of a wider liberating movement built on our own methods and mechanisms of critique, measurement, and judgment. Integral to such programs is embracing the notion that explorations of identity and being comfortable with one's own identity are often challenging and lengthy processes (Elder, 2008). The process of learning is as important as the content. Central to the provision of opportunities to strengthen cultural identity are culturally based environments and processes which are acutely aware of participants' wellbeing (Hopkirk, 2010). Culturally safe learning environments such as *wānanga*, *Marae noho*, and *hui*, and teaching practices which support the development of best practice will encourage access to Māori world views, language, and ways of knowing (Hopkirk, 2010; Sheehan and Jansen, 2006). Irrespective of one's level of cultural affiliation or historical and contemporary access to the resources of *Te Ao Māori*, the development of a specialized Indigenous body of health knowledge and practice is a lifelong journey for all Indigenous practitioners (Sones et al., 2010).

Prioritizing Indigenous Agendas

Alongside the emphasis on greater participation by Māori in the health workforce, there is also recognition 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 cultural safety and competency of the non-Māori health workforce.

It is beyond the scope of this paper to critique the cultural competency frameworks currently utilized. 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 intense personally challenging nature of cultural competency journeys, as underlying values and knowledge bases are reflected on, challenged, and realigned. Cultural competency encompasses significantly more than the individual acquisition of technical competencies.

It has also been argued that the cultural competency framework is deliberately utilized because it is perceived as a less politicized mechanism for addressing the needs of diverse groups. This is evidenced by cultural competency being predominantly constructed and taught within a skill acquisition paradigm, far removed from a social justice paradigm which seeks societal transformation (DeSouza, 2008). That organizations and systems are also required to be culturally competent to realize effective individual practice tends to be obscured by the current approach to cultural competency. Others have argued that inconsistent definitions, understanding, 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 approaches and support for the implementation of Māori models of health and wellbeing, agendas focused on the development of a culturally competent non-Māori workforce have tended to be prioritized at the expense of Māori driven and determined Indigenous health practice development. Not only

has this 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 genuine 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 Nurse, Nurse Practitioner, and Enrolled Nurse.

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 Tapuhi o Aotearoa, 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 Tapuhi o Aotearoa, 2008).

Compliance with the *HPCA Act* 2003 also resulted in the development of frameworks for continuing competence, the recertification of practicing certificates, and the reviewing of competence (Te Kaunihera Tapuhi o Aotearoa, 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 Tapuhi o Aotearoa, 2013).

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 submission of a practice portfolio are also required. The criteria for advancement through PDRP programs are determined by the delivery organization, not the Nursing Council (Te Kaunihera Tapuhi o Aotearoa, 2008).

Huarahi Whakatū

As at 21 March 2011, there were a total of 45,318 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 recording the higher practice areas for Māori RNs (Te Kaunihera Tapuhi o Aotearoa, 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*[1] project focused on developing and retaining Māori nursing 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 2003, 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 Māramatanga* (New Zealand College of Mental Health Nurses), and *Ngā Ngaru Hauora 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.

1 *Te Rau Matatini* is a Māori workforce development organization, established in 2002 to develop, coordinate, and deliver a range of national programs that contribute to health, Māori mental health, addiction, primary health, and public health workforce priorities in *Aotearoa*, New Zealand.

Since its accreditation, a total of 200 Māori RNs from DHBs, nongovernment organizations (NGO), *hauora* Māori providers, mental health and addiction services, primary healthcare, older adult, child and youth health, public health and *whānau ora* 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, ill 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-

arate but interlinked *pou*. One *pou* reflects clinical competencies (*Pukenga Haumanu*) which are drawn from the Nursing Council. The other *pou* reflects cultural competencies (*Pukenga Māori Motuhake*) and are informed by *Te Ao Māori*. Tailored specifically by and for Māori RNs, the framework encompasses four domains within *Pukenga Haumanu* and six domains identified as being integral to practice by and for Māori in *Pukenga Māori Motuhake*. There are four practice levels (*puna*) which ascend in recognition of the mastery of nursing practice, reflecting competency stages in each of the *pou*. Recognizing the diversity among nurses and the need to provide tailored approaches to the clinical and cultural professional goals and career pathways of individual nurses, the framework is flexible in that it enables nurses to exist at different levels in each *pou*. 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 specialized practice as Māori RNs.

A heavily self-directed program, *Huarahi Whakatū* comprises regional *wānanga* which are tailored for each group of Māori RNs, encouraging clinical and cultural reflective practice, and providing 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 assessors. Program participants are supported by a program coordinator, who is a Māori RN, as well as a governance group. Participants are expected to compile a written portfolio of evidence which includes self-assessment, peer review, performance appraisal, practice narrative, curriculum vitae, professional development and practice hours, and evidence related specifically to their chosen practice level.

The *whakamatautau* (assessment) process consists 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 include clients, *whānau*, colleagues and senior staff, and the *whakamatautau* panel. The assessment panel consists of two Māori RNs, a *Kaumatua* and/or *Kuia* 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 RNs who had participated in *Huarahi Whakatū* were sent a short online survey to complete. Of the 60 participants, 50% had over 20 years nursing experience, 25% had 10 years or more nursing experience, with the remaining 25% having under 10 years of nursing experience.

Drawing on evaluative material from the initial pilot process, 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 confidence 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 90% of participants felt that *Huarahi Whakatū* had affirmed their practice 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 cultural practice; 84% felt the program had encouraged them to incorporate *tikanga* into their practice; and 90% felt *Huarahi Whakatū* helped with identifying and clarifying their professional development needs as Māori RNs.

Participant employers also commented on outcomes observed as a result of their RNs participating in *Huarahi Whakatū*. These included a growth in confidence and practice, the professional development 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 characteristics included: confidence; motivation to initiate change; innovation in service delivery; the ability to encompass *kawa*, *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 participate in ongoing knowledge and training.

All pilot program participant employers believed it was important to have a Māori body of knowledge incorporated in a professional development 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 exposure and access to Māori world views and resources, 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 personally and in terms of additional workload. For some, particularly those for whom there had been limited opportunities for active engagement with, and exposure to, *Te Ao Māori*, it was important to progress slowly and gently; facilitating moments of connection with "being Māori" which could provide a safe foundation for participants to move forward in their own personal journey. The journey for each participant was unique. It was evident that some participants were not at a point where they were ready to engage. Of importance was that the program was able to recognize, support, and guide those participants to understand what they might need to do to reach that point of readiness. Reflecting this, some evaluation participants emphasized the importance of actively considering the impact of colonization and the often unrealistic expectations placed on Māori RNs in their workplaces.

These findings support previous research which has emphasized diverse and shifting Māori identities, the challenging and often lengthy nature of identity exploration, and the development of a body of knowledge and practice underpinning Indigenous health practice as a lifelong journey for all Indigenous practitioners. Understanding how cultural identity is affected by marginalization from mainstream society and cultural alienation from, and differential access to, the resources of *Te Ao Māori*, as well as internalized racism, provides a context for understanding how to best support a diverse range of Māori RNs on their journey as specialist Indigenous health practitioners.

It was also clear that some participants found bridging the interface between Indigenous and Western world views in nursing practice challenging. This required a program focus on working with nurses to assist them to better understand and clearly articulate what it was they did as Indigenous practitioners and what it meant to practice as a RN from Māori world views. The provision of guidance, support, and resources to assist nurses to not only reach and internalize these moments of illumination, but to articulate an evidence base around them, was critical.

As has been identified in previous research, the cultural context of learning is important. Feedback from *Huarahi Whakatū* participants indicated that although some elements of the program, for example those undertaken on *marae*, caused anxiety and were challenging, having a *roopu tautoko* and a safe space to share one's practice enabled them to overcome these challenges. The *marae tikanga* and presence of *kaumātua* also provided a context in which cultural values and processes could be com-

municated as the norm, particularly that of *wairua*.

The reality of the issues described above challenge commonly made underlying assumptions in relation to competency acquisition, particularly that such programs focus on the acquisition of technical skills, and will have a common start and end point for all participants. Bridging two knowledge bases and value systems, with clinical and cultural dimensions not positioned as contradictory or in competition, requires interrelated and interconnected frameworks, as well as recognition of the importance of what Sones et al. (2010) describe as being comfortable with ambiguity and the unknown.

Huarahi Whakatū is considered a relevant PDRP for any Māori RN. However, of critical importance is that the program is sufficiently flexible to support participants to engage on the basis of their own levels of readiness. Building the competency of Indigenous practitioners as specialists in their own right is a life long journey, with as much of the learning occurring as a result of the learning process itself as via program content. Reflecting the diversity of Māori cultural identities, the pace of learning varied among participants. At times this may conflict with the Nursing Council requirements for three yearly assessments of competence.

Mentoring support

The evaluation findings demonstrated the important role played by mentors in *Huarahi Whakatū*. Key values identified as influencing the significance of mentoring were *manaaki*, *whanaungatanga*, *tautoko*, and *matauranga*, with these contributing to the enhancement of clarity, the sharing of knowledge, and the extension of professional development as specifically relevant to practice as a Māori RN. For some, the utilization of Māori specific models of mentoring was of particular benefit. A need to spend more time with mentors was identified, as were the particular challenges for more rurally based nurses who faced difficulties accessing resources such as nursing networks, leadership and information.

Wider systemic support

Program participants and their employers have identified the importance of raising the profile of Māori RNs, so that the specific elements brought by Māori 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 Māori 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 wide 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 across 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.

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Maria Baker (*Ngapuhi nui tonu, Te Rarawa*) has a background in nursing, with a focus in mental health and Māori health. In the past decade, she has concentrated on Indigenous workforce and health service innovation and development. She was part of the establishment of the *Huarahi Whakatū* program with *Te Rau Matatini* whilst working for *Iwi* Māori, and continues to support the delivery of this dual competency based program to Māori Registered Nurses in *Aotearoa*. She is a national committee member of *Te Ao Maramatanga* (College of Mental Health Nurses), and a PhD student with Massey University.
m.baker@matatini.co.nz

Michelle Levy (*Waikato, Ngāti Mahuta*) has a background in community psychology, with a focus on research, evaluation and policy development. She has a particular interest in Māori health workforce development from the perspective of prioritizing the core training and ongoing professional development needs of Indigenous health practitioners as specialists in their own right. Michelle currently provides consultancy support to *Te Rau Matatini* across a range of program areas.
michellebeqqi@gmail.com