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Whakapiki Ake i ngā Kaitiaki

Developing and strengthening the Health Protection workforce through the voices of Māori kaimahi.

A thesis presented in partial fulfilment
of the requirements for the degree of

Masters of Health Science
at Massey University, Palmerston North, Aotearoa, New Zealand

Renee Waipaina Cubitt

2026

Karakia Timatanga | Opening Karakia

Tēnei au, tēnei au

Te hōkai nei i taku tapuwae

Ko te hōkai-nuku

Ko te hōkai-rangi

Ko te hōkai a tō tipuna a Tāne-nui-a-rangi

I pikitia ai ki ngā Rangi-tūhāhā

Ki Tihi-i-Manono

I rokohina atu rā

Ko Io-Matua-Kore anake

I riro iho ai ngā kete o te wānanga

Ko te kete tuauri

Ko te kete tuatea

Ko te kete aronui

Ka tiritiria, ka poupoua

Ki a Papatūānuku

Ka puta te ira tangata

Ki te whai ao

Ki te ao mārama

Tihei mauri ora!

(Taonui, 2012)

Traditions concerning the acquisition of ngā kete o te wānanga vary, with some accounts identifying Tāwhaki and others Tāne-nui-a-rangi as undertaking the journey to obtain the baskets of knowledge. In this thesis, the tradition of Tāne-nui-a-rangi is followed because it aligns with Ngā Poutama Whetū and the conceptual framing used throughout the research (Taonui, 2012). The opening tauparapara therefore reflects Tāne's ascent through the heavens and retrieval of ngā kete o te wānanga.

Acknowledgements

Tēnei te ara a Ranginui, tēnei te ara a Papatūānuku. The opening karakia is a call to celebrate our ancient traditions, our tīpuna, and the great journey of Tāwhaki in his pursuit for ngā kete o mātauranga (the baskets of knowledge). It embraces our whakapapa (genealogy), our atua (divine beings) and te ao mārama (the world of light).

E mihi atu ki ngā manawa tītī – acknowledgements to the participants who donated their time and energy to this kaupapa, helping to illuminate a path for the next generation of Māori Health Protection Officers and help make it a safe career for them to thrive within.

I would like to acknowledge Te Rau Pūawai for their scholarship and support, not just financially but also with support and the opportunity to connected with tauira like me who are isolated in their journey, as is the way with correspondence studies.

Finally, I would like to acknowledge my whānau, my partner for his support, my children for their patience and their grandparents for being present when mum is busy on her computer – it takes a village, and my village is tino ora.

Abstract

Māori remain significantly under-represented in the Health Protection Officer (HPO) workforce, despite holding unique cultural knowledge and community relationships that are essential to protecting hauora (health and wellbeing) and whenua (land). This thesis investigates how the Māori Health Protection workforce can be developed and expanded by listening to the lived experiences of current and former Māori HPOs. Guided by a Kaupapa Māori methodology and the Ngā Poutama Whetū framework, this study explores the pathways Māori take into Health Protection, the barriers and enablers they encounter, and the factors that shape their retention and capability development within the National Public Health Service (NPHS).

Seven Māori HPOs and trainees participated in semi-structured interviews supported by descriptive statistical analysis. Five interrelated mātāpono (values) emerged as shaping entry pathways: Whakapapa (motivation grounded in kaitiakitanga and collective responsibility); Whanaungatanga (relational guidance compensating for unclear formal pathways); Ōritetanga (tailored, equitable entry mechanisms such as scholarships and Māori-specific roles); Māramatanga (barriers created by the invisibility of the profession and opaque designation processes); and Mana Motuhake (the lack of preparation for Crown responsibilities and Te Tiriti practice). These findings highlight that Māori do not enter Health Protection through system-designed pipelines, but through cultural obligation, relational support, and chance discovery.

Retention factors were shaped by organisational culture rather than individual resilience. Positive experiences occurred where leadership demonstrated manaakitanga, invested in Māori capability, and normalised Te Ao Māori practices. However, participants also described inconsistent cultural support, inflexible qualification requirements, inequitable access to professional development, cultural taxation, and widespread institutional racism. Role conflict and cultural labour were prominent themes, with Māori often expected to carry responsibility for tikanga, Māori community relationships, and equity mahi beyond their formal roles. These conditions influenced burnout, job satisfaction, and long-term retention.

The cultural competence of non-Māori staff was the most significant determinant of Māori experiences across the pipeline. Limited cultural capability amplified racism, reinforced Western dominance in training and practice, and undermined Māori identity within the role. Conversely, genuine partnership, kaupapa-aligned leadership, and meaningful integration of mātauranga Māori enhanced cultural safety, belonging, and retention.

The study concludes that developing and expanding the Māori Health Protection workforce requires systemic transformation rather than incremental improvements. Recommendations include co-designing dedicated Māori HPO roles, redeveloping qualification pathways to recognise mātauranga Māori and iwi expertise, implementing Māori-led recruitment pipelines, strengthening relational infrastructure (such as tuakana–teina networks), increasing Māori leadership representation, and embedding sincere Treaty partnership across Health Protection. By honouring mana motuhake, recognising Māori expertise, and upholding Te Tiriti, Aotearoa can build a Health Protection workforce that protects not only public health but also whakapapa, whenua, and the wellbeing of future generations.

Keywords: Kaimahi Māori, Health Protection, Workforce, Pathways, Recruitment, Retention, Cultural Capabilities, Kaitiaki, Public Health, Equity

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Preface: Ko Wai Au?

"E kore au e ngaro, he kākano i ruia mai i Rangiātea."
"I will never be lost, for I am a seed of Rangiātea"

I te taha o tōku papa, e tū ana au i te Tau Ihu o Te Waka a Maui. Titiro atu ki Tōtaranui ki Arapaoa, tō mātou moutere tapu, he takotoranga i tō mātou tīpuna. Ka maumaharatia te hekenga o ō matou tīpuna mai i te Taranaki ki Te Waipounamu. Ka huri taku aro ki tihi o maunga piripiri, titiro whakararo ki te whenua o Te Ati Awa. Ka tau ki Waikawa Marae. Māku, Mōu, Mō ngā iwi katoa.

A person's whakapapa is the blueprint of their identity and connection to the world. It carries us from Ranginui's tears on the maunga, through the rivers, to the ocean. Whakapapa grounds us in the atua, their mana a seed within us. Mine feels incomplete, parts hidden, waiting to be rediscovered and passed on. At thirty, I am finally ready to seek the answer to the question I have always carried: Who am I?

I am not alone. Many Māori across Aotearoa share this disconnection. Erin Lincoln (2023) notes how colonisation and distance from whenua and whakapapa can create feelings of inadequacy, pushing us toward spaces that feel easier or safer. I have fair skin, blue eyes, and my surviving tīpuna are Scottish. My Māori grandparents died young, reflecting life expectancy inequities. My Grandad, who died of cancer at 65, never spoke of his whakapapa. Growing up in Ōtautahi, Māori identity was tokenised, rarely celebrated. Still, I know where I descend from and strive to keep links with my marae for my tamariki and mokopuna.

My mum's whakapapa is more complex. Though perceived as "more Māori," she was a whāngai into a family where she suffered neglect and abuse. Cut off from her iwi, she abandoned Māoritanga to protect us from her pain. As Taina Pohatu (2011) describes her mauri rests in a "moe state," withdrawn and hurt. Because of this, I grew up distanced from te ao Māori. In my 20s, I never advertised my identity, not from shame, but because I did not know enough. Questions like "How Māori are you?" deepened the doubt in myself. I felt panic when spoken to in te reo, unable to go beyond "kei te pai." Now, as

my children grow, I regret not exposing them earlier, knowing they too will struggle to catch up.

The pūrākau of Waitara illustrates this journey. Like Whare-Matangi, who had to find his father to realise his potential, we must know our whakapapa to thrive. Today, many Māori are reclaiming this knowledge, sparking a renaissance of pride and identity. Professionally, my path has always been shaped by the intersection of health and environment. Leaving school young and pregnant, I pursued science to shape a future. As a Compliance Officer, then Health Protection Officer (HPO), I saw parallels between environmental health and kaitiakitanga. COVID-19 propelled me into leadership, and I now hold a senior role within public health. Our team fights for Māori voices in health, even as political forces threaten to dismantle them. Despite instability, the strength of my colleagues has deepened my understanding and dissolved feelings of isolation. Dame Whina Cooper envisioned an Aotearoa where Māori and Pākehā walk together, sharing wisdom from both worlds. My journey reflects that tension and potential. Coming home to Waikawa with my tamariki, learning stories like Ropoama's Well, reminds me that Māori-led public health and mana motuhake are vital for our people's future.

This thesis is a manifestation of my journey, following my dart, and weaving Te Ao Māori and Te Ao Pākehā, seeking a path where both worlds help our people thrive. My journey of reconnection with my whakapapa is not separate from my research, it is the foundation. The questions I have carried about my own identity mirror the challenges faced by many Māori in the health protection workforce. This thesis is both a personal and collective pursuit: to understand the barriers, reclaim our stories, and create pathways for Māori leadership in public health.

Chapter 1: Introduction and Research Approach

1.1 Introduction

1.1.1 Public Health and Health Protection in Aotearoa

Health Protection sits at the intersection of public health, environmental stewardship, and regulatory practice in Aotearoa. As a specialised field within the National Public Health Service, the role of Health Protection Officers (HPOs) extends beyond technical enforcement to safeguarding the wellbeing of communities and environments through both preventative and responsive measures. Understanding the scope of this profession provides essential context for examining how Māori enter, experience, and influence this workforce.

In Aotearoa, an HPO is an enforcement officer designated by the Director-General of Health. Their primary role is to safeguard public health through regulatory enforcement, environmental monitoring, disease prevention and control and by leading or supporting public health emergency responses. An HPO's role is varied, and they may also be designated under several other acts including the Hazardous Substances and New Organisms Act 1996, Biosecurity Act 1993, Prostitution Reform Act 2003, Burial and Cremation Act 1964, Smokefree Environments and Regulated Products Act 1990, Psychoactive Substances Act 2013, and Misuse of Drugs Act 1975. The enforcement of public health legislation is now the responsibility of the National Public Health Service of Health New Zealand (a Crown agent established by section 11 of the Pae Ora (Healthy Futures) Act 2022) through their appointed officers. HPOs have accountabilities as designated officers, as Health New Zealand employees and as public servants. Their work programmes are driven not only by legislative requirements but also through the priorities of their public health service.

Health protection is defined by the Public Health Authority and is described in the document *The Public Health Services Health Protection Service Specification T2* (Health New Zealand, 2024)

:

> Traditionally health protection activities have focussed in areas where cause and effect relationships between human health and the environment have been established (Health New Zealand, 2024, p.4). The early focus in health protection has resulted in huge gains in population health globally, principally due to improved drinking water quality, food quality, communicable disease control and sewage management. An ecological approach to public health recognises that individuals and communities inhabit and interact with social, cultural, physical and biological ecosystems. When considering the role of these environments on the health of populations, the concepts of safe, healthy and supportive environments must be included. Ecological public health promotes the creation and maintenance of environments that are conducive to health, to make healthy choices easier choices. It requires a comprehensive approach to public health including developing linkages between existing areas of public health activity.

HPO functions and the ecological approach underpinning health protection illustrate the breadth and complexity of the profession while also highlighting the highly technical, regulatory, and system-driven nature of the role. By situating contemporary health protection within wider Māori perspectives of health, environment, and collective wellbeing, we can more clearly identify where the current system aligns with, or diverges from, Māori ways of knowing and practising.

1.1.2 Personal Context and Motivation

My interest in health protection is both professional and personal. As outlined in my mihi (Ko Wai Au), my journey has been shaped by experiences of disconnection from whakapapa, the impacts of colonisation, and the ongoing search for belonging and identity as Māori. The questions that have guided my personal journey, are the same questions that underpin this research - Who am I? Where do I belong? How can I contribute to the wellbeing of my whānau and community? By weaving together my lived experience and the collective experiences of Māori HPOs, this thesis seeks to illuminate

both the barriers and the opportunities that exist within our Health Protection Workforce. My story is not separate from this research; it is the foundation upon which it is built.

1.1.3 History of Public Health in Aotearoa

Understanding the history of public health in Aotearoa provides important context for the development of Health Protection as a profession, and for the experiences of Māori within it. The evolution of public health structures, early legislation, and the impacts of colonisation have shaped both the health challenges faced by Māori and the systems designed to address them. This historical foundation helps illuminate how past decisions, policies, and leadership continue to influence Māori participation and wellbeing in the health sector today.

Public health was introduced to New Zealand law via the Public Health Act in 1876, in response to the mounting public health concerns that grew with the influx of settlers to New Zealand shores (Anderson, Binney & Harris, 2014). Poor infrastructure, contaminated water and overcrowding were many factors that contributed to disease outbreaks such as typhoid and scarlet fever (Rice, n.d). For Māori, these problems were in addition to the impacts of colonisation, with land confiscation and displacement forcing them into unsanitary living conditions (Lange, 2014). The impacts this had on the Māori population were devastating and resulted in disproportionate loss of life (Ministry of Health, 2017).

In 1890, the Young Māori Party was formed, seeking to improve Māori health and living conditions by adopting Western medical practices while also preserving cultural autonomy (Lange, 2014). In 1900, the first Māori medical doctor by the name of Māui Pōmare was appointed as a Native Health Officer. He is well known for his promotion of sanitary practices, hygiene and disease prevention within Māori communities. The designation of a Native Health Officer fell into both central and local government legislation, with shared interests between the Public Health Department and the Māori Councils Act 1900 (Lange, 2014). Other prominent Māori leaders at this time included Sir Peter Buck and Sir Apirana Ngata, believing that Māori health could be improved through a synthesis of Western medicine and Māori cultural values. Additionally, the work of Te Puea Herangi in the early 1900s helped reduce typhoid and tuberculosis rates through her promotion and advocacy.

Public health in Aotearoa has long been concerned with sanitation, disease control, and environmental conditions, yet Māori leaders have always recognised the need to blend Western approaches with cultural autonomy and Indigenous knowledge. These early efforts laid the groundwork for ongoing conversations about what truly supports Māori wellbeing. Moving from this colonial and legislative history, the next section now turns to Te Ao Māori perspectives of health protection, perspectives grounded not in regulation, but in whakapapa, relationships with te taiao, and holistic understandings of ora that continue to shape Māori approaches to health today.

1.1.4 Te Ao Māori Perspective of Health Protection

While the development of public health systems in Aotearoa was heavily shaped by colonial legislation and Western medical models, Māori understandings of health and environmental stewardship pre-date these structures by centuries. To fully grasp how Health Protection has evolved it is essential to first ground the discussion in Te Ao Māori perspectives of health, whakapapa, and the interconnected relationship between people and te taiao.

Whakapapa is the core principle through which Māori order the universe and understand the interconnectivity of all things; it also provides a genealogical framework that explains how humans are connected to the environment. of how we are connected to the environment (Hikuroa, 2016). Mātauranga Māori, Te Reo Māori and Tikanga Māori breathe life into this understanding and go back to the creation of Te Ao Mārama after the long embrace of Papatūānuku and Ranginui (Atua, Gods of sky and earth), pūrākau (stories) from some iwi describing humans as the descendants of Tāne Mahuta and Hine-Ahuone (Nicholson, 2019).

Sir Mason Durie defines Environmental Protection in Te Pae Mahutonga using Wai Ora to illustrate how the human condition is intimately connected to the wider domains of Ranginui and Papatūānuku. Durie describes Māori health as “constructed from land, language and whānau; from marae and hapū; from Rangi and Papa; from the ashes of colonisation; from adequate opportunity for cultural expression; and from being able to participate fully within society” (Durie, 2003). This is reflected in Cram et al. (2003)

notations of the holistic values of Māori health being contextualised within the whenua, te taiao, te reo and whanaungatanga. Te Atawhai o Te Ao, the Independent Institute for Environment and Health, reaffirms the intrinsic link between us and the environment, stating "Human existence, the life-principle of humans itself, is reliant on knowledge of Papatūānuku… If we fail to take care of her, we sicken and die." (Te Atawhai o te Ao, N.D). Through this whakapapa, we position ourselves in the same realm as te taiao (the environment) being born of the flesh of Papatūānuku and the gifts of the atua driving our essence as human beings.

Health protection is not a foreign or modern concept for Māori, but an inherent expression of whakapapa, whenua, and relational balance. Understanding health through this lens naturally leads into the practical ways Māori communities historically protected both physical and spiritual wellbeing.

1.1.5 Early Māori Health Protection Practices

Early Māori health protection practices illustrate a sophisticated and holistic system of care grounded in whakapapa, tikanga, and relational balance with te taiao. The success of these practices can be evidenced by early accounts of Māori recorded by James Cook in 1769 describing Māori as being strong, raw-boned, well-made active people who enjoyed a good state of health (Belich, 2001). Salmond (1991) similarly argues that Māori lived as long as non-Māori at the time of early encounters.

Before the introduction of Western medical practices, Māori used tapu, rongoa, and mirimiri as effective health protection tools, the tikanga (the right way) accepted by Māori communities to protect themselves from physical and spiritual risks (Gillies, 2006; Ahuriri-Driscoll, Lee, & Came, 2020). Māori connection to whenua and te taiao gave them the insights required to successfully support their health systems (Graham & Masters-Awatere, 2020; Durie, 2003).

Leadership in health was the role of a tohunga (Tipene, 2017) who delivered education and promotion activities through wānanga (collective learning) (Gillies, 2006). The focus was about more than just physical ailments and would nourish the spiritual aspects of a person and whānau. This nourishes the wairua of a person and whānau, a holistic

viewpoint that has been incorporated into Sir Mason Durie's Te Whare Tapa Whā model of health (Durie, 1999).

Other examples of early Māori health protection practices are demonstrated in the design and location of Pā (village) reflecting the knowledge of public health measures. Pā were built in locations that were safe and dry, close to clean water and the order of operations was done in a way that would prevent cross-contamination, utilising tapu, noa and rāhui as the guiding tools. Materials selected to build a whare allowed for breathable walls and insulation, contributing to a healthier indoor climate. These concepts were a kaupapa Māori approach to environmental and resource management, protecting both whānau and the whenua (Tipene, 2017).

Despite the effectiveness of these early Māori health protection systems, colonisation, legislative suppression such as the Tohunga Suppression Act 1907, and the rise of Western medical authority disrupted the transmission of mātauranga Māori and reshaped how health was governed. The health sector continues to be influenced by colonial structures, inequitable policy decisions, and inconsistent recognition of Māori knowledge. Understanding this historical disruption provides critical context for examining the current state of Aotearoa's health system and its ongoing struggles to honour Te Tiriti o Waitangi, uphold Māori autonomy, and support equitable health outcomes.

1.1.6 The Current State of Aotearoa Health System

As traditional knowledge systems were marginalised, decision-making shifted away from Māori control, reshaping how health was governed in Aotearoa. This legacy of disruption provides essential context for understanding how today's health system has evolved and why significant inequities persist for Māori.

In 2019, the Waitangi Tribunal's *Hauora* report (Wai 2575) found that the health system failed to provide Māori with Treaty-consistent control over health design and delivery, highlighted inequitable funding for Māori providers, and noted little improvement in Māori health outcomes since the Public Health and Disability Act 2000. The Tribunal recommended legislative amendment and a renewed Crown commitment to achieving equity.

In 2021, the Government restructured the health system, replacing 20 District Health Boards with Te Whatu Ora and establishing the National Public Health Service (NPHS). The Pae Ora Act also created Te Aka Whai Ora in 2022 as an independent statutory authority responsible for Māori health policy and outcomes. The Tribunal later affirmed Te Aka Whai Ora as essential for giving effect to Te Tiriti obligations. Public health reform also intensified during COVID-19.

The 2023 *Haumaru* report identified several Treaty breaches, including disproportionate infection risks for Māori, increased strain on Māori and Whānau Ora providers, and decisions made contrary to Māori expert advice. After the 2023 election, the incoming coalition Government moved to repeal "race-based" policies and disestablish Te Aka Whai Ora. The Waitangi Tribunal's *Hautupua* report (2024) again found breaches of Te Tiriti particularly in consultation, good faith, active protection, and redress.

The contemporary health landscape reflects these historical shifts, with repeated Waitangi Tribunal findings and recent political developments highlighting ongoing breaches of Te Tiriti o Waitangi, inequitable funding structures, inconsistent Māori leadership, and the marginalisation of mātauranga Māori in health system design and delivery. These systemic issues create the environment in which Māori HPOs work today, shaping both their experiences and the barriers they encounter. Together, these factors lead directly to the research problem at the heart of this thesis: whether the current health system provides meaningful, Treaty-honouring pathways for Māori to participate, lead, and thrive within Health Protection and how Māori experiences can guide the transformation required to achieve equity.

1.2 Research Context

1.2.1 Research problem

This research is grounded in my own experiences as a Māori HPO and the intergenerational impacts of colonisation that have shaped my whānau. Navigating a health system that often fails to reflect Māori realities has shown me both the potential of Health Protection and the limitations imposed by structures not designed with Māori in mind. My journey, guided by kaitiakitanga, whanaungatanga, and a desire to serve my

people, mirrors challenges shared by many Māori in the workforce. These lived experiences form the basis of this inquiry: to understand whether the barriers I have encountered are individual or systemic, and how Māori voices can guide meaningful change.

This thesis therefore investigates whether current systems enable or constrain the development of a strong Māori Health Protection workforce. It argues that building and nurturing Māori capability is not only an equity imperative but a constitutional obligation, one essential to achieving a health protection system that upholds mana motuhake, protects Māori communities, and honours Te Tiriti o Waitangi.

1.2.3 Literature gap

Building on the research problem which highlights systemic barriers, it is important to situate this study within the limited body of existing work. Earlier contributions by Webber (2004) and Gillies (2006) provide foundational insight into Māori participation in Health Protection and the wider Māori health workforce. This thesis extends that foundation by focusing directly on the lived experiences of Māori HPOs, offering contemporary perspectives on the pathways, challenges, and opportunities that shape their journeys.

By grounding this study in the voices of Māori HPOs, the research addresses a gap in recent literature and the wider equity issues outlined in the research problem. These insights create a clear platform for defining the aims of this thesis: to investigate the pathways Māori take into Health Protection, to understand the factors that influence their retention, and to examine how cultural capability and system design shape their experiences.

1.2.4 Objective

This thesis aims to explore the under-representation and experiences of Māori HPOs in Aotearoa. The objectives are to explore 3 areas:

Pathways:

examine the pathways that Māori Health Protection Officers took, highlighting barriers and enablers that they met through the pipeline from secondary school to employment.

Retention:

listen to the lived experiences of Māori Health Protection Officers, paying attention to the retention factors such as motivation, leadership opportunities, cultural support, role conflict and working environments

Capability:

evaluate the cultural capability of the health protection workforce, including the effectiveness of training, support structures and integration of Mātauranga Māori and Te Tiriti

1.2.5 Research Questions

Underpinning this research project is one primary research question with two subsidiary questions:

How can the Māori Health Protection workforce be developed and expanded by listening to the experiences of previous and current kaimahi Māori Health Protection Officers?

(i) What are the key pathways, barriers, and enablers that influence Māori entry into Health Protection Officer roles?
(ii) What factors support the retention and capability development of Māori Health Protection Officers within the public health system?

These research questions guide the direction of the thesis, focusing on the pathways, retention factors, and capability development of Māori HPOs.

1.2.6 Scope and Limitations

This thesis explores the experiences of past and present kaimahi Māori HPOs within Aotearoa's public health system. The study focuses on key themes relating to pathways into Health Protection, retention factors, and workforce capability. The research employs semi-structured interviews guided by Kaupapa Māori principles and the Ngā Poutama Whetū framework. Findings are analysed thematically to identify both shared and unique experiences across participants.

The research reflects the lived experiences of participants before, during, and after significant health sector reforms between 2022 and 2025, including the COVID-19 pandemic and the disestablishment of Te Aka Whai Ora.

While this research provides valuable insights, there are several limitations as follows:

Sample Size and Representation:

The study is based on a small, purposively selected group of participants (n = 7). While this aligns with qualitative and Kaupapa Māori research approaches, it may not capture the full diversity of experiences among all Māori HPOs across Aotearoa. The findings are therefore not intended to be statistically generalisable.

Data Availability:

There is a lack of recent, centralised, and consistent data on the Māori health workforce, particularly in the post-COVID-19 context and following recent health reforms. As a result, some findings rely on self-reported experiences and participant perceptions.

Scope of Inquiry:

This research focuses specifically on Māori HPOs and does not include non-Māori perspectives or the experiences of Māori working in other public health roles. Broader systemic issues within the health sector are discussed only where they directly relate to the research questions.

Acknowledgement of Bias:

As the researcher, I bring my own lived experience and positionality as a Māori HPO to the study. While this perspective enriches the research, it may also introduce subjectivity. Reflexive practice and peer review have been used throughout the research process to mitigate this.

Changing Policy Environment:

The health sector in Aotearoa continues to undergo rapid change. As such, some findings and recommendations may be influenced by future policy shifts or organisational restructuring.

1.3 Methodological Overview

This research adopts a Kaupapa Māori methodology, privileging Māori worldviews, values, and ways of knowing throughout the research process. The approach is informed

by the literature, which highlights the importance of culturally grounded, participatory, and reflexive methods when exploring Māori health workforce experiences.

1.3.1 Literature Review

The literature review was conducted using the Ngā Poutama Whetū framework, an approach that centres Māori perspectives and critically examines both Māori and non-Māori sources (see *2.2 Literature Review Methodology* in *Chapter 2*). Key themes were identified relating to pathways into the health protection workforce, retention factors, and the importance of cultural capability and institutional context. The review informed the development of research questions and the design of the study, ensuring alignment with Māori aspirations and the realities of the health sector.

1.3.2 Research Project

This thesis uses a qualitative design, guided by Kaupapa Māori principles. Data were collected through semi-structured interviews with current and former Māori HPOs, as well as those in training (see *Interview Methodology* in *Chapter 3*). The Ngā Poutama Whetū framework also guided the analysis, supporting thematic coding and interpretation that honours participant voices and lived experiences. Reflexivity and peer review were used to ensure rigour and cultural safety throughout the research process. By integrating insights from the literature with Kaupapa Māori research practice, this thesis seeks to generate findings that are both academically robust and meaningful for Māori communities and the health protection workforce.

1.4 Thesis Structure

Each of the following chapters of this thesis contributes a specific part of the overall research.

Chapter 2 includes an overview of existing literature on Māori health workers and HPOs. Following the introduction, the chapter is organised into three kete – pathways, retention and capability. The findings and gaps of the literature review informed the design of the questionnaire.

Chapter 3 introduces the conversations had with participants of the study. The findings are organised into themes and infused with the voices and lived experiences of the

participants. The findings are the unabridged tellings from the interviews and have not yet been subjected to interpretation.

Chapter 4 analyses the findings, guided by my own personal reflexivity and supported by past research that was identified during the literature review.

Chapter 5 provides conclusions and recommendations for future research and discusses the perceived strengths and limitations of the work as a whole.

1.5 Conclusion

Chapter 1 has outlined the historical, political, and cultural context that frames this research, highlighting how colonisation, system design, and ongoing breaches of Te Tiriti continue to shape Māori experiences within public health and Health Protection. It has also established the research problem, questions, and objectives that guide this study, acknowledging both the longstanding inequities in the health system and the potential for transformation when Māori leadership, mātauranga Māori, and kaupapa Māori values are centred.

With this foundation in place, the next chapter turns to the existing body of literature to examine what is already known about Māori participation in the Health Protection workforce. Chapter 2 explores the pathways, retention factors, and cultural capabilities identified in previous research, providing the academic framework necessary to situate and interpret the findings of this thesis.

Chapter 2: Literature Review

2.1 Introduction

The purpose of this chapter is to examine the existing literature on Māori health workers and Health Protection Officers (HPOs). Māori health workers play a vital role in delivering culturally appropriate care to Māori and their whānau, and in shaping how the wider health workforce understands and responds to Māori health needs. Yet, as highlighted by Rawson (2020), a significant burden placed on many Māori kaimahi is the expectation that they shoulder cultural responsibility on behalf of non-Māori colleagues, reflecting wider gaps in cultural capability across the sector.

As acknowledged in the opening karakia, traditions concerning the retrieval of ngā kete o te wānanga differ across iwi, with some accounts identifying Tāwhaki and others Tāne-nui-a-rangi as undertaking the journey to obtain knowledge. This thesis does not seek to privilege one tradition over another; rather, it follows the kōrero of Tāne-nui-a-rangi reflected in the Ngā Poutama Whetū framework used to structure this literature review. Within this framing, the three kete represent different dimensions of knowledge, providing a metaphor through which the three interrelated problem statements of this research are explored. In doing so, the kete are not treated as direct equivalents of the research questions, but as a conceptual structure for organising and extending knowledge about pathways into the Māori health protection workforce, the experiences that influence retention, and the cultural capability of the wider health protection workforce.

This chapter begins with an overview of the kaupapa Māori methodology that shaped the review, followed by a discussion of the limitations and gaps in the current evidence base. The literature is then organised into three kete aligned with the research problem:

- **Kete Tuatahi** explores pathways into the health protection workforce, examining the role of academic institutions, pipeline interventions, affirmative action strategies, whānau engagement, curriculum development, co-design, and Mātauranga Māori. Each subsection considers barriers and enablers across the educational and career journey.

- **Kete Tuarua** focuses on factors influencing the retention of Māori health professionals, including motivation, leadership, cultural support, cultural identity, whakawhanaungatanga, role conflict, dual competencies, and burnout. This kete highlights the importance of culturally grounded support systems and the challenges Māori face within mainstream environments.
- **Kete Tuatoru** examines the cultural capability of the non-Māori health protection workforce. It covers cultural safety, core competencies, reflective practice, appropriation, institutional racism, mono-cultural environments, Te Tiriti and anti-racism, and recruitment bias—emphasising the systemic changes required to create culturally safe and equitable practice.

The chapter concludes by drawing together key insights from the review and identifying the gaps and unanswered questions that inform the direction of this research.

2.2 Literature Review Methodology

The approach to this literature review follows Ngā Poutama Whetū (NPW) (Figure 1), a seven-step Kaupapa Māori framework developed by Hapeta, Palmer, Kuroda, and Hermansson (2019). The framework is grounded in Kaupapa Māori research, an approach shaped by Māori scholars including Graham Smith (1997). This approach is employed to privilege a Māori perspective within health protection by using an adapted "culturally progressive" review process (Onwuegbuzie & Frels, 2016). It incorporates a Māori worldview, challenges the dominance of Western voices within the literature, and deliberately excludes deficit-based narratives about Māori (Hapeta et al., 2019).

As discussed in the preface, Tāne Mahuta is a significant atua within Māori creation narratives. The use of the Ngā Poutama Whetū framework acknowledges Tāne Mahuta through its depiction of his ascent to retrieve the three baskets of knowledge from the heavens, and the trials and tribulations he endured to ensure access to intergenerational knowledge spanning the past (wāmua), present (wātu), and future (wāmuri).

Figure 1. Recreation of Hapeta et al.'s Ngā Poutama Whetū literature review framework. Sections 2.2.1 through to 2.2.7 describe how the literature review is structured in alignment with the Ngā Poutama Whetū framework.



Figure 1: recreation of Hapeta et al., Ngā Poutama Whetū literature review framework

2.2.1 Kaupapa: Identifying the Collective Aims and Aspirations of Māori.

In this literature review, three core problem statements are explored. These are organised into kete that align with Tāne Māhuta's pursuit of knowledge.

- **Kete Tuatahi – Pathways:**
  This kete explores the barriers Māori face when entering the public health workforce.
- **Kete Tuarua – Retention factors:**
  This kete examines the experiences of past and present Māori within the public health workforce, with a focus on factors that influence retention.
- **Kete Tuatoru – Cultural capabilities:**
  This kete considers how the cultural capability of the health protection workforce impacts kaimahi Māori.

The epistemology underpinning this review is grounded in the researcher's own experiences as Māori within the health sector, specifically within the health protection workforce. The researcher's axiology privileges kaupapa Māori and Māori-centred methodologies, recognising that health protection has largely been designed and

delivered through Western scientific paradigms. This positioning requires that narratives relating to deficit outcomes are understood, at least in part, as consequences of the historical and ongoing impacts of colonisation within Aotearoa.

The literature review is informed by the following assumptions:

- Māori experience systemic barriers to entering the health workforce.
- Health protection and Te Ao Māori share aligned values, ways of thinking, and aspirations in relation to human health and the environment.
- Māori participation in health protection remains under-researched.
- The cultural capability of mainstream health organisations is limited.

2.2.2 Tino Rangatiratanga: Decisions Made by the Researcher

Search databases were limited to Google Scholar, Health New Zealand Massey University Library. Articles that were recommended but had not come up in database searches were explored. Articles found within the reference list of selected articles were also reviewed to acknowledge the original source of information and gain deeper understanding where applicable. Inclusion date range for were limited to 2010-2025.
Search terms included:

- Māori, Public Health AND workforce; Māori AND Environmental Health AND workforce;
- Māori AND Health AND workforce barriers; Māori AND Health AND workforce retention;
- Māori health AND the environment; Māori health and sciences
- Mātauranga Māori in curriculum

As it is assumed the topic of health protection and Māori is an under researched inquiry, articles that fell outside of the date range were considered if they related specifically to health protection.

Selected articles were based on a positionality of Te Tiriti and/or mātauranga Māori, Western centred research was excluded. Crown documents were included if Māori were involved in its development. Research about Māori without any input from Māori were excluded.

2.2.3 Ako: Organising Information and Coding

The abstracts were examined and put through the following criteria:

- Written by or with Māori AND
- Is centred on Te Tiriti OR Mātauranga Māori AND
- Discusses Māori health workforce OR Māori health workforce pathways OR cultural capabilities of non-Māori health workforce OR Māori scientists
- Literature pertaining to the experiences of the Māori health workforce will be explored across the health sector, not limiting this to experiences within public health as experiences may be similar in clinical and non-clinical settings.

Audit trail of searches are entered into an excel spreadsheet and coding was applied (See Appendix1: Audit Trail of Literature Review)

2.2.4 Taonga Tuku Iho: Selecting or Deselecting Information

Selected articles were read in full and were selected depending on the strength of their alignment with the kaupapa. This ranged from Green, strongly aligned and will be used; Amber, somewhat aligned and may be used and Red; does not align and is deselected. This was documented in the Audit Trail (See appendix 1: Audit Trail of Literature Review)

2.2.5 Kia Piki i ngā Raruraru: Who's Knowledge is Valid.

The information sources were considered if the author is considered an expert in the subject, either by academic pursuit; experience; by endorsement of iwi or hapū. Consideration of literature is given to Māori academic's rangatira and kaumatua. Pākehā or non-Māori research is considered if it aligns with step 2.2.3 Ako: Organising Information and Coding.

2.2.6 Raranga: Using Māori Concept to Explain the Findings.

The research is using the process of mahi raranga, harvesting harakeke in preparation for weaving a kete, to analyse our search. We start with karakia (search term), and Pā Harakeke (Database). From here we can begin to organise the information into codes, categories, themes and concepts.

Cutting (Tapahi) = Codes: Gathering raw data (keywords/phrases).

Splitting (Pakohu) = Categories: Grouping similar ideas from codes.

Sorting (Whiriwhiri) = Themes: Organizing categories into larger patterns or topics.

Scraping (Hāpine) = Concepts: Refining themes to form abstract, theoretical insights.

Just as the harakeke process ensures that the flax is prepared to be woven into a kete, this methodical approach to organising the literature review ensures that each layer of analysis builds on the last, resulting in a coherent, insightful research output.

2.2.7 Kaupapa

In this section we weave together the information we gathered from our review. The review is organised into the three kete: Pathways; Retention Factors; and Cultural Capabilities. Studies specific to Māori HPOs were limited and somewhat dated, yielding only three results that fit within the scope of this project. In 2004, Chris Webber (Ngāti Toa Rangatira, Ngāti Raukawa ki te Tonga, Te Atiawa) developed a scoping paper examining Māori and Health Protection. Soon after in 2006, Annemarie Gillies (Ngāti Kahungunu, Ngāti Awa, The Whānau-a-Apanui, Te Arawa) focused her thesis on "Anchoring Māori Health Workforce Potential", with particular attention to the Māori health protection workforce. The most recent contribution was a quantitative study by Emma Waimarie Rawson (2020), which explored the experiences of senior kaimahi Māori working in public health, including those in Health Protection roles.

2.3 Limitations of Literature

This literature review has identified significant limitations in the available data and research on the Māori health workforce. The most recent comprehensive review was undertaken by Te Rau Matatini (now Te Rau Ora) in 2017, titled *Profiling the Māori Health Workforce*, followed by a subsequent report in 2018, *Te iti me te rahi – everyone counts Māori health workforce report*, which examined the state and needs of the Māori health workforce.

These data no longer provide an accurate representation of the contemporary Māori health workforce. This is particularly evident given the significant events that have occurred since their publication, including the COVID-19 pandemic, major health system reforms

in 2022, the disestablishment of Te Aka Whai Ora in 2023, and more recent proposals for a health system reset in 2025.

The studies themselves also acknowledged methodological limitations, noting the absence of a centralised and consistent record of Māori workforce data. As a result, workforce information has been collected using varied and inconsistent methods, limiting its reliability and completeness. It is therefore likely that the Māori health workforce remains under-reported (Sewell, 2017).

2.4 Kete Tuatahi: Pathways

Increasing Māori participation in the Health Protection workforce is an important component of developing a workforce that better reflects and responds to the needs and aspirations of Māori communities. This section explores the pathways that support and enable Māori entry into the health protection workforce, including the role of academic institutions, pipeline interventions, affirmative action strategies, and whānau engagement in shaping educational and career trajectories. By examining these pathways, this review identifies strategies that can contribute to the development of a robust and sustainable Māori health protection workforce.

2.4.1 Role of Academic Institutions

Academic institutions significantly influence the health workforce through their policies and practices relating to student recruitment and retention (Sise et al., 2024). However, evidence indicates that tertiary institutions continue to produce inequitable academic outcomes for Māori students, resulting in persistent underrepresentation in both participation and graduation rates (Wikaire et al., 2016). Māori and Pacific students are more likely to attend low-decile schools, and the combined effects of social determinants and historical disadvantage hinder their ability to successfully enter and navigate tertiary education (Sise et al., 2024; Curtis et al., 2015; Wikaire et al., 2016). Sise et al. (2024) further demonstrate that inequitable educational opportunity has persisted and in some cases worsened over a 30-year period, marginalising students from the lowest socio-economic quintiles and limiting their access to tertiary study compared with more advantaged peers. These patterns illustrate that, without deliberate and equity-focused reform, academic institutions will continue to reproduce structural disadvantage and constrain Māori participation across the health workforce pipeline.

Inequities are evident earlier in the educational pathway. Secondary schools are more likely to allow Māori students to leave school with lower formal qualifications, and students are more frequently guided toward vocational subject choices that reduce their likelihood of attaining university entrance (Madjar et al., 2009; Te Rau Ora, 2022; Curtis et al., 2015). Many Māori students who do enter tertiary education are the first in their families to do so, increasing the importance of career advisors, bridging programmes, and targeted support during the transition into tertiary environments. Without such supports, whānau may lack the institutional knowledge required to navigate complex educational systems (Bryers et al., 2021; Curtis et al., 2015; Sise et al., 2024; Wikaire et al., 2016).

Academic institutions therefore play a pivotal role in shaping the health workforce. Persistent inequities across schooling and tertiary education highlight the need for targeted, Māori-centred interventions. While tertiary institutions are a critical component of workforce development, it is equally important to consider the entire educational journey. This broader perspective leads into the concept of pipeline interventions, which address the pathway from school through to entry into the health workforce.

2.4.2 Pipeline Interventions

Addressing workforce inequities requires targeted interventions across the entire pipeline, defined as the pathway that extends from schooling through tertiary education and into the health and disability workforce (Middleton et al., 2019). Each stage of this pipeline should equip students with the qualifications and skills required for successful recruitment into health careers. However, despite some improvement over time, persistent inequities continue to limit Māori access to these pathways (Sise et al., 2024).

Whānau in Bryers et al.'s (2022) study of the Whakapiki Ake Programme emphasised the need for stronger engagement at the secondary school level, particularly through accurate and up-to-date career guidance. Te Rau Ora (2022) similarly critiques the prevailing "one-size-fits-all" educational model, noting that it exacerbates inequities for Māori learners. In response to these longstanding issues, Ratima et al. (2007) and Curtis et al. (2015) propose an expanded Māori health and disability workforce pipeline encompassing five interconnected phases: pre-secondary school, secondary school and

second-chance entry, tertiary education, transition into the workforce, and the workforce phase itself.

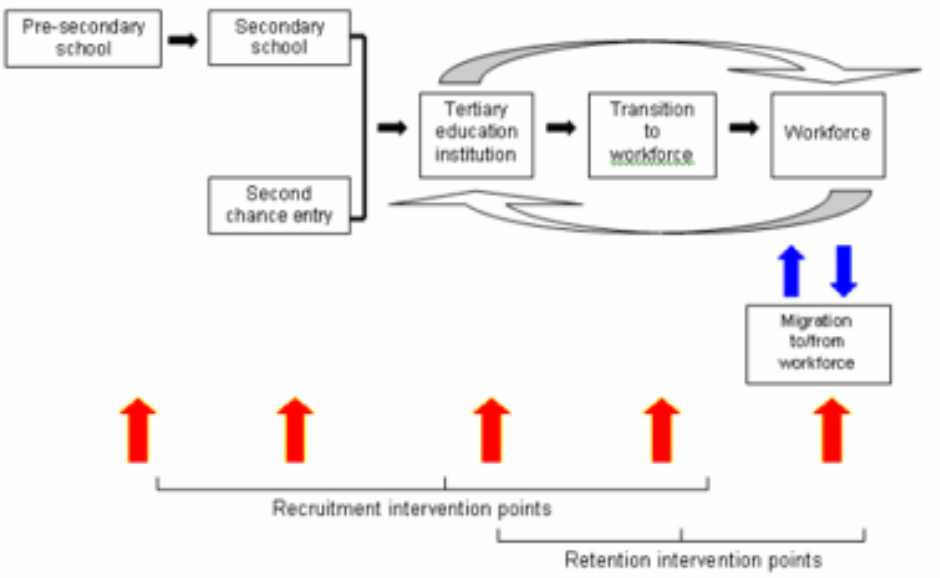


Figure 2: Māori health and Disability workforce development pathway (Ratima et al., 2007)

Interventions across the entire pipeline play a critical role in supporting Māori entry into the health workforce. These include the use of Indigenous role models, mentoring, and active community involvement in recruitment activities, as well as creating opportunities for secondary and tertiary students to gain health-related work experience. Several studies also emphasise the importance of ongoing evaluation and tracking, the inclusion of spiritual and cultural values within recruitment processes, and the presence of a clearly articulated tertiary mission or vision (Curtis & Reid, 2012). Collectively, these pipeline interventions help prepare Māori students with the qualifications and skills required for health careers while addressing persistent inequities across the educational journey. To meaningfully reduce these inequities, affirmative action strategies are also essential, as they increase the representation of historically under-represented groups and contribute to a more equitable health workforce.

2.4.3 Affirmative Action

Affirmative action strategies seek to increase the representation of historically under-represented or excluded groups and are grounded in Te Tiriti–based and equity-based justifications (Sise et al., 2024). Realising Māori potential requires fostering "culturally responsive interactions" and "social and emotional learning" (Kersey et al.,

2018). While Sise et al. (2024) observed an increase in Māori student participation over a 30-year period attributed to strengthened recruitment, admissions, and student support policies they emphasise that further progress depends on extending outreach recruitment, developing bridging programmes, and implementing equity-focused admission and support initiatives.

For universities committed to growing the Māori health workforce, alternative pathways are essential, particularly given that many prospective Māori students face educational and social barriers that limit direct entry into tertiary health programmes (Curtis et al., 2015). This includes critically reviewing admission processes, programme content, and institutional environments to ensure they address these barriers comprehensively (Wikaire et al., 2016), reaffirming the need to look beyond secondary school results alone when assessing applicants (Curtis et al., 2015).

Jameson and Smith (2011) and Curtis et al. (2015) describe health career pathways as highly competitive, with limited placements available each year, underscoring the importance of preparing Māori students through scholarships and early familiarity with the university environment. Supporting this, Wikaire et al. (2018) found that Māori students encounter varying combinations of barriers depending on the tertiary context and its responsiveness to socio-demographic realities.

In summary, affirmative action strategies are vital for ensuring equitable representation in the health workforce, guided by Te Tiriti and equity-based justifications. A critical component of these strategies is the engagement of whānau, as involving families in educational decision-making and support structures can enhance Māori student success within health career pathways.

2.4.4 Whānau Engagement

Engagement and participation of whānau in programmes such as Whakapiki Ake and the Māori and Pacific Admission Scheme (designed to support Māori and Pacific school leavers who have not achieved University Entrance) highlight the importance of whānau-centred models. These approaches have been shown to foster cultural growth, deepen understanding of inequities in Māori health, and support whānau to transition

alongside students as they prepare for tertiary study, helping to strengthen positive cultural identity (Bryers et al., 2021; Curtis et al., 2015).

Because health-career information is often limited and difficult to access, many tertiary students rely on informal networks. Approximately half of the respondents in Ratima et al.'s (2007) study reported learning about health careers through "word of mouth" within Māori networks, including advice from friends and whānau. Curtis and Reid (2012) and Bryers et al. (2021) reinforce this finding, noting that early involvement of parents increases exposure to career possibilities due to the strong influence of whānau.

Bryers et al. (2021) also emphasise the importance of connections with other Māori students in reducing feelings of isolation within tertiary settings, observing that these relationships foster a sense of belonging through the affirmation of cultural identity. This is supported by Davis and Came (2022), who argue that Māori students require access to appropriate pastoral care, and by Ahuriri-Driscoll (2020), who highlights the need for educators engaged in decolonising work to have access to the same supports.

In conclusion, whānau engagement is critical to Māori student success, nurturing cultural identity, strengthening awareness of health inequities, and providing collective support throughout the educational journey. To further uphold these outcomes, curricula must be culturally responsive, recognising the unique needs of Māori students and meaningfully incorporating Indigenous knowledge into educational frameworks.

2.4.5 Curriculum Development

Recognising that traditional models of tertiary education delivery are failing to meet the needs of all learners is particularly important for developing the Māori health workforce (Kersey et al., 2018). Curtis et al. (2015) emphasise the need for educators to provide culturally safe teaching and learning environments for Indigenous and ethnic minority secondary school students, noting that deficit theorising by teachers remains a significant barrier to Māori educational achievement.

Indigenous health is increasingly recognised as its own discipline, grounded in the decolonisation of curricula. This shift has created a need for expertise in Indigenous health curriculum design and the development of decolonised content within tertiary institutions (Pitama et al., 2018). However, Curtis et al. (2015) highlight that public health

educators teaching Indigenous health within health sciences often work in isolation within Eurocentric environments, leaving them vulnerable to marginalisation or objectification.

Ahuriri-Driscoll et al., (2021) identify three key priorities for improving public health curricula: challenging existing knowledge hierarchies, strengthening understanding of historical and social contexts, and cultivating relational practice. These priorities align closely with those identified by Veenstra et al., (2024), who argue that colonisation continues to influence all aspects of curriculum design in contemporary settings.

Both Pitama et al., (2018) and Ahuriri-Driscoll et al., (2021) outline the essential components of successful Indigenous curriculum design: Indigenous leadership, Indigenous health teaching staff, dedicated resourcing, and protected space within existing programmes. These elements support the meaningful inclusion of Indigenous knowledge, enhance cultural responsiveness, prepare students to work effectively with Indigenous communities, and ensure deliberate attention to equity and institutional racism (Ahuriri-Driscoll, Lee, & Came, 2020). Despite this, Pitama et al., (2018) note that progress toward Indigenous health curricula is often driven by government directives rather than institutional commitment, leaving funding and resourcing vulnerable to shifting political priorities.

Curriculum development that genuinely incorporates Indigenous knowledge and responds to the needs of Māori students is essential for their success in health education. Alongside this, co-design and collaboration with Māori communities are critical to ensuring that educational programmes remain relevant, culturally grounded, and effective.

2.4.6 Co-design and Collaboration

The education sector is struggling to ensure equitable academic outcomes for Indigenous students in health professional study (Wikaire et al., 2016). Co-design of public and environmental health curriculum delivery is important in ensuring the design meets the expectations of hapori Māori. Students and whānau being active collaborators, empowers them to think positively about their ability to make changes and master issues experienced in their social environment (Kersey et al. (2018); Shaw et al., 2023). Similar interventions described as “health science academies” in South Auckland proved successful in

improving NCEA results of Māori and Pacific students, contributing the collaboration between students, teachers, whānau as a critical factor in the positive outcomes (Middleton et al. (2019).

More recent expressions of Māori public health have drawn on both Māori and Western public health knowledges (Ahuriri-Driscoll, et.al., 2020), with the Tertiary Education Strategy requiring tertiary providers to meaningfully incorporate of te reo me ōna tikanga and uphold Te Tiriti principles within teaching practice (Ministry of Education, 2020). However, without sincere partnership with Māori in the planning, design and implementation of this curriculum, there is a risk of Māori concepts being simplified and misappropriated (Veenstra et al., 2024).

Co-design and collaboration with Māori communities ensure that educational programs are culturally relevant and effective in meeting the needs of Māori students. A key aspect of this struggle is the integration of Mātauranga Māori. By valuing and incorporating Māori knowledge systems, we can create a more inclusive and supportive educational environment.

2.4.7 Mātauranga Māori

Institutionalised racism is evident in the educational inequities within New Zealand. Māori have been excluded and marginalised in the sciences (Moko-Painting et al., 2023), facing challenges associated with excess labour, racism, inadequate supervision, limited publication opportunities, and restricted career progression (Haar & Martin, 2022). Durie (1999) argues that leadership should reflect a multidisciplinary skill set beyond technical qualifications, emphasising the importance of a workforce grounded in te reo me ōna tikanga and Mātauranga Māori. Such foundations are critical for addressing the growing prevalence of complex health and social issues that require culturally led interventions (Te Rau Ora, 2025). Despite this, the pathway to becoming a designated Health Protection Officer (HPO) prioritises academic qualifications over Indigenous measures of expertise and lived experience (Moko-Painting et al., 2023).

Figure 3 outlines the qualifications required to become a designated HPO. Notably, these requirements lack a Māori perspective or cultural training (Gillies, 2006; Kewene et al., 2023). As a result, Māori are required to train and work within non-Māori environments,

where Western worldviews dominate and marginalise Māori perspectives (Webber, 2004). This approach dismisses the legitimacy of Mātauranga Māori within health protection roles and creates inconsistencies by privileging formal qualifications, even when such roles require knowledge of Mātauranga Māori (Rawson, 2020).



Figure 3: Equivalent qualifications required to become an Environmental Health Officer
Source: Ministry of Health (2024)

Mātauranga Māori is grounded in the knowledge, culture, and values of tūpuna, offering explanations of natural phenomena from a Māori worldview (Hikuroa, 2016). Within public health, applications of Mātauranga Māori include the use of tikanga and kawa to minimise disease and protect water supplies, food sources, and the wellbeing of people (Ahuriri-Driscoll et al., 2020).

The discipline of health protection is largely founded upon environmental health science, which is grounded in Western epistemology. Decolonising qualification pathways and integrating te ao Māori ways of knowing are essential to overcoming longstanding distrust of health sciences and attracting Māori into this field (Moko-Painting et al., 2023). The transformation of science through Māori inclusion has given rise to Pūtaiao, a research methodology grounded in kaupapa Māori. Pūtaiao is firmly positioned within a Māori worldview and informed by te reo, Mātauranga Māori, and tikanga, which are holistically interwoven through whakapapa and expressed through whanaungatanga as an approach to scientific inquiry (Moko-Painting et al., 2023).

This approach acknowledges settler-colonial power structures and directly addresses the inequities and injustices that limit opportunities for Māori researchers (Moko-Painting et al., 2023). Importantly, Pūtaiao does not seek to dismiss the validity of Western scientific constructs; rather, it offers a means to decolonise how science is approached in Aotearoa. By acknowledging the historical harm inflicted upon Māori through colonial imperialism, relationships between Western science and Māori knowledge systems can be rebuilt through humility. This enables the advancement of knowledge through dual approaches and allows health protection and environmental health to be redefined through Māori perspectives (Moko-Painting et al., 2023).

Integrating Mātauranga Māori into the curriculum not only enriches the educational experience but also honours the cultural heritage, knowledge systems, and lived realities of Māori students.

2.4.8 Kete Summary

In conclusion, increasing the Māori Health Protection workforce requires a multifaceted approach that includes supportive academic institutions, effective pipeline interventions, affirmative action, and active whānau engagement. By addressing these areas, we can create a more equitable and culturally competent health workforce. Having explored the pathways to increase the Māori Health Protection workforce, it is essential to consider not only how we bring Māori into the health sector but also how we retain them. The journey does not end with entry into the workforce; it continues with ensuring that Māori health professionals feel supported, valued, and able to thrive in their roles. This brings us to the next critical aspect of our review: retention. In the following section, we will

delve into the experiences of the current Māori Public Health workforce, examining the factors that influence their retention. By understanding these experiences, we can identify strategies to create a more supportive and sustainable work environment for Māori health professionals.

2.5 Kete Tuarua: Retention factors

To achieve the best health outcomes for diverse populations, it is critical that healthcare practitioners have adequate and diverse representation that reflects the communities they serve (Heke, Came, Birk, & Gambrell, 2022; Curtis et al., 2015). The retention of Māori health workers is a critical aspect of ensuring effective and culturally appropriate healthcare for Māori communities. This section explores the various factors that influence the retention of Māori health professionals, including their motivation, leadership, cultural support, whakawhanaungatanga, role conflict, dual competencies, and burnout. By understanding these factors, we can identify strategies to create a more supportive and sustainable work environment for Māori health workers, ultimately improving health outcomes for the communities they serve

2.5.1 Motivation

Māori feel safer when working with Māori colleagues and supported by their whānau. Stewart and Gardner (2015) identified that Māori kaimahi were optimistic about their roles in health, citing they felt they were making a positive contribution to advancing Māori clients' needs while also feeling stronger by working with Māori colleagues and their whānau (Stewart & Gardner, 2015). The aims and aspirations of many Māori in the workplace are driven by the satisfaction of sincerely making a difference to and being a role model for Māori (Stewart & Gardner, 2015). Motivated by contributing to their communities, they often push themselves to take on challenging roles in diverse environments. This is supported by successful examples of Māori health leadership such as Apirana Ngata, Māui Pōmare, Peter Buck, Tutere Wirepa, and Whina Cooper working alongside Māori communities, advocating for autonomy, leadership, and participation as an integral action to the survival of the people (Gillies, 2006; Ahuriri-Driscoll, Lee, & Came, 2020). During COVID-19, Māori leaders across New Zealand demonstrated leadership through self-determining actions, resulting in positive health outcomes for Māori despite "devastating" predictions (Russell et al., 2023). Building on the strong sense of motivation driven by cultural identity and community contribution, effective

leadership plays a crucial role in harnessing this motivation to influence public health outcomes and support Māori health workers.

2.5.2 Leadership

Community-based leadership is central to supporting whānau autonomy and decision-making, reflecting the promises of Te Tiriti o Waitangi. In Tipene's (2017) study, participants described effective leadership as grounded in a deep sense of identity knowing who they are and standing with unwavering conviction so that communities can trust and have confidence in their positionality. Māori health leaders therefore tend to favour community-based approaches that uphold whānau decision-making and self-determination. From this perspective, drawing Māori into Western health structures can at times be experienced as diverting the Māori workforce away from community-led kaupapa (Rawson, 2020).

Kaumātua play a vital role within this leadership landscape. As respected leaders in Māori communities, they provide cultural guidance, pastoral care, and continuity of intergenerational mātauranga. Their deep knowledge of whenua, history, social relationships, and tikanga positions them as central decision-makers in matters affecting their people (Rawson, 2020; Ahuriri-Driscoll, Lee, & Came, 2020). In this way, kaumātua act as a bridge between past and present, supporting communities to navigate the complexities of a colonial health system.

However, when Māori are expected to lead cultural practices within mainstream health settings, these environments can become culturally unsafe. Participants described the pressure to represent culture in spaces where tikanga is misunderstood, tokenised, or undervalued. Without appropriate cultural support structures, Māori kaimahi are at increased risk of burnout, role conflict, and cultural isolation. Strengthening the resilience of this workforce therefore requires deliberate investment in cultural support networks, mentorship, and Māori-centred leadership pathways, ensuring that Māori can lead safely, authentically, and sustainably within the system.

2.5.3 Cultural Support and Identity

Participants in Rawson's (2020) study described the discomfort Māori kaimahi experienced when they were assimilated into teams where they were the only Māori, often

resulting in isolation. Having Māori networks to return to was critical for navigating these experiences. This mirrors Moko-Painting et al., (2023), who found that the collectivisation of Māori scientists was essential for cultural safety, providing mentorship, empowerment, and a collective ability to challenge institutionally racist structures. Within public health units, Māori staff frequently relied on networking groups and cultural supervision as safe spaces to support one another and to withstand the pressures of being Māori in predominantly Western environments. Yet, as Webber (2004) noted, there has historically been little evidence of formal cultural safety mechanisms within Health Protection, a concern echoed years later when only 34.5% of respondents in the *Te Iti Mai Te Rā* report reported access to cultural supervision (McClintock et al., 2018).

Positive cultural identity is further strengthened when Māori kaimahi are able to connect with whānau and Māori communities. In Tipene's (2017) Māori leadership case study, participants described reconnecting with culture as a moment of realisation, an affirmation of identity even for those raised outside of Māori worlds. Creating environments that support these connections enables Māori kaimahi to stand confidently in their roles and develop the courage to lead (Rawson, 2020).

However, access to kaupapa Māori professional development remains limited. Rawson (2020) found that opportunities to engage with mātauranga Māori or kaupapa Māori training were often scarce, optional, or inconsistently offered. When only some staff complete this training, Māori kaimahi frequently shoulder a disproportionate burden of implementing cultural practices and translating learnings into workplace contexts (Gillies, 2006). While cultural support structures are vital for reinforcing identity and wellbeing, the daily practice of whakawhanaungatanga is equally important, fostering the personal relationships and trust that make workplaces culturally safe for Māori.

2.5.4 Whanaungatanga

Establishing personal connections is central to achieving positive outcomes for Māori. Whanaungatanga, which involves sharing personal details and building genuine relational bonds, is a critical component of culturally safe practice (McClintock & McClintock, 2018). Yet this approach is often undervalued in mainstream health environments. Webber (2004) observed that non-Māori Health Protection staff typically operated in

individualistic ways, which sits in tension with the relational foundations of kaupapa Māori practice.

Rawson (2021) similarly found that senior Māori staff perceived kaupapa Māori practices such as whanaungatanga to be frequently characterised as "too time-consuming" within Western-structured workplaces. Participants reported being scrutinised more harshly than their non-Māori colleagues when engaging in relational or cultural practices, with the implication that they were underperforming or misusing resources. This experience resonates with findings from Heke et al. (2022), where Māori nurses described being judged as unprofessional for engaging in culturally appropriate ways of relating to patients.

Strong relationships also play a crucial role in bridging the perceived divide between tikanga and scientific practice. Haar and Martin (2022) note that while the technical aspects of environmental health may be less central to Māori ways of working, the strength of the relationship itself creates confidence that public health responsibilities will be carried out appropriately, enabling Māori to focus on collective outcomes.

While whanaungatanga fosters trust, connection, and effective practice, Māori health workers often navigate complex and competing expectations as they balance cultural responsibilities with professional demands. These pressures contribute to role conflict and occupational stress, underscoring the need for workplaces to recognise relational practice not as an optional cultural extra, but as essential to safe, effective, and culturally appropriate engagement with Māori communities.

2.5.5 Role Conflict Theory and Dual Competencies

Māori experience unique occupational stress within the health system due to institutional racism and the tension between cultural values and Western workplace expectations. Huria et al. (2014) identified dual competencies and burnout as key reasons Māori have left the health workforce. Role Conflict Theory, first defined by Kahn, Wolfe, and Quinn (1964) as the "simultaneous occurrence of two (or more) sets of pressures such that compliance with one makes more difficult compliance with the other," provides a useful framework for understanding these experiences. Māori researcher Jarrod Haar (Ngāti Maniapoto, Ngāti Mahuta) advanced this theory in 2021 by reframing these pressures as

a “cultural double shift,” highlighting that Māori face not only work–life role conflict but also cultural role tensions that are seldom acknowledged in Eurocentric workplaces.

Strengthening cultural identity is a critical component of effective public health practice for Māori working in Western settings. Rawson (2020) noted that cultural identity is not simply a personal attribute but represents living mātauranga brought into public health practice by Māori kaimahi. However, Haar et al. (2022) emphasise that this cultural identity can be both a source of strength and an additional burden, contributing to emotional strain and burnout when workplaces fail to recognise or support it.

Dual competencies cultural and clinical are frequently under-recognised, undervalued, and poorly understood. A culturally informed understanding of the pressures faced by Māori is essential for appreciating the unique factors shaping their work experience (Haar & Martin, 2022). Despite this, mātauranga Māori and tikanga practices remain marginalised within many health settings, even as organisations rely on Māori cultural knowledge to demonstrate “cultural competence” (Rawson, 2020). This lack of organisational commitment to Māori values often results in Māori staff feeling pressured to provide cultural advice, translation, and support without recognition or remuneration. Huria et al. (2014) found that the failure to acknowledge both cultural and clinical workloads contributed significantly to frustration among Māori nurses. Stewart and Gardner (2015) similarly observed that Māori staff frequently hold dual obligations to both their iwi and employer and are often expected formally or informally to provide guidance on tikanga Māori and te reo Māori alongside their other duties.

Rawson (2020) further described senior public health professionals feeling obligated to be “culturally responsive,” even when this work sat outside their job descriptions and was not compensated. Māori scientists reported similar challenges, having to simultaneously explain scientific concepts to Māori communities while guiding non-Māori colleagues in appropriate tikanga (Haar & Martin, 2022).

Role conflict and dual competencies are therefore not isolated pressures but systemic features of workplaces that rely on Māori cultural expertise without adequately valuing or supporting it. This dynamic contributes to occupational stress, burnout, and inequitable

workplace expectations, underscoring the need for structural change that recognises, resources, and fairly distributes cultural labour across the health protection workforce.

2.5.6 Burnout

Māori health workers often operate beyond their capacity due to funding constraints and high workloads. Despite limited resources, Māori kaimahi are known for "making things happen," frequently working through structural barriers and stretching themselves to support their communities (Rawson, 2020). This commitment reflects core Māori values of manaakitanga and whanaungatanga, qualities that strongly characterise the Māori health workforce (Stewart & Gardner, 2015). While this passion for supporting whānau is a source of strength (Brausch, 2022), it can also come at the cost of personal wellbeing when structural supports are lacking (Haar & Martin, 2022).

Workload pressures are intensified by the low proportion of Māori across the wider health workforce and compounded by limited cultural competence among non-Māori staff. In 2018, only 7.2% of the mainstream health workforce identified as Māori (McClintock, Stephens, Baker, & Huriwai, 2018), resulting in disproportionate expectations being placed on those few who are present (Stewart & Gardner, 2015). Haar et al. (2022) similarly note that the small number of Māori in scientific fields creates unique workload pressures for graduates entering their professions. Collectively, these factors contribute to significant fatigue within the Māori health workforce, driven by chronic under-resourcing and sustained high workloads (Brausch, 2022).

2.5.7 Kete Summary

The retention of Māori health workers is shaped by several interrelated factors, including motivation, leadership, cultural support, whanaungatanga, role conflict, dual competencies, and burnout. Māori health workers are strongly motivated by contributing to their communities and are sustained through their cultural identity and connections to whānau. Effective leadership both within Māori communities and across broader public health settings plays a critical role in guiding, protecting, and sustaining this workforce. Cultural support structures, such as networking groups and access to professional development, are essential but remain inconsistently available.

The practice of whanaungatanga fosters relational trust and connection, which are vital for culturally safe and effective practice. However, Māori health workers also face unique challenges arising from role conflict and the dual cultural and clinical competencies required of them. These pressures often contribute to occupational stress and burnout. Addressing these interconnected factors is therefore essential for creating supportive, culturally safe, and sustainable working environments that enable Māori health professionals to remain, thrive, and lead within the health sector.

2.6 Kete Tuatoru: Cultural Capabilities

Improving the cultural competency of the non-Māori health protection workforce is crucial for delivering effective and culturally appropriate healthcare to Māori communities (Wikaire et al., 2016). This section examines key dimensions of cultural capability, including cultural safety, core competencies, reflective practice, and the challenges posed by monocultural environments and institutional racism. Strengthening the cultural capabilities of non-Māori health professionals is essential to ensuring they are equipped to meet the needs of hapori Māori and the wider workforce, and to fostering a more inclusive and equitable health protection system.

2.6.1 Cultural safety

Public servants must understand the Māori–Crown relationship, recognise the nuances of institutional racism, and be able to appropriately embed tikanga and te reo Māori within culturally safe practice. Cultural safety is therefore essential to delivering effective and equitable health protection for Māori communities. Achieving this requires an organisational commitment to developing, recruiting, and training non-Māori staff so that mainstream health settings have the cultural capability necessary to work safely with Māori (Rawson, 2020; Veenstra, Kewene, Morgaine, & Crengle, 2024).

Durie (2001) notes that cultural competency requires gaining the knowledge needed to understand members of other cultures. Within Western systems, this involves sustained engagement with decolonising practice and normalising Māori cultural frameworks (Hooker, 2015). Training must authentically reflect Te Tiriti, build cultural safety capability, address unconscious bias, and respond to the complexities of a multicultural population (Shaw, Atkins, Hoskyn, Stretton, & Hamer, 2023). Yet, in practice, Stewart and Gardner (2015) found that cultural safety was often lacking, with non-Māori

colleagues frequently undervaluing Māori cultural competencies. Māori staff were routinely left to manage perceived "Māori issues," reflecting the limited cultural capability of the surrounding workforce and reinforcing inequitable expectations (Haar et al., 2022).

These challenges highlight a critical shift needed within the sector: cultural safety cannot rely on individual goodwill; it must be embedded as a core competency across the entire Health Protection workforce.

2.6.2 Core Competency

Cultural safety is a core competency required of health professionals working with Māori communities. Veenstra et al., (2024) identify two levels of responsibility: individual attitudes and behaviours, and the wider obligation to contribute to organisational culture and systemic change. Plans developed without genuine involvement or understanding of whānau and community cultures are more likely to fail, not due to technical flaws, but because they overlook cultural beliefs and values (McClintock & McClintock, 2018). This issue is longstanding. Webber (2004) noted that health protection legislation and practice lacked Māori input, and that collaboration is unlikely when staff do not have the skills or confidence to work effectively with Māori communities. As a result, Māori kaimahi are often assigned to Māori populations simply because non-Māori staff feel uncomfortable in these roles (Gillies, 2006). A bicultural approach to workforce development is therefore essential to ensure all staff are responsive to Māori needs (Heke, Wilson, & Came, 2018).

To achieve the best health outcomes, cultural competence should be assessed at registration and embedded in ongoing professional education (McClintock & McClintock, 2018), including reflective practice (Veenstra, Kewene, Morgaine, & Crengle, 2024). Yet access to meaningful cultural competency training remains limited for non-Māori staff (Stewart & Gardner, 2015). These gaps not only undermine cultural safety but also create conditions where Māori concepts are applied without depth or understanding risking cultural appropriation.

2.6.3 Cultural Appropriation

Misapplication of mātauranga Māori within non-Māori systems compromises its integrity and highlights why a culturally competent workforce is essential to actively protect these concepts. Moko-Painting et al., note that appropriate use of te reo Māori requires deep, contextual understanding, far beyond simple English translations. A clear example is the use of the term *manaaki* in the COVID-19 Care in the Community framework, where it was described as "reducing the burden on our hospitals and wider health system," a meaning that directly contrasts with its true intent: to support, care for, protect, and uphold the dignity of others (Te Whatu Ora; Te Aka; E Tū Whānau).

Misunderstanding and misappropriation of Māori concepts is not new. Gillies (2006) observed that *tapu* was often misinterpreted by Pākehā as "native superstitions," demonstrating how limited knowledge can distort cultural meaning. Participants in anti-racism studies similarly emphasised that non-Māori have a responsibility to privilege Māori concepts and ways of knowing—while also recognising when to "stay in their lane" to avoid causing harm (Rawson, 2022).

These examples show that cultural competence is not only about correct practice but about preventing the misuse of Māori knowledge. However, even the strongest cultural safety frameworks cannot be effective without addressing the broader structural forces that undermine them and we must look to address institutional racism in the health sector.

2.6.4 Institutional Racism

Cultural misappropriation does not occur in isolation, it emerges within systems where Māori knowledge, values, and authority are marginalised. This brings us directly to the broader structural issue underpinning these patterns: institutional racism. Institutional racism refers to the policies, practices, and norms that systematically advantage some groups while disadvantaging others, expressed through unequal access to resources, opportunities, and power, and sustained through monoculturalism (Came, 2012). Addressing these structural forces is essential to creating a genuinely inclusive and culturally competent health system.

Institutional racism is well-established as a major determinant of health. Both the Health Quality and Safety Commission (2019) and the Waitangi Tribunal's *Hauora* report

(2019) identify it as a critical barrier preventing equitable access to care for Māori (Rawson, 2020). Systematic bias against Māori has been documented at every level of the health system from governance and investment decisions to day-to-day clinical practice (Waitangi Tribunal, 2019). Recent research reinforces this pattern: Cormack et al., (2024) and Sise et al., (2024) found racism, discrimination, bullying, and harassment to be widespread issues among medical students and physicians. Alarmingly, 48% of Māori medical students and 62% of Māori physicians had considered leaving medicine due to these experiences (Cormack et al., 2024). Māori health workers also report distinct occupational stress driven by institutional racism and cultural incompetence within their workplaces (Stewart & Gardner, 2015).

Monocultural environments are a reproduction of the historical harms of colonisation through omission and exclusion (Rawson, 2020). These environments create tensions between Māori cultural values and Western clinical expectations, contributing to the occupational stress described by Stewart and Gardner (2015). Public Health Units therefore have an obligation to foster anti-racist practice, embed culturally inclusive ways of working, and rectify colonial imbalances (Heke, Came, Birk, & Gambrell, 2022). Yet, public health workplaces continue to be environments that do not reflect or uphold Māori ways of being (Webber, 2004; Gillies, 2006), presenting ongoing challenges for Māori kaimahi.

Te Tiriti o Waitangi is fundamental to anti-racism, providing both the constitutional foundation and moral imperative for Māori leadership and self-determination in public policy. However, colonisation has systematically excluded Indigenous processes from education and health systems (Heke, Came, Birk, & Gambrell, 2022), constraining the growth of the Māori health workforce. Participants in Rawson's (2020) study highlighted their organisations' inconsistent commitment to Te Tiriti, expressing frustration at the lack of understanding and fulfilment of Crown obligations. This conflict was most visible in funding decisions. Although Public Health Units often stated a commitment to addressing Māori health outcomes, their resource allocation rarely reflected this intent (Rawson, 2020). Projects intended to benefit Māori were easily deprioritised or under-resourced, perpetuating inequity and setting Māori initiatives up to fail (Gillies, 2006; Rawson, 2020). At the same time, Kaupapa Māori services were systematically disadvantaged by funding models requiring them to compete with mainstream services (Brausch, 2022).

The shortage of Māori health professionals is the cumulative result of historical, political, cultural, academic, and financial inequities, all of which reflect longstanding breaches of Te Tiriti (Curtis et al., 2015). Workforce planning that fails to recognise the Māori workforce as a Treaty right, rather than a diversity metric, continues to exacerbate these gaps (Shaw et al., 2023). Hiring practices further entrench inequity. Biases in job descriptions, credentialing requirements, and selection processes often exclude Māori candidates by privileging Eurocentric qualifications and undervaluing Māori cultural expertise (Heke et al., 2022). The lack of cultural competence among hiring committees compounds this by leading to the exclusion of well-qualified Māori applicants.

Addressing these biases requires culturally responsive job design, Māori involvement in recruitment decisions, and alignment with Te Tiriti obligations (Smith, 1999). To overcome these barriers, targeted recruitment strategies are essential. These should include clear pathways for Māori students into health professions, Māori-led mentorship and support structures, and recruitment processes grounded in partnership and equity principles. By addressing the root causes of bias and discrimination, we can build a health workforce that is diverse, culturally competent, and capable of meeting the needs of Māori communities (Curtis et al., 2015).

2.6.5 Kete Summary

This section has examined the importance of strengthening the cultural capability of the Health Protection workforce to ensure responses are appropriately aligned with the needs of Māori communities.

It has highlighted the responsibility of Crown agents to understand their role within the Māori–Crown relationship, acknowledge and address institutional racism, and shift away from monocultural environments toward ways of working that reflect te ao Māori. Despite the recognised importance of these factors, significant gaps remain in workforce capability due to limited training and organisational support. Professional development related to cultural safety is frequently undervalued and, in some contexts, treated as optional rather than essential.

This section has also illustrated the risks associated with cultural appropriation and the insincere inclusion of Māori concepts. When Māori knowledge is applied within

non-Māori systems without sufficient understanding, its integrity and effectiveness are compromised. Together, these findings underscore the need for system-level commitment to cultural capability as a foundation for culturally safe, equitable Health Protection practice.

2.7 Literature Review Discussion

2.7.1 Kete Tuatahi Pathways

From the literature review, it is evident that increasing the Māori Health Protection workforce requires identifying and addressing barriers experienced by students across the educational pipeline. Academic institutions hold significant influence, as their processes and pathways shape Māori access to tertiary education and entry into the health workforce. Secondary schools play a critical role in ensuring Māori students are adequately prepared for tertiary environments and have access to a full range of educational pathways to overcome social and economic disadvantage.

Despite increasing numbers of Māori entering health sciences, inequitable policies continue to marginalise Māori students, resulting in persistent underrepresentation in graduation rates. The near exclusion of students from lower-decile schools further underscores the need for targeted interventions and improved admission policies. Career advisors and bridging programmes are particularly important for Māori students transitioning into tertiary education, especially given that many are the first in their families to enter university. These supports assist students to navigate complex tertiary systems and provide essential academic and pastoral support. Interventions grounded in affirmative action and guided by Te Tiriti o Waitangi are therefore necessary to address the enduring impacts of colonisation. Culturally appropriate approaches across the pipeline from education through to workforce entry must also adopt a whānau-centred model, engaging families and providing collective support throughout the student journey. A range of interventions implemented over time across different points in the pipeline have contributed to increased Māori participation in health sciences.

The expanded Māori health and disability workforce pipeline further reinforces the need for a holistic approach, encompassing five interconnected phases: pre-secondary school, secondary school and second-chance entry, tertiary education, transition into the

workforce, and the workforce phase itself. This comprehensive model supports continuity and sustained development. Ongoing evaluation and monitoring of pipeline interventions are essential to assess effectiveness and guide refinement, including through research, the inclusion of spiritual and cultural values in recruitment processes, and the articulation of a clear tertiary mission or vision. The literature also highlights the need to redesign public health curricula to better embed mātauranga Māori and cultural safety. Achieving this requires adequate resourcing, genuine co-design with Māori, and delivery by culturally capable teaching staff.

2.7.2 Kete Tuarua Retention factors

The literature highlights the experiences of the contemporary Māori public health workforce and identifies key factors that influence decisions to remain in, or leave, the health sector. A central motivator for Māori health workers is their connection to community, with many deriving satisfaction from contributing positively to the wellbeing of their whānau and wider communities. Māori health leadership is frequently community-based, reflecting a preference for leading from within hapori Māori. Supporting such leadership models is essential to avoid drawing Māori leaders away from their communities and cultural values, and to ensure that leadership remains aligned with community priorities and practices.

For Māori working within mainstream health settings, cultural support structures are critical for navigating isolation, institutional racism, and sustaining cultural practice. Whanaungatanga plays a particularly important role, connecting kaimahi Māori with their communities and maintaining their relationship to Te Ao Māori while operating within predominantly Western systems. At the same time, Māori health workers experience distinct forms of role conflict, navigating between cultural and clinical expectations. This "cultural double shift" contributes to heightened occupational stress and increases the risk of burnout, as Māori are often required to support community understanding while also assisting colleagues to engage appropriately with Māori communities.

Access to kaupapa Māori professional development opportunities remains limited. Where such opportunities do exist, they are frequently optional and inconsistently taken up, making it difficult to embed learning across teams and organisations. As a result, Māori health workers are often left to carry responsibility for cultural implementation in

workplaces where shared understanding and capability are uneven. Together, these dynamics underscore the importance of system-level approaches to retention that recognise cultural labour, strengthen collective capability, and create environments in which Māori health professionals can remain, thrive, and lead.

2.7.3 Kete Tuatoru Cultural Capabilities

The literature review identifies a substantial body of recent research examining cultural safety and racism within healthcare work environments. These issues are central contributors to the challenges identified in Kete Tuatahi and Kete Tuarua and must be addressed to support the sustainable growth of the Māori health workforce. Cultural safety should be embedded as a core competency for health professionals, supported by ongoing training in anti-racist and culturally safe practice throughout their careers. This training must include a clear understanding of colonial history, its ongoing impacts on Māori health outcomes, and the role of unconscious bias. Reflective practice is also essential and should be incorporated into ongoing professional education, enabling health professionals to continuously strengthen their cultural competence and responsiveness.

Institutional racism remains a significant barrier to Māori entry into the health workforce, operating across both education and health sectors and perpetuating inequitable access. Even when Māori enter the workforce, they frequently encounter racist attitudes and monocultural work environments that fail to reflect or embrace Te Ao Māori.

The application of mātauranga Māori within non-Māori systems also presents significant risks when undertaken without sufficient understanding. Misuse of Māori concepts, such as *manaaki*, can compromise their integrity and undermine cultural safety. Institutional racism further exacerbates these challenges by contributing to poor retention outcomes, with many Māori health professionals considering leaving the sector due to experiences of racism, discrimination, harassment, and bullying. Addressing these interconnected issues is therefore critical to retaining a diverse, culturally competent, and sustainable health workforce.

2.8 Conclusion

This literature review has woven together the many strands that shape Māori entry into, and survival within, the Health Protection workforce. Across the pipeline, the evidence

demonstrates a system grounded in Western assumptions, with qualification pathways that privilege academic credentials over mātauranga and iwi knowledge, tertiary environments that remain culturally unsafe, and workplace structures that continue to reproduce inequity.

Alongside these barriers, the literature also highlights the transformative potential of kaupapa Māori approaches, including whānau-centred support, affirmative action pathways, culturally grounded curricula, and interventions that prioritise collective wellbeing over individual advancement. These insights directly informed the design of this research project. The absence of contemporary studies focused specifically on Māori Health Protection Officers (HPOs), combined with the persistent structural issues identified in the literature, underscored the need for a kaupapa Māori methodology.

By drawing on Ngā Poutama Whetū and organising the review into the three kete of Pathways, Retention, and Cultural Capabilities, the literature provided not only the thematic foundation for this study but also the conceptual ethic guiding how the research needed to unfold.

Reflexively, my own experiences as a Māori HPO resonated strongly with many of the tensions described in the literature, including navigating invisible pathways, carrying cultural responsibilities unrecognised by the system, and seeking belonging within spaces not designed for Māori. These resonances sharpened awareness of what was absent from the existing evidence base and reinforced the importance of creating a research space where Māori HPOs could speak freely, safely, and on their own terms.

In this way, the literature review has not only illuminated the historical and structural forces shaping the Health Protection workforce but has also made clear the need for this research: to centre the contemporary voices of Māori HPOs, to examine whether the patterns identified in the literature persist in current practice, and to better understand the aspirations, challenges, and cultural strengths that Māori bring to Health Protection. These insights now prepare the ground for the findings presented in the following chapter.

Chapter 3: Findings

3.1 Introduction

The purpose of this chapter is to present the kōrero shared by current and former Māori Health Protection Officers (HPOs), as well as those in training. These interviews form the heart of the study, offering contemporary insights into the pathways, challenges, and strengths experienced by Māori across the Health Protection landscape.

Sections 3.2 to 3.11 outline the methodology underpinning this work. The chapter introduces the structure of the findings and describes the Kaupapa Māori approach that guided each stage of the research. The use of the Ngā Poutama Whetū framework shaped how information was gathered, protected, and analysed, ensuring the process aligned with tikanga Māori and upheld the mana of participants. This section details the qualitative design, my positionality as a wahine Māori within public health, the recruitment and selection process, and the ethical foundations of tika, pono, and aroha that ensured cultural safety, confidentiality, and participant autonomy. It also explains the mixed-method analysis, which combined thematic coding, descriptive statistics, and demographic cross-tabulation, and concludes by outlining how the findings were returned to participants.

Sections 3.12 to 3.14 present the core findings, organised into thematic kete that mirror the structure of the literature review. Kete Tuatahi explores the pathways into Health Protection, shaped by whakapapa, whanaungatanga, tailored supports, barriers to entry, and reflections on preparation for Crown responsibilities. Kete Tuarua examines retention factors within the workplace, including leadership, cultural support, role conflict, cultural safety, and institutional racism. These themes are grounded in participant voices and supported by quantitative and qualitative data. Kete Tuatoru introduces the theme of cultural capabilities, setting the foundation for the deeper discussion in Chapter 4 on cultural competence, anti-racism, and genuine Te Tiriti partnership.

3.2 Interview Methodology

This thesis uses a qualitative design grounded in Kaupapa Māori principles. Semi-structured interviews were conducted with current and former Māori Health Protection Officers, as well as those in training, creating space for participants to share

their experiences in their own words and on their own terms. The Ngā Poutama Whetū framework, first applied in the literature review, also guided the analysis, supporting thematic coding and interpretation that honoured participant voices, whakapapa, and lived realities. Reflexivity and peer review further strengthened the rigour of the research, ensuring cultural safety and alignment with the tikanga values that shaped the study.

This approach legitimises the experiences of kaimahi Māori working within mainstream settings, honouring their mana and right to tino rangatiratanga by giving them control over the direction of the kōrero through open-ended, participant-led discussion (Smith & Reid, 2000). It revitalises Māori ways of knowing and positions rangahau Māori as valid and necessary within Western-dominated domains. The methodology mirrors the academic and professional journeys of Māori HPOs who must navigate Western structures while remaining grounded in their own cultural foundations and Atuatanga.

The analysis followed the seven interwoven steps of the Ngā Poutama Whetū model originally developed by Hapeta et al. (2019) and adapted for this research:

- Kaupapa: defining the design and scope of the project
- Tino Rangatiratanga: upholding the self-determination of the researcher
- Ako: collecting and organising information
- Taonga tuku iho: protecting the integrity of participant knowledge
- Kia piki i ngā raruraru: ensuring ethical and cultural considerations
- Raranga: applying mixed-method analysis
- Kaupapa: reporting findings in a way that honours participant voices

Together, these steps ensured the research remained firmly grounded in Te Ao Māori, guided by tikanga and kawa throughout.

3.3 Kaupapa: Design and Scope

The approach to this research is a qualitative design that provides space for kaimahi Māori Health Protection Officers (HPOs) to share their stories. This approach aligns with Linda Tuhiwai Smith's Kaupapa Māori theory, which places Māori at the centre of the research and is underpinned by mana motuhake and tino rangatiratanga (Smith & Reid, 2000).
The aims of these interviews were to:

Explore pathways into Health Protection: to understand how Māori HPOs first encountered the profession, the supports and barriers experienced across the educational and employment pipeline, and the factors that shaped their decisions to pursue the role.

Examine workplace experiences: to identify the organisational, cultural, and relational factors that influence the retention, wellbeing, and capability development of Māori HPOs within the public health system.

Inform how the Māori HPO workforce can be strengthened: by centring lived experience to reveal what enables Māori to enter, remain, and thrive in Health Protection, and to identify the systemic changes required.

The researcher is a wahine Māori who has worked within public health for ten years, initially as a Māori Health Protection Officer and more recently as a Kaitohutohu Matua (Senior Advisor) within Hauora Māori Tūmatanui (Māori Public Health Directorate). This positionality informs the research through an insider understanding of the systems, responsibilities, and cultural contexts within which Māori HPOs work, while reflexive practice has been used throughout to uphold rigour and cultural integrity.

3.3.1 Consultation

No formal consultation with iwi or hapori (community) Māori was undertaken. The scope of this project is centred specifically on the experiences of kaimahi Māori HPOs working within the National Public Health Service, and no questions were asked that collected iwi-specific or community-level data. For this reason, broader community consultation was not required. However, to ensure the research aligned with kaupapa Māori principles and upheld cultural integrity, the methodology and ethics application were reviewed by the Public Health Association New Zealand Māori Caucus.

The Māori Caucus provides national leadership in Māori public health and brings collective expertise in Māori health research, ethics, equity, and Te Tiriti obligations. Their endorsement on 18 February 2025 ensured that the research design was culturally safe, methodologically sound, and aligned with Māori aspirations for self-determination within the health sector. Their guidance offered an additional layer of accountability and

cultural oversight, strengthening the integrity of the study in the absence of iwi or hapori consultation.

3.3.2 Recruitment

The recruitment process consisted of an "Expression of Interest" advertisement cascaded through internal NPHS (National Public Health Service) networks, notices, pānui and teams (See Appendix 2 Expression of Interest Advertisement). This approach ensured that the opportunity to participate was widely communicated within the organisation. To mitigate any potential feelings of coercion due to power imbalances, kaimahi who were junior to the researcher in the organizational structure were not approached directly by the researcher. This step was crucial in maintaining an ethical recruitment process and ensuring voluntary participation. For participants who no longer work within NPHS or Te Whatu Ora, existing relationships were leveraged to identify and invite them to participate. These individuals were also encouraged to share the advertisement with their networks, further broadening the reach and ensuring a diverse pool of participants.

3.3.3 Participants

The study consisted of interviews with seven participants, four identified as currently designated HPOs, two identified as past HPOs and one identified as in training. Of the currently designated HPOs, one is now fulfilling different roles within NPHS or Te Whatu Ora. The criteria for selection included the requirement to have whakapapa Māori AND are or were a designated HPO. Participants were selected using purposive sampling, aligning with the methodology Emma Rawsons (2020) used in her thesis, ensuring participants had the cultural and political capacity to recognise and articulate their experiences of working as a Māori HPO and the pathways into the role (Rawson, 2020). Once the ideal candidates were identified, a letter of invitation was sent to them via email along with a consent form (See Appendix 3 Letter of Invitation and Appendix 4 Consent Form). Once the forms were returned, contact was made to whanaungatanga and book in time for an interview. Participants had two weeks to respond to the invitation.

3.4 Ako: Collecting information

3.4.1 Interviews

Where possible, interviews were grounded in the principles of whanaungatanga, with the researcher and participant establishing a relationship prior to the interview commencing.

This approach upheld *aroha ki te tāngata* and *titiro whakarongo-kōrero*, ensuring that participants were supported to share their experiences in a culturally safe and respectful manner.

Participants were able to choose the interview format, including whether the interview was conducted face-to-face or via online platforms, the time of day that best suited them, and whether they wished to have a support person present. No time limit was placed on the kōrero, allowing participants the space and closure needed to fully articulate their experiences. Participants were also able to pause interviews and reconvene at another time if required.

Interview questions were provided to participants in advance to allow time for reflection. Participants were also offered the option of responding to the interview questions via an online Microsoft Office form if an interview format was not suitable for them. During the period in which interviews were scheduled, a measles outbreak was declared. As measles is a highly infectious disease, the initial response required significant public health resources to isolate and quarantine individuals to prevent transmission. As a result, some participants working within the National Public Health Service were no longer available to participate in interviews and instead chose to complete the interview questions independently in their own time.

Interviews typically took approximately 90 minutes to complete.

3.5 Taonga Tuku Iho: Protecting Information

3.5.1 Data storage

Interviews were guided by questions in a Microsoft Form stored on Massey University's OneDrive. As the conversation unfolded, answers were typed directly into the form, or candidates put it directly in the form themselves. The interview questions (See Appendix 5 Interview Schedule) were developed in collaboration with a kaimahi Māori principal advisor and a former HPO from NPHS Hauora Māori Tūmatanui before the interviews commenced.

3.5.2 Transcription

During interviews, the answers to the interview were typed into the form as the conversation unfolded. The researcher has a moderate understanding of te reo Māori to be able to capture basic korero. The responses to the questions were shared with participants to ensure it has been articulated accurately. No identifying information will be produced in the report, protecting the anonymity of the participants.

3.6 Kia Piki i ngā Raruraru - Ethics and Cultural Considerations

Participants were selected using purposive sampling, aligning with Emma Rawsons (2020) approach, ensuring participants had the cultural and political capacity to recognise and articulate their experiences of working as a Māori HPO and the pathways into the role (Rawson, 2020). The ethics application was peer reviewed by research supervisor Hemi Whaanga and was accepted by Massey University Ohu Matatika 1 ethics committee on 3 September 2025. Information sheet (Appendix 3) was shared with the participants and consent was given by signing the consent form (Appendix 4). The tikanga of the interviews followed tika (doing things the right way as per Māori tikanga and kawa), pono (open and honest sharing of intentions and information) and aroha (demonstrating kindness and empathy for the participants). These concepts protect the mana of the participant as we discuss their experiences.

3.7 Raranga – Mixed Method Analysis

The analysis of the information collected was done so by finding themes within the answers.

For the first section, themes were identified under the following areas:

- Motivating factors to becoming a HPO
- Guidance received along the pipeline
- Identification of tailored pathways into the role
- Barriers experienced in becoming a HPO
- Preparation to act as a Te Tiriti partner

Through this process information was filtered based on themes that emerged from the conversations. Once the sorting of themes was complete, a report was written to discuss the findings. To identify experiences specific to kaimahi Māori HPOs, 18 five-point scale questions were asked to determine if participants had experienced the same cultural

loadings highlighted in Stewart and Gardner's kaimahi Māori occupational stress study (Stewart & Gardner, 2015) and to what extent. Participants also had the opportunity to describe these experiences in greater detail, ensuring the voice of the participant could give the data appropriate context.

Analysis of answers included:

- **Descriptive Statistics:** Identifying the mean, median and mode of each of the questions to provide an overview of the overall sentiment and common experiences of participants
- **Response Distribution:** Identify the most common shared experiences and any outliers.
- **Demographic cross-tabulation:** will be used to identify the differences in experiences.

3.8 Kaupapa - Reporting

On completion of the analysis, findings will be articulated in a report and shared with the participants.

3.9 Conclusion

This methodology section outlines a comprehensive approach to understanding the experiences of kaimahi Māori HPOs. By employing a qualitative design grounded in Kaupapa Māori theory, the research honours the mana and tino rangatiratanga of participants, allowing them to guide the discussion and share their stories. The recruitment process was carefully designed to ensure ethical considerations, inclusivity, and voluntary participation. Participants were selected using purposive sampling, ensuring they had the cultural and political capacity to articulate their experiences. The interviews, structured into three key parts, provided a holistic view of the pathways into the role, workplace experiences, and future aspirations. The analysis employed a mixed-method approach, combining thematic analysis with descriptive statistics and demographic cross-tabulation. This allowed for a nuanced understanding of both the qualitative and quantitative data, identifying common themes and variations in experiences. By following the Ngā Poutama Whetū framework, the research is firmly grounded in Te Ao Māori, ensuring that tikanga and kawa are respected throughout the process. This methodology not only legitimizes the experiences of kaimahi Māori but also

provides valuable insights that can inform future initiatives and improvements within the HPO role.

3.10 Kete Tuatahi: Pathways

A pipeline is the journey a person takes from secondary school, through tertiary education and into the workforce. This section explores the experiences of kaimahi Māori HPOs in their journey through this pipeline. In the first phase of the interview, five core themes emerged from the kōrero with participants, each grounded in Māori mātāpono (Māori values) Whakapapa, Whakawhanaungatanga, Ōritetanga, Māramatanga and Mana Motuhake. Below is a detailed summary of the findings from the interviews.

3.10.1 Whakapapa

The overarching theme that emerged was whakapapa, expressed through participants' deep connections to te taiao, their role as kaitiaki, and their love for whānau and Māori communities. For many, entering Health Protection was described as an extension of inherited responsibilities: *"I want to help Papatūānuku and our taiao be better."*

Kaitiakitanga was a common motivating factor. Participants described recognising a strong alignment between the role of a Health Protection Officer and their cultural duty to protect whakapapa through an environmental lens. One participant noted the synergy between the profession and Māori worldviews: *"It's a great role. I think it aligns with the Māori worldview, especially te taiao, kaitiakitanga, and manaakitanga."*

Ōritetanga also shaped motivation for several participants. Learning about health inequities and the systemic challenges faced by Māori inspired some to work within the system to influence change: *"I became inspired to work within the system. I didn't like hearing or seeing what was happening to Māori."* For others, personal or whānau experiences of illness reinforced their commitment to contributing to Māori health: *"As someone with Māori whakapapa, non-communicable diseases ran in my whānau—my nan died pretty young."*

Manaakitanga surfaced as another motivator, with participants expressing a desire to help others succeed and to uplift their communities. A different form of whakapapa journey emerged for those motivated by changing their own futures. One participant shared: *"I*

left school at 15 and worked in factories and helped aunties cleaning offices. My dream at that age was to work in an office." Similarly, another reflected on how growing up around active, health-focused whānau shaped their pathway into the health sector.
While the desire to protect whakapapa was the central driver behind participants' decisions to pursue this career, it was whanaungatanga that transformed motivation into action. Relationships and connections illuminated an otherwise obscure profession and gave participants the confidence to move forward.

3.10.2 Whanaungatanga

Motivation alone was not enough to illuminate an unfamiliar and often invisible profession. Instead, it was through whanaungatanga that participants found their way forward. Quiet encouragement from a manager, a nudge from a whānau friend, or the belief of colleagues who recognised their potential played a pivotal role in guiding them toward Health Protection. Guidance and support during the early stages of becoming an HPO were grounded in relationships, and participants experienced either a strong presence or notable absence of whanaungatanga, which directly shaped their journey.

Manaakitanga and belief in their potential were central to many participants' decision to pursue the role. As one reflected, *"In the last year of uni a whānau friend said they were looking for a technical officer (trainee HPO) so I took the opportunity."* Another described a manager who encouraged them back into study, while a trainee noted that several colleagues had approached them to pursue the career, with one person in particular expressing steadfast belief in their capability. For many, without existing relationships with kaimahi already working in public health, the path to becoming an HPO may never have been illuminated.

Once in the role, participants spoke about the strengths and challenges of the designation process. Most valued having peers to navigate the process alongside them, describing how collective study, shared experiences, and emotional support made a demanding journey feel achievable. As one said, *"I had teammates who helped with my study as they also did the same papers."* Others emphasised how support from colleagues helped them balance study and work. In contrast, one participant who lacked this relational support described feeling directionless, with "no regular check-ins or guidance," leaving them uncertain about *"where to from here."*

These experiences demonstrate that whanaungatanga served as a critical bridge for Māori entering the Health Protection workforce. When relationships were strong, participants could step confidently into new roles, access guidance through the complexities of the designation process, and feel supported in balancing work, study, and whānau responsibilities. When absent, the pathway felt uncertain, isolating, and difficult to navigate. This variation highlights the structural gaps that Ōritetanga seeks to address.

3.10.3 Ōritetanga

Ōritetanga reflects the equitable, tailored approaches that supported kaimahi Māori into Health Protection at both tertiary and employment stages of the pipeline. At the tertiary level, one participant entered through qualifications specifically designed to increase Māori and Pacific representation in the health workforce, providing an opportunity to pursue further study in health. Two candidates received "higher-level" scholarships from the Ministry of Health, enabling them to expand into new areas of the health sector and ultimately discover Health Protection. One participant also received practical help completing scholarship applications, a process they described as complex and not always straightforward.

At the employment level, most candidates were supported by their employer financially and with time allowances to complete the required qualification. Some began as "Technical Officers," allowing them to gain on-the-job experience while studying. One participant reflected, "*Working within public health helped me with my studies both financially and academically,"* while another noted, *"I found it valuable to be doing the Graduate Diploma whilst working in the field."* Several participants entered the profession through Māori-specific HPO positions, a deliberate strategy to increase the number of Māori in the workforce.

These findings show that becoming an HPO is time-consuming, costly, and often complex, and that tailored pathways significantly improve Māori engagement and create opportunities to enter the profession. However, while Ōritetanga initiatives successfully supported Māori entry, participants also highlighted that these supports were not always visible, accessible, or easy to navigate. This reflects a broader challenge of Māramatanga,

where gaps in transparency and system design continue to shape Māori experiences of becoming an HPO.

3.10.4 Māramatanga

Māramatanga addresses the understanding and insight of the Health Protection profession. Sub-themes include *whakatere* (navigating different systems and pathways), *moumou* (the sense of wasted or lost time and money), and *kitenga* (the visibility of the role to those outside the system). One participant described the academic barriers created by unclear qualification pathways: *"Limiting for individuals who want a career in health protection as many people do courses in health science but have to take other papers or a new degree to meet the academic requirement for an HPO."*

Across the kōrero, the most overwhelming finding was the invisibility of the profession. Participants frequently stated that they had not heard of Health Protection until already working in public health. One shared, *"I didn't set out to become a Health Protection Officer and honestly hadn't even heard of the role."* Another noted the lack of visibility among rangatahi: *"When we speak to youth, they have no idea what we do and never thought this could be an education and career path."* Many expressed that they had not initially seen themselves in health at all: *"I didn't even know what public health/health protection was. I had never heard of a Health Protection Officer or what their role is."* Participants also reflected on the moumou, lost time and money caused by this lack of visibility. As one said, *"I had zero understanding about a career as an HPO… If I had adequate knowledge I would have saved a lot of time and money."* Others described entering better-paid work prior to discovering trainee roles or taking years to complete additional qualifications after realising what was required. One participant noted that designation alone took a full year to complete.

Access and navigation barriers were also significant. Geographical constraints made distance learning difficult, with one participant explaining, *"Access to the library meant travelling to Albany or Auckland."* Others described being "passed around" when trying to obtain basic information: *"There is no clear pathway for designation… I kind of figured it out on my own through trial and lots of error."* Participants also identified tertiary system barriers such as poorly designed Studylink processes, lack of career guidance at

school, and limited support in Westernised educational environments. As one noted, *"Going to uni was hard… I didn't have the same type of support I had at Hoani Waititi."*

Māramatanga is therefore not only about understanding the profession itself but also the need for structural clarity, visibility, and transparency so Māori can enter Health Protection without unnecessary burden. Gaps in guidance and visibility do more than delay entry, they undermine Māori confidence, autonomy, and equitable access to the profession. It is precisely in response to these systemic shortcomings that the next theme, *Mana Motuhake*, becomes essential

3.10.5 Mana Motuhake

When asked how the qualification or designation pathway prepared them to act as Crown agents, the consensus across all participants was clear: neither process equipped them for this responsibility. This finding underscores the importance of mana motuhake, as participants could not rely on organisational training to prepare them to uphold Te Tiriti obligations in their roles.

Participants consistently described learning about Te Tiriti responsibilities through their own efforts rather than through formal training. One stated, *"Really easy to answer this. No. Zero. Knowledge came from my own study, from my community and working with Māori."* Another described their understanding as *"part of my life… something I learnt, grew up around from a young age."* Several reflected that they had been left to *"wing it,"* relying on informal guidance from Māori colleagues, including Māori Medical Officers of Health, while others shared that they *"didn't grasp or understand how to apply [Te Tiriti] to the work"* at the time.

Although Health New Zealand provides some training, participants described it as generic and lacking practical application. One candidate identified what was missing: *"Opportunities to actively build and illustrate cultural safety skills as part of the designation process, not just theoretical knowledge… More guidance on engaging with Māori communities, including examples of culturally safe practice and demonstrating competency in Māori health perspectives."* Another participant supported this, saying that *"more support, practical examples, and active reinforcement of Te Tiriti in daily HPO*

work would make cultural safety and upstream engagement more embedded across the service."

Collectively, these findings highlight that the qualification and designation pathways lack a sincere commitment to Te Tiriti by failing to adequately prepare staff to work in a way that honours it.

3.10.6 Kete Summary

These five themes: whakapapa, whanaungatanga, Ōritetanga, māramatanga, and mana motuhake, show how values-based motivations guide Māori into Health Protection roles while also revealing the systemic barriers they face. Together, they point to the need for pathways that uphold Māori autonomy and cultural identity and provide a foundation for strengthening recruitment and retention in the Māori HPO workforce.

3.11 Kete Turua: Retention factors

This section explored the candidates' experiences within the workplace, focusing on Māori leadership, cultural support, role conflict theory, cultural safety and institutional racism. Each participant answered 18 scale-based questions ranging from 1 Strongly Disagree to 5 Strongly Agree. Questions that were left blank were assigned 0 -No Answer.

3.11.1 Leadership

Candidates were asked two questions relating to opportunities that have been available to them in growing into a leadership role.

Q1 "My employer gives me ample opportunities for career progression in my role"

Most candidates **strongly agreed** with this statement (n=4), describing genuine encouragement and support from their managers. One participant noted *"My manager is a great mentor who encourages me to be a good leader, she is very supportive and provides me with training opportunities. I am very grateful to her."*

Positive responses were commonly associated with access to scholarships, opportunities to progress into senior roles, and leadership that actively invested in their development.

However, not all experiences were consistent. Some candidates highlighted that budget constraints limited their ability to pursue additional development *"I think that the intention is there but the execution and follow-up is lacking. I think spending restrictions have created barriers."* Another participant reinforced this, reflecting *"No, that's mainly because of budget squeeze. HPOs were lucky that the Ministry of Health would support the training for becoming an HPO. No additional training resource for anything else."* These mixed responses indicate that while individual leaders may be supportive, structural constraints such as resourcing significantly influence access to leadership development.

Q2 "I have not been passed over for a role or development opportunity because I don't have the right qualifications."

Responses to this statement were strongly mixed, with most candidates **strongly disagreeing** (n=4), indicating they had experienced being passed over due to qualification requirements.

One participant shared their disappointment despite holding substantial practical experience *"I was really disappointed with the opportunity being taken from me. I was even encouraged by my team of peers to go for it, as they thought I was already leading the team and keeping everyone accountable and in check."*

Interestingly, the opposite experience was also reported. Another participant described a situation where a candidate without the required qualifications was appointed, despite others meeting the criteria*"...I did have the right qualifications for the role, however someone who didn't have the right qualifications was successful."*

These contrasting experiences highlight inconsistencies in how qualification criteria are applied, reinforcing broader findings about inequitable access to leadership pathways and the variable interpretation of "merit" across teams.

3.11.2 Cultural Support

Candidates were asked four questions pertaining to cultural support within their workplace.

Q3 "My employer enables opportunities to explore my cultural identity including access to kaupapa Māori professional development"

Responses to this statement were mixed. Participants were evenly split between **strongly disagreeing (2)** and **agreeing (2)**. Some participants highlighted structural barriers, with one noting the limitations of contractual expectations *"you don't know what you don't know. Contracts tell you what you should do."* Others questioned whether NPHS was aware of, or actively promoting, available kaupapa Māori professional development, with one stating there was "*not much access"* to Māori-centred opportunities.

In contrast, participants who agreed described strong managerial support *"My manager is supportive of Māori seeking opportunities for Māori… She has approved me to attend the Digital Indigenous Ltd course in 2026 Leadership Training for Māori in Public Health.".* Another participant noted *"My manager is Māori so encourages and embraces cultural identity. She encourages us to participate in kaupapa Māori development and creates a safe environment for the team."*

These experiences illustrate significant variation in access to professional development, largely dependent on leadership and local awareness.

Q4 "Te Ao Māori practices and values are normalised in my workplace"

Responses to this statement were mostly **agree (2)** or **neutral (2)**. One participant described the current level of cultural practice as *"bare minimum stuff, mihi whakatau, waiata, karakia."* Another observed that although efforts were limited, the attempts made by non-Māori colleagues were meaningful. Participants also noted regional variation—one office consistently normalised Te Ao Māori practice, while another in the same region had *"a lot of progress still to be made."*

Team composition also shaped experiences "*The Health Promotion team are all Māori… Whereas the Health Protection team, I am the only Māori in my team, and we have a Māori Manager."*

Overall, normalisation of Te Ao Māori was evident in some contexts, but inconsistent across teams and regions.

Q5 "My employer values the process of whakawhanaungatanga and it is embedded into our ways of working"

Responses leaned slightly positive: **neutral (3)**, **agree (2)**, and **strongly agree (1)**. However, participants emphasised differences between Māori-led and mainstream teams "*When I was in a Māori team – yes. But not when I wasn't. It felt clunky and tokenistic."* Others felt progress was occurring but incomplete *"We are still getting there, but we are moving in the right direction.""We could do better… people get straight into the mahi but forget to incorporate whanaungatanga, especially when working with Māori."*

These reflections suggest that while whakawhanaungatanga is valued conceptually, its practical application varies widely depending on team culture and leadership.

Q6 "I have access to cultural support networks that support my mental and spiritual wellbeing within the workplace"

Most participants felt **neutral (3)**, indicating inconsistent access to cultural support.
Some participants described proactive efforts to create internal support structures, such as establishing a rōpū when a new Māori health manager joined, or setting up peer support programmes during the COVID-19 response. One participant referred to supportive colleagues as their "mahi aunties."

Others spoke of strong and established networks *"daily waiata/karakia sessions, a Māori kaimahi networking group, Hauora Māori Tūmatanui, cultural advisors available through the hospital."* These examples demonstrate that while cultural support networks can be highly effective when present, they are not universally available, resulting in uneven support experiences across the workforce.

3.11.3 Role Conflict theory

In this section we explore whether candidates have had any experience with role conflict theory.

Q 7 "I have not been put in a position to carry out cultural practices or provide training of these practices outside of my job description"

Most candidates **strongly disagreed** with this statement (n=3), followed by candidates who **strongly agreed** (n=2). One candidate who strongly disagreed commented *"we all have, the brown problems given to the brown person."*Another supported this by saying *"I have been asked to carry out practices/approve equity comms etc, although this is not within my role."*One participant described pushing back against these expectations *"When I first started, I was kind of looked at as the TOKEN Māori, but I pushed back as I do not agree with being made to do the karakia, sing the waiata, based on the colour of my skin. I'm not even fluent in the reo but I know enough to get by. I also won't speak on behalf of a team that does not always support Māori kaupapa. I'm not that person for just anybody either, only for my whānau."*

Conversely, one candidate who strongly agreed noted *"I was never expected or asked to do anything like karakia, waiata (which they did often), or teach about anything cultural. They were very cautious about this with me and all other ethnic people for that matter."*

Q8 "I have not been unfairly asked to hols relationships with Māori outside of our organisation because of my ethnicity and/or cultural identity"

Responses were split evenly, with strong disagreement (n=3) and strong agreement (n=3). Those who strongly disagreed shared experiences such as *"I was it in that space. If you weren't holding that relationship directly, somehow you are the relationship facilitator."* Another participant noted *"It has been strongly indicated to me to make introductions to whānau who work for Māori Health Providers."* A participant who refused some requests explained *"I didn't feel like I was the right person to do that. I think we have a better chance of nurturing relationships if it is by the right person."*

Q9 "The application of tikanga and mātauranga Māori is recognised as a special skill and is renumerated"

Responses skewed toward the negative, with most candidates **strongly disagreeing** (n=4). One candidate explained that mātauranga Māori was viewed as *"superfluous"* by others in their organisation. A participant who responded neutrally stated they were unsure whether it was remunerated, but believed the organisation recognised it as a special skill.

Q10 "My employer is flexible and supports me to fulfil my roles for my marae"

Most candidates did not answer this question, noting the scenario had not arisen for them. Those who strongly agreed said they were afforded bereavement leave for tangihanga (three days). Another participant added *"My manager has been supportive of me to attend kaupapa Māori at the marae and in the community. As long as the outcomes involve Health Protection theories and it aligns with our mahi."*

Q11 "I have not felt conflicted between my role as an HPO and my role within my iwi"

Most candidates **strongly agreed** with this statement. One participant reported conflict between mana whenua and their role as an HPO, though not with their own iwi. Another described tensions between HPO regulatory functions and Te Tiriti *"some of the things we do in regulatory function opposes rangatiratanga and mana motuhake… compulsory fluoridation/chlorination, quarantine. It comes down to how good is our relationship to be able to have a disagreement and continue to move forward."*

A candidate who strongly agreed spoke instead about concerns relating to a colleague's *conduct "This has caused huge concerns and red flags, and I worry about how that will affect my iwi and our rohe. I keep thinking 'what if' and 'gee that's dangerous.'"*
One participant who felt neutral described *"getting a bit of slack"*from extended whānau for their involvement in contact tracing and vaccination.

3.11.4 Cultural Safety

In this section we explore whether candidates have had any experience with cultural safety.

Q12 Our organisation has strong relationships with Mana Whenua

Reactions to this statement were mixed. One candidate noted *"I have worked in different areas, some places were good, and would catch up regularly with mana whenua. Other places they didn't. There would be engagement plans and strategies with stakeholders but not mana whenua."* Another candidate who disagreed stated *"While our organisation may think it has strong relationships with mana whenua, in reality there is still a lot of work to be done."* They went on to explain that trust had been eroded between Māori and Public Health after years of disingenuous attempts at partnership and exclusion from decision-making.

A participant who agreed with the statement pointed to the changing demographic of the workforce, acknowledging the embedding of Kai Hāpai Oranga roles into their team. One participant who felt neutral said *"Not that I've seen, physically anyway. There's talk about engaging with mana whenua but I haven't seen it in practice yet."*

Q13 "My workplace prioritises the ongoing training and development of all staff to practice in culturally safe ways"

Most candidates agreed with this statement. One explained *"As they are in a predominantly non-Māori place/setting, their training and development in respect to Māoritanga is for sure limited."*. A neutral respondent noted that training occurred only when appropriate leadership was in place *"Only when the Māori manager was put in place. we did training around cultural intelligence. There was training, but with the right leadership in place."* Another participant added *"My workplace would love for all staff to practice in culturally safe ways, but I wouldn't say they prioritise it. We have targets to meet."*

Q14 "My colleagues have the confidence and capabilities to work with Māori communities"

Most candidates felt neutral about this statement. One described their colleagues' engagement with Māori as "clunky" they were engaging, but unsure if they were doing so well. A participant who strongly disagreed stated *"Some worse than others. Some I would trust in those spaces… others I would not allow them to do that. That's to protect both parties."* Another supported this concern *"Some I do not believe are culturally safe, although they would believe that they are. I do not believe that all of our staff have the confidence and capabilities to work upstream with Māori communities. We still want to play saviour, rather than partner."*

Q15 *"Māori concepts are not appropriated in the workplace"*

Most candidates strongly disagreed with this statement or did not answer. One participant wanted to say that Māori concepts were *not* appropriated, but was unsure. Those who felt neutral provided examples such as karakia that felt tokenistic *"but they tried."*
A participant who strongly disagreed described an instance where Māori concepts were deliberately misconstrued to support approaches that do not work for Māori.

3.11.5 Institutional Racism

In this section we explore whether candidates have had any experience with institutional racism.

Q16 I have not experienced or witnessed racism from my colleagues or employer

Most candidates **strongly disagreed** with this statement. One participant noted *"never had any direct racist dialogue, other than my colleagues rolling their eyes when I brought up mātauranga, because for them it wasn't in the legislation or standards so in that way they were being complicit."* Another described two instances where Medical Officers of Health had received complaints for racist behaviour. A further candidate spoke of her workplace having *"racial undertones and privilege"* among colleagues.

One participant reported experiencing direct racist commentary *"He took an opportunity (when we were alone off site) to refer to me as 'people like you' can get any role you want, and we have it easy. He believed I was given my role on the basis of race, rather than the fact I was technically the most qualified person within the entire protection team, and had strong relationships within health sector."*

Q17 Responses – The number of Māori HOPs in my workplace is representative of our Māori population

Most candidates **strongly disagreed** with this statement. One described Māori HPOs as *"few and far between,"* while another noted that they were the only Māori HPO in their office. The participant who agreed with the statement explained that *"It may not [be] representative, but that was not for the lack of trying. They really wanted Māori HPOs and tried many times to get approval for funding to support Māori into such roles. They definitely got funding to make one Māori-specific role, however there are such low number of Māori doing this career as you may know."*

Q18 My employer sincerely meets their obligations to Te Tiriti o Waitangi

Responses to this statement ranged from **strongly disagree** to **strongly agree**.
One participant observed *"Some of our staff and management are really motivated in this space, whilst others are not confident, or do not believe they hold specific obligations to Te Tiriti o Waitangi."*

A candidate who strongly agreed believed their employer made every attempt within their knowledge to advance and embed Te Tiriti, acknowledging the limits. A neutral participant stated *"not everyone fully understands how to apply Te Tiriti o Waitangi into their mahi,"* but went on to say that their employer *does* try to meet these obligations sincerely.

3.11.6 Kete Summary

Overall, the findings highlight a complex and uneven landscape shaping Māori HPO retention. While supportive leadership and isolated examples of culturally affirming practice positively influenced candidates' experiences, these were inconsistently applied across teams and regions. Limited access to kaupapa Māori professional development, frequent role conflict through unrecognised cultural labour, variable cultural safety, and persistent experiences of institutional racism emerged as significant barriers to retention. Collectively, the findings suggest that retention of Māori HPOs relies not on individual goodwill, but on sustained structural change that meaningfully embeds Te Tiriti

obligations, values mātauranga Māori, and equitably supports Māori cultural and professional identities within the workplace.

3.12 Kete Tuatoru: Cultural Capabilities

Throughout the interviews the underlying cause of barriers and negative experiences with recruitment and retention for kaimahi Māori rests with the cultural capability of non-Māori. Where organisations demonstrate genuine commitment to Te Tiriti and the integration of mātauranga Māori and tikanga in everyday practice, Māori candidates are more willing to enter the career as a place where they can see themselves reflected in the environment.

Additionally, day-to-day cultural safety by peers and leaders directly affected candidates' experiences within the workplace, determining whether their contributions were perceived as valuable or if they were at risk of burn-out from being overburdened by role conflict. Where the capabilities of non-Māori kaimahi were weaker, some candidates were expected to carry the responsibility of cultural practices alone.

This kete identifies how different areas of cultural capability has impacted the experiences of Māori HPOs across the pipeline and throughout their career.

3.12.1 Structural Cultural Capability

Participants consistently described the structural environment of Health Protection as grounded in Western frameworks that neither reflected Māori realities nor prepared kaimahi Māori for their Treaty responsibilities. Several reported that their qualification pathway lacked New Zealand-specific or mātauranga-centred content, noting *"The content was disappointing… none of them had any New Zealand context, no contextualisation of Indigenous views, no Te Tiriti o Waitangi, no mātauranga."*

This absence shaped how participants saw themselves within the profession. Some described the HPO role as *"black and white"* or *"rule-based,"* making it difficult to incorporate relational, whakapapa-based approaches. Others felt the profession aligned conceptually with Māori worldviews but that organisational systems did not enable this alignment in practice.

Structural cultural capability also influenced the visibility of Māori in the workforce and the degree to which they felt reflected in the environment. When systems privileged Western ideology, mātauranga Māori and Indigenous approaches were marginalised, creating conditions in which Māori identity and ways of working were constrained.

3.12.2 Relational Cultural Capability

Participants described highly variable experiences of relational cultural capability, the extent to which teams enabled genuine Māori-centred practice. When Māori leadership and kaupapa-aligned support were present, participants experienced safety, confidence, and meaningful inclusion: *"My manager is Māori and encourages us to participate in kaupapa Māori development. She creates a safe environment for the team."* Others discussed the ability to authentically embed tikanga into operational roles, such as when dealing with bones or engaging with whānau.

However, relational capability was inconsistent. In many teams, Māori practices such as karakia became "*tick-box,*" lacking depth or understanding. Participants reported feeling uncomfortable when asked to lead cultural practices based on ethnicity rather than expertise, particularly when team cultures did not uphold Māori values. These inconsistencies created environments where Māori were at risk of being symbolically included but not structurally supported.

Relational capability therefore acted as the bridge—either enabling Māori to work in authentically Māori ways or reinforcing cultural isolation when absent.

3.12.3 Cultural Labour and Role Conflict

Participants highlighted that when cultural capability among non-Māori colleagues was limited, Māori kaimahi were routinely expected to "fill the gaps." This included leading cultural practices, holding relationships with Māori communities, approving equity communications, or mediating culturally sensitive situations all responsibilities outside their job descriptions. One participant described this pattern plainly *"I was lumped with the brown problems."* Others explained that colleagues assumed they were the

appropriate person to engage with Māori based solely on appearance or whakapapa, not role or skill. Some Māori staff felt obligated to step in to prevent cultural harm when colleagues lacked confidence or capability, for example *"It wouldn't have been safe for them."*

These experiences illustrate a cultural double-shift: Māori kaimahi were required to navigate their formal HPO responsibilities while simultaneously carrying cultural, relational, and protective labour for the organisation. This pattern of unrecognised cultural labour deepened role conflict and contributed to emotional and professional strain.

3.12.4 Racism and Cultural Safety

Participants described racism as a persistent and systemic force that intensified cultural labour and undermined cultural safety. Experiences ranged from overt comments to subtle microaggressions, such as Eye-rolling when mātauranga Māori was raised, resistance toward Māori workforce initiatives, racialised assumptions about competence or entitlement and challenges to their Māori identity or legitimacy.

Structural racism also emerged through the privileging of Western ideology, inconsistent application of Te Tiriti obligations, and dismissal of mātauranga Māori unless it aligned with Western standards. These patterns mirror broader Māori health workforce research and highlight that racism is not incidental it also shapes how Māori enter, experience, and remain within Health Protection. Critically, participants noted that culturally capable leadership played a protective role. Leaders who understood Te Tiriti, intervened early, and demonstrated cultural humility created psychological safety and mitigated harm: *"My manager was disgusted and dealt with it in a way I felt comfortable with."* Cultural capability at the leadership level therefore determined whether environments upheld mana and safety, or reproduced inequity and risk.

3.12.5 Kete Summary

At the structural level, participants described Health Protection as shaped by Western frameworks that provided little space for Māori worldviews. Qualification pathways lacked Aotearoa-specific content, mātauranga Māori, or applied Treaty practice, leaving

Māori HPOs underprepared for their Crown responsibilities. This absence also affected how Māori saw themselves within the profession, some felt the role was rigid, rule-bound, and misaligned with relational, whakapapa-based approaches. Although participants recognised strong conceptual alignment between Health Protection and values such as te taiao, kaitiakitanga, and manaakitanga, organisational systems often prevented these from being expressed in practice. This structural environment limited Māori visibility, constrained cultural identity, and reinforced Western norms as the default way of working.

Chapter 4: Discussion

4.1 Introduction

The purpose of this chapter is to interpret the findings presented in Chapter 3 in relation to the research question, objectives, and existing literature.

How can the Māori Health Protection workforce be developed and expanded by listening to the experiences of previous and current kaimahi Māori Health Protection Officers?

This study explored the lived experiences of Māori Health Protection Officers (HPOs) to identify the pathways, barriers, and retention factors that shape workforce development. The findings demonstrate that Māori entry into, and retention within, health protection roles are influenced by deeply relational, values-based motivations, systemic inequities, and organisational culture. Together, these insights provide a foundation for strategies that honour Māori autonomy and embed Te Tiriti o Waitangi principles into workforce planning and practice.

The approach taken in this chapter is grounded in kaupapa Māori and Te Tiriti principles and integrates participants' voices alongside my own interpretive commentary to critically engage with the findings.

4.2 Kete Tuatahi: Pathways

Below is an analysis of the core themes identified in the findings and address the research sub question "What are the key pathways, barriers, and enablers that influence Māori entry into Health Protection Officer roles?"

Participants' experiences were not a linear process but a journey through a complex pipeline. This section is organised into five core themes that emerged from the findings: Whakapapa Whanaungatanga, Ōritetanga, Māramatanga and Mana Motuhake, describing how Māori have had to navigate the pathway into the role of a HPO

4.2.1 Whakapapa

The first theme to emerge from participants' kōrero was whakapapa, which shaped not only their motivations for entering Health Protection but also their understanding of the

role itself. Participants described Health Protection as an extension of inherited responsibilities to protect whānau, whenua, and te taiao, echoing Hikuroa's and Durie's articulation of Māori health as inseparable from land, language, and kinship. Their reflections that they were *"passionate about Papatūānuku and te taiao"* and that environmental protection felt *"naturally embedded"* as Māori demonstrate that whakapapa operates as a primary driver of career choice rather than a secondary influence. This aligns with literature showing that Māori motivations are relational and collective, grounded in kaitiakitanga and manaakitanga rather than individual advancement. It also extends the literature by illustrating how environmental whakapapa specifically anchors attraction to a profession traditionally framed through Western regulatory science.

At present, entry into the profession is structured through Eurocentric worldviews that treat humans and the environment as separate, often positioning people as superior to the natural world. This framing sits in direct contrast to te ao Māori perspectives, where relational balance and interconnectedness are fundamental. Strategically positioning Health Protection work programmes as expressions of kaitiakitanga and manaakitanga could make the profession more visible and culturally resonant for Māori, while also strengthening the sector's understanding of the holistic nature of human and environmental wellbeing.

Whakapapa therefore functions as a powerful internal motivator, positioning Health Protection not merely as a technical occupation but as an expression of inherited duty and cultural continuity. However, participants' experiences also show that whakapapa alone does not create accessible or navigable pathways into the profession. Recognising Health Protection as an extension of kaitiakitanga must be supported by relational structures, particularly whanaungatanga, that make the role visible, attainable, and culturally grounded.

4.2.2 Whanaungatanga

While whakapapa establishes the foundational motivations that draw Māori toward Health Protection, it is whanaungatanga that transforms these motivations into tangible entry pathways. Whanaungatanga functioned as a critical enabler that compensated for the absence of clear, system-designed routes into the profession. Participants described

being guided into Health Protection through relationships with Māori colleagues and Māori networks, often "all done via word-of-mouth networking." Outside of these relationships, they were required to proactively reach out to the sector themselves, highlighting the lack of visible or accessible pathways.

In practice, whanaungatanga acted as an informal recruitment and navigation mechanism, providing practical support that the formal system did not. These relational structures not only helped participants understand and access the profession but also supported them to sustain their Māori identity within predominantly Westernised environments. Trust in those guiding them provided confidence to take on the financial, cultural, and personal risks associated with studying for a niche qualification with no guaranteed employment outcome.

These findings reinforce broader calls to formalise relational structures, such as Māori staff networks, tuakana–teina mentorship, and kaupapa Māori induction, as core components of workforce development. Such approaches ensure that support is grounded in Māori values including manaakitanga and whanaungatanga, rather than dependent on chance or individual goodwill. While relational guidance mitigated inequities, it also highlighted a systemic reliance on informal support mechanisms instead of deliberate workforce design. To move beyond chance encounters and ad hoc guidance, the pipeline must be strengthened through Ōritetanga, with the intentional creation of equitable, tailored pathways such as Māori scholarships, paid apprenticeships, and Māori specific development initiatives.

4.2.3 Ōritetanga

Ōritetanga builds on the relational foundations established through whanaungatanga, offering equitable and tailored pathways that support Māori entry into Health Protection. Participants' experiences highlighted the enabling power of scholarships, Māori-specific trainee roles, on-the-job learning, and flexible employment arrangements, which reduced both financial and logistical barriers. Consistent with the literature on pipeline interventions and affirmative action, every participant had accessed at least one of these opportunities. Without them, pursuing this career would have been perceived as risky, given the time, financial pressures, and whānau responsibilities involved.

Despite their effectiveness, these pathways were not consistently available across regions. Access often depended on local priorities, leadership, or chance. Participants described a broader lack of clarity and visibility surrounding Health Protection as a profession. Even with tailored supports, many still experienced confusion, trial-and-error navigation, and unnecessary financial or academic detours before finding their way into the role.

These patterns point toward the next critical theme, Māramatanga, which captures participants' reflections on the absence of clear information, guidance, and system-level transparency. Māramatanga shifts the focus from whether equity supports exist to the deeper structural issue of visibility, how poorly understood pathways obstruct Māori entry into Health Protection, and why illuminating these pathways is essential for building a sustainable and culturally grounded workforce.

4.2.4 Māramatanga

While Ōritetanga highlights the enabling power of equitable, well-designed pathways, participants' experiences also show that these supports operate within a wider context of limited visibility and systemic opacity. Even when scholarships, Māori-specific trainee roles, or flexible learning arrangements were available, many Māori still described entering Health Protection only by chance.

A lack of clarity around the profession impeded early entry for participants, with most discovering Health Protection only after already working in public health. Several reflected that with adequate guidance they would have saved time, money, and unnecessary detours. This invisibility mirrors broader inequities in schooling and tertiary transitions, particularly for first-generation Māori students, for whom specialised roles like HPO are seldom visible or actively promoted.

The consequence is *moumou*, rangatahi pursuing unrelated qualifications before later pivoting into Health Protection. Illuminating this profession for Māori requires proactive, whānau-centred outreach at the secondary and tertiary levels, including clear career maps that describe HPO work in kaupapa Māori terms. Even when Māori eventually find their way into the profession, many enter without preparation for the broader responsibilities of serving as Crown agents in ways that uphold Te Tiriti. Participants' reflections show that while improved clarity and early guidance can reduce moumou and strengthen entry

pathways, the next challenge lies in how Māori are supported to fulfil the Treaty-aligned dimensions of the role, leading directly into the theme of Mana Motuhake.

4.2.5 Mana Motuhake

Mana Motuhake highlights a structural gap between the technical requirements of designation and the Treaty-grounded responsibilities of being a Crown agent. Participants consistently reported that neither the qualification nor the designation pathway prepared them to uphold Te Tiriti in practice, with course content lacking New Zealand context, Indigenous views, mātauranga Māori, and Treaty application.

In the absence of robust training, participants relied on personal knowledge, whakapapa, and informal mentorship to navigate their Crown obligations, an unsustainable burden that reflects systemic omission rather than individual deficit. The responsibility to be a sincere Treaty partner was placed at the individual level, creating inconsistent practice across kaimahi and often leaving those who were committed to this work carrying it alone, sometimes in adversarial environments.

Participants also noted that when Māori-specific roles were created, they were often designed without Māori involvement. This risks producing HPOs who simply "happen to be Māori," rather than intentionally cultivating a kaupapa Māori Health Protection workforce grounded in mana motuhake.

Collectively, these findings show that current qualification and designation pathways leave Māori HPOs underprepared for the Treaty-grounded responsibilities embedded in their roles. Inadequate training, reliance on informal mentorship, and exclusion of Māori from designing Māori-specific positions all undermine mana motuhake and place disproportionate cultural labour on Māori kaimahi. Addressing these gaps requires co-designed, Māori-led training that embeds mātauranga, cultural safety, and applied Treaty practice as core competencies and not optional additions. As this kete demonstrates, strengthening pathways into Health Protection is not solely about access, but ensuring Māori can enter, remain, and lead within the workforce in ways that uphold their responsibilities to whānau, whenua, and Te Tiriti.

4.2.6 Kete Summary

The findings demonstrate that Māori entry into Health Protection is shaped by whakapapa-driven motivation, relational forms of guidance, and equity-focused opportunities, while simultaneously constrained by limited visibility of the profession and insufficient preparation for Treaty-based practice. These insights respond directly to the research questions by showing that Māori pathways into the role are neither linear nor system-generated, but instead carried by values such as kaitiakitanga, manaakitanga, and whanaungatanga.

My own experiences navigating similar barriers reinforce that these challenges are not theoretical but lived realities that continue to define how Māori access, experience, and remain within the profession. Strengthening the Māori Health Protection workforce therefore requires intentionally designed pathways, the formalisation of relational support structures, consistent equity mechanisms, and the redesign of qualification and designation processes to embed culturally grounded, Treaty-aligned competencies.

Collectively, these findings highlight that expanding and sustaining the Māori HPO workforce depends not only on recruitment, but on transforming the environments in which Māori work, ensuring they are culturally safe, structurally supportive, and reflective of mana motuhake.

4.3 Kete Tuarua: Retention factors

This section interprets the findings on retention factors for Māori HPOs, guided by the outstanding themes that were identified in the literature including leadership, cultural support, role conflict, cultural safety, and institutional racism. The analysis situates these findings within Kaupapa Māori principles and relevant theoretical frameworks, highlighting systemic barriers and enablers that shape Māori workforce experiences.

The second research sub-question asked: *What factors support the retention and capability development of Māori Health Protection Officers within the public health system?*

The literature highlighted that retention is strongly linked to organisational culture, leadership, and recognition of cultural expertise. While leadership and organisational

intent are influential, they are not sufficient on their own to ensure the retention and wellbeing of Māori HPOs. What ultimately shapes day-to-day experiences is the extent to which workplaces create environments where Māori identity, values, and ways of being are genuinely supported rather than merely acknowledged. The inconsistency observed across regions ranging from meaningful engagement with Te Ao Māori to tokenistic or superficial practice. This highlights that cultural support remains a critical yet uneven determinant of whether Māori staff feel connected, safe, and able to thrive.

4.3.1 Leadership

While the previous section outlined how organisational culture shapes Māori experiences broadly, participants' reflections show that cultural support operates as the first and most immediate layer of cultural safety in practice with leadership acting as a powerful determinant of retention. Participants who strongly agreed that they had opportunities for progression had described supportive managers, access to scholarships, and intentional mentoring as contributing factors to their success. These leaders enacted manaakitanga and whanaungatanga, shaping environments where Māori staff felt seen, supported, and encouraged to grow.

However, as discussed this was not universal. Budget constraints, rigid qualification criteria, and inconsistent support created inequitable experiences across teams and regions. Some participants were blocked from applying for leadership roles despite clear capability, while others observed the opposite phenomenon, stating that people without appropriate qualifications were given the opportunity, the implication being that the preferred candidate "was easier to control" in a Pākehā working environment. These contradictions signal structural inequities within the system and reinforce the literature's argument that Māori advancement is often limited by Eurocentric credentialism, inconsistent organisational processes, and insufficient recognition of lived experience and cultural expertise.

Taken together, the findings show that Māori retention flourishes when leadership aligns with kaupapa Māori values, but falters where leadership is constrained by systemic biases or resource limitations. Yet even strong leadership cannot fully mitigate the pressures created by systemic inequities, inconsistent expectations, and uneven cultural capability

across teams. For many Māori kaimahi, these gaps manifest as additional responsibilities that fall outside their formal roles but are nonetheless expected of them. This dynamic signals a deeper pattern within the workforce: Māori staff are often required to navigate multiple, and at times competing, sets of obligations. These experiences align closely with the concept of role conflict, where Māori HPOs carry not only their technical responsibilities but also cultural labour that is frequently unrecognised and uncompensated.

4.3.2 Cultural Support

Cultural support varied significantly between workplaces. Some participants experienced environments where Te Ao Māori practices were normalised and where Māori identity was actively embraced. These teams created culturally safe climates, supported access to kaupapa Māori development, and fostered networks such as rōpū Māori, "mahi aunties," and daily karakia or waiata. Yet for others, cultural support was minimal, tokenistic, or inconsistently applied.

Additionally, some participants noted that professional development opportunities were unclear or unavailable and cultural initiatives depended heavily on individual leaders rather than organisational policy. This meant that there was significant variation between offices, even within the same region, and cultural inclusion often amounted to "bare minimum" gestures rather than meaningful practice.

Overall, these findings demonstrate that cultural support is not yet a guaranteed feature of the Health Protection landscape but one that fluctuates across teams, regions, and individual leaders. This inconsistency places Māori kaimahi in environments where their cultural wellbeing depends more on personalities than on policy, and more on goodwill than on system design. As Māori staff repeatedly emphasised, cultural safety cannot be optional or personality-driven, it requires system-level commitment, resourcing, and leadership. Such variability underscores the vital role of leadership in shaping supportive or unsupportive environments.

4.3.3 Role Conflict Theory

Good leadership alone cannot counteract the deeper structural pressures Māori face in their day-to-day work. Across regions, Māori staff described being positioned in ways

that required them to absorb additional cultural, relational, and equity-focused responsibilities, tasks that extended well beyond their formal job descriptions. These expectations highlight a persistent pattern within the workforce: Māori are often called upon to carry cultural labour because of who they are, rather than because the role is designed or resourced for it.

Role conflict was one of the most pronounced findings, reinforcing Jarrod Haar's conceptualisation of the "cultural double shift." Many Māori HPOs reported being expected to carry out activates such as perform karakia and waiata, lead equity work, approve Māori communications, hold or manage Māori community relationships, and provide cultural advice or training. These expectations were placed upon those who already held substantive roles as per their job descriptions.

Often these responsibilities were assigned *because they were Māori*, not because they were resourced, recognised, nor was it included in their job descriptions. As one participant noted "The brown problems given to the brown person." Another described having to set boundaries to avoid becoming the "token Māori," illustrating the emotional and cultural labour required to maintain both integrity and role clarity. Conversely, a minority reported never being asked to take on cultural duties, highlighting again the inconsistent expectations across teams.

Role conflict is not an isolated or incidental issue, but a structural outcome of workplaces that have not yet fully centred cultural safety or recognised mātauranga Māori as legitimate expertise. The inconsistent expectations placed on Māori ranging from being the "go-to" person for cultural advice to being shielded from cultural duties entirely reflect deeper organisational uncertainty about how to engage meaningfully with Māori knowledge and communities. This inconsistency underscores the need for system-level cultural capability, not piecemeal or individualised approaches.

4.3.4 Cultural Safety

When Māori HPOs are routinely relied upon to carry cultural responsibilities that are neither resourced nor formally recognised, it signals not only inequitable workload distribution but also significant gaps in the cultural safety of the wider workforce. These

pressures do not emerge in isolation; they are shaped by the extent to which organisations understand, value, and embed mātauranga Māori and kaupapa Māori in everyday practice.

Cultural safety training was identified as present but limited, often dependent on individual leaders rather than systemic prioritisation. In some instances, organisational cultural has had movement in the right direction, particularly when Māori leaders were present. However development opportunities for all employees in cultural safety were seen as optional and often reactive, sporadic, or dependent on individual leaders rather than embedded into organisational systems.

It is also evident that the application of mātauranga Māori and tikanga is superficial or tokenistic. Tikanga and kaupapa Māori applications were seen as appropriated or misunderstood and felt "clunky". Inconsistent application of cultural safety presents a risk when engaging with hapori Māori, particularly in places where attitudes are deficit-based and infused with saviour mentality, rather than partnership-based practice. This breaks down relationships between crown and Māori and often Māori kaimahi are asked to mend the rift and rebuild the relationship.

These findings reveal workforce-wide gaps in cultural capability, demonstrating that meaningful cultural safety cannot rely on the goodwill or competency of individual leaders. Instead, consistent, organisation-wide commitment that is guided and modelled by Māori leadership is essential to ensure that mātauranga Māori and tikanga are applied with integrity rather than superficially or in tokenistic ways. Without these foundations, engagement with hapori Māori remains vulnerable to deficit-based attitudes and saviour mentalities, placing the burden of repair on Māori kaimahi and weakening trust between Crown and Māori. These systemic inconsistencies highlight that cultural safety is not merely a technical skill set but a core Treaty obligation.

4.3.5 Te Tiriti o Waitangi Obligations

While cultural safety reflects the everyday practices through which Māori and non-Māori engage within the workplace, Te Tiriti obligations speak to the structural foundations that should guide those practices. Participants' reflections show that although some individuals and teams demonstrated genuine commitment to Te Tiriti, organisational

understanding and application of Treaty responsibilities remain uneven and often superficial. This inconsistency shapes not only how Māori HPOs experience their workplaces, but also how the Health Protection system interprets its role as a Crown agent.

Participants overwhelmingly felt that Māori representation within the HPO workforce was inadequate, meaning that the representation of Māori kaimahi was not reflective of the communities they serve. Many were the only Māori HPO in their office, reinforcing feelings of cultural isolation and intensifying role conflict pressures. The underrepresentation of Māori HPOs relative to population demographics reflects systemic barriers to recruitment and advancement, reinforcing the urgency of targeted strategies.

Comments around Te Tiriti obligations were mixed. Some saw genuine organisational effort, while others experienced uncertainty, inconsistency, or lack of understanding from colleagues and leaders. The lack of understanding of what it means to be a Māori HPO means that the Māori health protection workforce is being grown to serve a Western agenda, rather than positioning health protection practices in kaupapa Māori ways of working. Notably, one participant's reflection when signing up to the role captured the disconnect between expectations of a culturally purposeful role and the reality of a Westernised, regulatory environment not yet aligned with Māori aspirations or Te Tiriti-based practice. "I thought I was training to be a Māori HPO. But in the end, I was just an HPO that happened to be Māori."

These findings show that inadequate Māori representation, inconsistent Te Tiriti practice, and uncertainty about what it means to be a Māori HPO create conditions where Māori staff feel culturally isolated and structurally unsupported. While some pockets of sincere commitment exist, many participants described a workforce shaped more by Western regulatory norms than by kaupapa Māori values, leading to experiences of disconnection, unmet expectations, and a sense of being "an HPO who happened to be Māori" rather than part of a deliberately cultivated Māori Health Protection workforce. These dynamics point directly toward the next critical theme: the role of institutional racism in constraining Māori capability, wellbeing, and leadership within Health Protection.

4.3.6 Institutional Racism

While uneven understanding of Te Tiriti obligations highlights gaps in how the Crown's responsibilities are enacted within Health Protection, participants' experiences also reveal the deeper, structural forces that shape these inconsistencies. Institutional racism emerged as a significant and persistent influence, affecting not only how Māori concepts and Treaty commitments are interpreted, but also how Māori kaimahi are treated, valued, and supported in their daily work.

Experiences of racism were common. Participants described witnessing microaggressions such as eye-rolling when Māori knowledge was raised, racist commentary from colleagues, discriminatory decision-making, frustrations with tokenistic partnership behaviours and a lack of Māori representation across HPO roles.

Together, these experiences of racism demonstrate that institutional racism remains an active and harmful force within the Health Protection environment, shaping both the psychological safety and professional satisfaction of Māori HPOs. As participants described, racism was expressed not only through overt comments and discriminatory decisions but also through microaggressions, tokenistic partnership behaviours, and the persistent underrepresentation of Māori across HPO roles.

These findings reinforce that retention cannot be understood solely through supportive leadership or cultural initiatives if the structural realities of racism remain unaddressed. This final theme therefore completes the broader picture of Kete Tuarua, showing that Māori retention is fundamentally connected to organisational culture, cultural safety, equitable workload distribution, and the Crown's willingness to confront and dismantle institutional racism.

4.3.7 Kete Summary

Across Kete Tuarua, a clear message emerges as retention is fundamentally relational and structural not individual. The kōrero describes desirable working conditions for Māori HPOs when leadership is grounded in manaakitanga and integrity and genuine opportunities for advancement are constantly available thanks to organisational level

policies. Consistent cultural support and recognition was also a contributing factor, as well as organisational competence in Te Ao Māori and Te Tiriti, as inconsistent commitments to these meant a heavier workload for Māori HPOs, particularly when the Māori HPO workforce does not have the same capacity as the non-Māori.

Employees should feel safe in their workplace, with culture and environments being free from racism. Retention is threatened when differing levels of the organisational structure constantly undervalue mātauranga Māori and rely on Māori staff to carry cultural responsibilities. Workplaces that maintain monocultural or tokenistic practices and reproduce systemic inequities through recruitment, qualification requirements, or performance expectations fail to meaningfully uphold Te Tiriti are undesirable for Māori to work within. In essence, Māori retention is not simply about keeping Māori staff in roles it is about transforming systems so Māori staff can thrive, influence, and lead.

The retention findings contribute directly to the overarching research question *how the Māori Health Protection workforce can be developed and expanded* by showing that Māori HPOs remain in the workforce when organisational environments uphold kaupapa Māori values, provide consistent cultural support, and meaningfully enact Te Tiriti.

The evidence demonstrates that retention is not merely a matter of individual motivation, but is structurally shaped by leadership quality, cultural safety, and the distribution of cultural labour within teams. These insights answer sub-question two by illustrating that Māori HPO retention is strengthened through manaakitanga-based leadership, access to culturally grounded professional development, and organisational recognition of mātauranga Māori as legitimate expertise. Conversely, retention is undermined by institutional racism, tokenistic engagement with Māori concepts, and expectations that Māori kaimahi shoulder cultural responsibilities without recognition or resourcing. Taken together, these findings show that expanding the Māori Health Protection workforce requires more than recruitment strategies, it demands systemic shifts toward culturally safe practice, equitable workload distribution, and Treaty based organisational structures that enable Māori HPOs not only to stay, but to thrive and lead.

4.4 Kete Tuatoru: Cultural Capabilities

The findings in this kete demonstrate that cultural capability is not a peripheral consideration within Health Protection, but the central mechanism through which Māori entry, participation, and retention is shaped. When examined alongside the pathways and retention findings, cultural capability emerges as both the root cause of many barriers identified earlier and the key determinant of whether Māori HPOs experience cultural affirmation or cultural harm. This kete therefore interprets cultural capability as a multilayered system operating across structural, relational, and interpersonal domains, each deeply interconnected and each capable of either upholding or undermining mana motuhake within the profession.

4.4.1 Structural Cultural Capability

The structural dimension of cultural capability highlights the extent to which organisational systems continue to centre Western worldviews. Participants' descriptions of qualification pathways devoid of Aotearoa-specific content or mātauranga Māori mirror longstanding critiques in the literature that Indigenous knowledge is marginalised in health workforce training. The absence of Te Tiriti content is particularly significant given that HPOs are appointed as Crown agents; without training that reflects these constitutional obligations, Māori are required to draw instead on their own whakapapa-based knowledge or informal networks. This dynamic reinforces the pattern identified in Kete Tuatahi, where Māori entered Health Protection through relational, values-based pathways rather than system-designed ones.

Structurally, the profession's framing as technical, regulatory, and rule-bound positions Western epistemology as the default. Participants' reflections that the role felt *"black and white"* or misaligned with mana motuhake indicate the tension between Māori relational approaches and the rigid systems regulating their practice. Yet these tensions should not be misinterpreted as a mismatch between Māori and the kaupapa of health protection. Instead, they expose a structural misalignment between Western systems and Māori conceptions of kaitiakitanga, environmental stewardship, and collective wellbeing. Participants who emphasised the conceptual alignment between Health Protection and te ao Māori confirm that the issue lies not with the work itself, but with the organisational structures that govern it.

This discussion therefore positions structural cultural capability as a precondition for Māori identity and mātauranga to be expressed within Health Protection. Without it, the profession remains shaped by historical colonising logics that inhibit Māori visibility, legitimacy, and leadership.

4.4.2 Relational Cultural Capability

Relational cultural capability refers to how cultural competence is enacted within teams, workplaces, and everyday interactions. The findings show that relational capability is highly variable, dependent on the cultural literacy of leaders and colleagues rather than organisational consistency. This variability echoes Kete Tuarua, where cultural support was described as inconsistent, personality-driven, and often reliant on individual champions.

In culturally capable teams, participants experienced psychological safety, authentic inclusion, and opportunities to practise tikanga. These environments enabled Māori to work in ways aligned with their identity and values, strengthening their sense of belonging and contributing to workforce retention.

By contrast, teams with low relational capability often engaged in superficial or tokenistic cultural practices. *"Tick-box"* karakia and expectations that Māori staff lead or represent cultural practice based solely on ethnicity reflect environments where cultural forms are performed without cultural understanding. Such interactions not only undermine Māori kaimahi but also erode trust, reinforce tokenism, and perpetuate the structural marginalisation identified earlier.

The discussion therefore highlights relational capability as a mediating layer between organisational structure and individual experience. Even when structural settings are weak, relational capability can buffer or intensify their impacts. However, its inconsistency means it cannot substitute for system-level transformation.

4.4.3 Cultural Labour and Role Conflict

The findings show that cultural labour is not simply an interpersonal dynamic but a systemic outcome of organisational underinvestment in cultural capability. Māori kaimahi were frequently called upon to act as cultural translators, advisors, mediators,

and relationship-holders, regardless of job description or expertise. This reflects a wider phenomenon described in the literature as cultural taxation, where Indigenous staff disproportionately shoulder cultural responsibilities because organisations lack the capability to do so safely themselves.

This cultural double-shift deepens the role conflict already identified in Kete Tuarua, where Māori must balance professional expectations with cultural obligations, both those they willingly carry and those imposed upon them. For many, stepping in to prevent cultural harm or relational breaches was motivated by kaupapa Māori values, yet it came at emotional cost and reinforced inequitable workload distribution.

The discussion therefore interprets cultural labour as a structural indicator of organisational incapacity. It signals that cultural capability is unevenly distributed and that Māori staff are used to compensate for systemic gaps rather than being supported to work in roles where their cultural knowledge is recognised, valued, and appropriately resourced. This dynamic contributes to burnout and undermines retention, reinforcing the importance of redistributing cultural capability across the workforce.

4.4.4 Racism and Cultural Safety

Racism emerged across individual, interpersonal, and structural levels, intensifying the cultural labour burden and undermining cultural safety. Participants' experiences of microaggressions, identity challenges, and resistance to mātauranga Māori align with broader evidence of institutional racism in the health sector. These patterns reveal that cultural capability deficits are not merely skills-based gaps but reflections of deeper attitudes, norms, and power imbalances.

Structural racism was evident in the privileging of Western ideology, the inconsistent application of Te Tiriti, and the dismissal of Māori knowledge unless validated through Western standards. These dynamics reproduce the conditions described in Kete Tuatahi, where Māori pathways into the profession were obscured, and in Kete Tuarua, where Māori staff were often isolated as the only Māori in their teams.

Importantly, the findings also show that culturally capable leadership functions as a critical protective factor. Leaders who understood Te Tiriti, acted decisively when racism

occurred, and upheld Māori values created culturally safe environments even within structurally constrained systems. This reinforces the conclusion that cultural capability is not simply technical competence, but an ethical and relational orientation essential to workforce wellbeing and equity.

4.4.5 Kete Summary

Overall, this kete demonstrates that cultural capability is foundational to answering the research question of how the Māori Health Protection workforce can be developed and expanded. Structural capability determines whether Māori see the profession as a culturally aligned and accessible pathway. Relational capability shapes their daily experience of safety, belonging, and respect. The unequal distribution of cultural labour reveals systemic shortcomings that disproportionately burden Māori. Racism, both overt and systemic, compounds these challenges and threatens retention.

When cultural capability is strong, Māori can enter Health Protection through visible, values-aligned pathways, enact their roles confidently, and experience environments that uphold mana motuhake. When it is weak, the profession reproduces inequities that inhibit Māori participation and wellbeing.

My own experiences as a Māori HPO resonate strongly with these findings. I, too, have felt the tension between wanting to contribute as a kaitiaki and navigating systems not designed with Māori in mind. These insights underscore the importance of re-centring mātauranga Māori, strengthening cultural capability across all levels, and ensuring Health Protection becomes a place where Māori can thrive as both public servants and tangata whenua.

4.5 Implications for Practice and Policy

In this section, we will discuss the implications these findings have on practice and policy for the health sector.

The research question asks *"How can the Māori Health Protection workforce be developed and expanded by listening to the experiences of Māori HPOs?"* the discussion has highlighted that addressing this is impossible without systemic transformation.

4.5.1 What is a Māori Health Protection Officer

Defining a Māori Health Protection Officer is a critical policy decision that sits at the heart of expanding and retaining the Māori HPO workforce. The findings across this thesis make clear that Māori do not enter Health Protection through system-designed pathways, but through whakapapa, whanaungatanga, and a deep, inherited sense of kaitiakitanga. Participants repeatedly described their motivation as grounded in their relationship to te taiao and their obligation to protect their people: *"I want to help Papatūānuku and our taiao be better."* This reflects the cosmological foundations of Te Ao Māori, where the separation of Ranginui and Papatūānuku by Tāne Mahuta created Te Ao Mārama not for individual gain, but for the survival and flourishing of the collective.

Policy therefore must recognise that the role of a Māori HPO is inherently relational, ancestral, and grounded in whakapapa and not just technical. When the system frames Health Protection solely as a regulatory, compliance-driven role, it severs Māori HPOs from the very origins of their motivation. Participants described the profession as "*black and white*" and *"health police*," noting how difficult it was to align their cultural responsibilities with a role that had been shaped entirely through Western epistemologies.

To expand the workforce in a meaningful and sustainable way, policy must redefine the HPO role with Māori leadership, iwi partners, and existing Māori HPOs. Without this, the persistent gap between Māori and Western worldviews will continue to deter Māori from entering or remaining in the profession. As participants stated, *"I thought I was training to be a Māori HPO — but I ended up just being an HPO who happened to be Māori."* This statement signals a critical policy failure: Māori are entering a role expecting to enact kaitiakitanga, manaakitanga, and collective leadership, but instead are placed into structures that diminish those values.

To build and sustain a strong Māori Health Protection workforce, policy must move beyond simply placing Māori into existing Western structures. Instead, it must redefine what a Health Protection Officer is through whakapapa, kaupapa Māori values, and Te Tiriti o Waitangi. A Māori HPO is not merely a technical specialist; they are a kaitiaki whose work continues the legacy of Tāne Mahuta's ascent to secure the baskets of

knowledge, and the enduring relationships between Ranginui, Papatūānuku, and their descendants. This requires a dedicated, co-designed Māori HPO role description that embeds cultural expertise, iwi partnership, and mātauranga Māori as central to the profession ensuring that Māori can not only enter the role, but thrive, lead, and transform Health Protection for future generations.

4.5.2 Redesign Qualification Pathway

The qualification pathway into Health Protection continues to privilege Western academic credentials over mātauranga Māori, community experience, and iwi-based expertise. Participants repeatedly described entering the profession through "trial and error," discovering only after joining public health that additional, niche qualifications were required, qualifications that neither reflected Māori worldviews nor prepared them for the cultural load expected of them. One participant summarised this starkly: *"The content was disappointing… no New Zealand context, no Indigenous views, no mātauranga, no Tiriti."* Despite this absence, Māori HPOs were routinely expected to uphold Māori–Crown relational responsibilities and provide cultural leadership alongside their highly specialised technical duties. This structural mismatch reinforces inequity by undervaluing Māori knowledge systems while expecting Māori staff to carry cultural responsibilities the qualification pathway does not train *any* workforce to deliver.

The findings show that these qualification barriers are compounded by an educational pipeline never designed with Māori in mind. Participants often stumbled into Health Protection by chance or through the quiet encouragement of mentors and whānau networks *"I only learned about the role when someone in my whānau told me to apply,"* noted one trainee. This aligns with the broader literature highlighting persistent inequities across schooling, tertiary transitions, and professional entry for Māori. Pipeline interventions such as targeted outreach at secondary school, Māori and Pacific bridging programmes, and exposure to health careers earlier in the pipeline are proven mechanisms for improving access. Affirmative action approaches including equity-based admissions, alternative entry routes, and Māori-specific scholarships, also counteract historic and ongoing structural disadvantage. Whānau-centred engagement is equally essential: Māori students thrive when whānau are supported to navigate decision-making, pastoral care, and tertiary transitions alongside them.

Together, these findings signal a clear set of policy implications. Qualification and recruitment pathways for Health Protection must evolve to reflect kaupapa Māori values and evidence-based equity approaches. Recruitment criteria should recognise mātauranga Māori, iwi knowledge, whakapapa-based expertise, and community leadership as legitimate qualifications, particularly when designing Māori-specific roles or seeking to build a sustainable Māori workforce. This shift is not supplementary; participants emphasised that without it, Māori will continue entering roles feeling underprepared, undervalued, and culturally isolated.

Policy change must also focus on redesigning the qualification itself. To prepare all HPOs to be culturally competent Crown agents, the curriculum must embed experiential Treaty-based practice, applied cultural safety assessment, and mātauranga-informed approaches as core competencies, not optional additions. Participants noted that current training does not equip staff to honour Te Tiriti in practice, with one stating plainly: *"My knowledge came from my community, not the qualification."* If the system expects HPOs to act as Treaty partners, the qualification must explicitly prepare them to do so.

Finally, to ensure accuracy, integrity, and cultural legitimacy, curriculum redevelopment must be undertaken in partnership with Māori experts, iwi, and current Māori HPOs. Co-designed curriculum content is essential for addressing longstanding gaps and ensuring alignment with the relational, environmental, and values-based motivations that draw Māori into Health Protection. Embedding these reforms across the pipeline would create qualification pathways that are visible, equitable, and culturally grounded—enabling Māori to enter, remain, and thrive within Health Protection on their own terms.

4.5.3 Targeted recruitment strategies

We have identified that Māori do not enter Health Protection through conventional linear pathways but rather are encouraged into the roles through their kaupapa Māori understanding of the relationship between humans and the environment. This is further supported by the application of equitable pathways into the role and trusting relationships with those that can helped them to navigate unfamiliar and often Westernised working environments.

To expand the Māori health protection workforce, we must move from accidental discovery to intentional design with Māori, ensuring it is built upon kaupapa Māori motivations and embedding structured, culturally grounded support mechanisms. The pathway must be redesigned so Māori do not rely on word-of-mouth or chance relationships.

Barriers of visibility and Eurocentric requirements must be replaced with transparent, equitable, Māori-led pipelines. Enablers such as relational recruitment, scholarships, and kaupapa Māori framing must be standardised, not incidental. This can be addressed by creating nationally consistent Māori HPO scholarships, cadetships, and paid study-while-working pathways.

4.5.4 Strengthen Relational Infrastructure

We have discovered that kaimahi Māori thrive when they have access to culturally appropriate support networks in an otherwise non-Māori dominated environment. To support this, it is important the NPHS allows time and space for kaimahi Māori support networks that connect Māori from across the organisation, who might not otherwise have access to each other.

Additionally, when training for a role, it is often overwhelming particularly for Māori who not only navigate the designation process but also racism and cultural incompetence from their peers. Employing a tuakana-teina model of practice can help provide whanaungatanga and manaakitanga for new staff while also supporting them in obtaining their designations, making the experience less stressful and more likely to secure success.

4.5.5 Enhance Leadership Capability and Representation

The findings highlighted the importance of having the right leadership in place, particularly when the organisaiton is inconsistent with the application of tikanga and Mātauranga Māori. Leaders at all levels should be able to demonstrate competency in Māori–Crown relations before holding managerial authority as a bare minimum requirement as well as a firm understanding of equity.

It is important the more Māori are encouraged and supported into leadership positions with the investment in Māori leadership pipelines, including leadership training, secondments, and succession planning improving access.

Māori leadership should not solely come from within the organisation, but also from partnerships with Iwi Māori. Increase Māori representation in decision-making structures, including technical, operational, and governance levels can support iwi lead decision making

4.5.6 Sincere Commitment to Te Tiriti o Waitangi

Achieving equity for Māori in Health Protection requires confronting a clear finding of this research: Te Tiriti o Waitangi has been consistently dishonoured. Participants' kōrero showed how these breaches appear daily through institutional racism, cultural taxation, mono-cultural environments, and Western-centred frameworks that neither reflect nor prepare kaimahi Māori for their Crown obligations. Without a sincere, system-wide commitment to decolonising Health Protection, inequities will continue to deepen.

Health protection priorities, strategies, and policies must be co-designed with iwi, hapū, Māori Health Providers, and Māori HPOs to ensure they uphold mana motuhake and reflect the aspirations of the communities they serve. Where Māori are excluded from decision-making, policy becomes disconnected from Māori realities, contributing to isolation and tokenism. Authentic partnership instead strengthens accountability and positions Māori expertise at the centre.

Participants emphasised that Māori leadership, whanaungatanga, and cultural capability improved their experiences, yet these conditions were inconsistent and reliant on individual leaders. To address this, investment is needed in a Māori HPO workforce pipeline, including Māori-specific scholarships, cadetships, transition pathways, protected training time, and remuneration of mātauranga Māori expertise. Evidence from the literature confirms that pipeline interventions and affirmative action are essential to counter structural inequities.

A system committed to Te Tiriti must measure its performance against Treaty-based outcomes. These measures respond directly to evidence identifying institutional racism

as a key driver of workforce inequity and affirm the need for structural accountability rather than relying on individual goodwill.

Policy must uphold Te Tiriti through genuine partnership, intentional investment in the Māori Health Protection workforce, redesign of the role to reflect Māori aspirations, and robust accountability. Only through these changes can Aotearoa build a Health Protection system that honours whakapapa, protects te taiao, and enables Māori to thrive as kaitiaki and Crown partners.

4.5.7 Accountability and Monitoring Framework

The findings across this thesis show that inconsistency is embedded within the Health Protection system. Participants described variable leadership capability, uneven cultural practice, and significant regional differences in support for Māori staff. These variations reflect a lack of structural accountability and place Māori kaimahi at continual risk of cultural harm, cultural taxation, and burnout. As HPOs operate as Crown agents, consistent cultural capability and Treaty practice cannot depend on individual leaders or isolated pockets of good practice. A coherent accountability framework is therefore essential.

Such a framework would shift responsibility from Māori individuals to the system itself. First, it would require transparent monitoring of Māori workforce equity, including recruitment, progression, and retention. Regular reporting on Māori representation would make visible the gaps currently masked by fragmented or absent data and provide a baseline for measuring system performance. This responds directly to findings from Kete Tuatahi and Tuarua, which showed that Māori often enter and remain in Health Protection despite structural barriers rather than because of deliberate workforce design.

Second, the framework must include clear expectations for cultural capability. Leadership competence in Te Tiriti, cultural safety, and Māori–Crown relations must be mandatory, not discretionary. Participants repeatedly emphasised that leadership capability directly affected whether they experienced safety or harm. Embedding cultural competence into performance criteria and appointment processes would ensure that cultural capability is treated as a core requirement for practice, not an optional attribute.

A further component involves monitoring the distribution of cultural labour. The findings showed that Māori kaimahi disproportionately carried cultural responsibilities due to organisational gaps in capability. An accountability framework would identify where this labour is falling, ensure it is recognised and remunerated appropriately, and require teams to distribute cultural responsibilities equitably. This is central to addressing the "cultural double-shift" experienced by participants across the country.

Racism must also be formally accounted for. Participants described racism in interpersonal interactions, workplace culture, and organisational systems. A credible accountability framework requires safe reporting mechanisms, transparent investigation processes, and clear expectations for timely and meaningful responses. Without this, cultural safety remains contingent on individual leadership rather than guaranteed by the system.

Finally, any accountability mechanism must be overseen by Māori. Māori-led governance ensures that performance is assessed against Māori values, aspirations, and Treaty expectations rather than Crown-defined benchmarks. Oversight by iwi partners, Māori health providers, and Māori HPOs gives legitimacy to the process and ensures that monitoring remains grounded in kaupapa Māori.

Together, these measures create the consistency and oversight that the current system lacks. An accountability and monitoring framework would ensure that cultural capability, Māori workforce development, and Treaty practice become organisational responsibilities rather than burdens carried by Māori staff. Such a framework is essential to building a Health Protection workforce where Māori can thrive as kaitiaki, leaders, and Crown partners.

4.5.8 Summary

This research demonstrates that the future of the Māori Health Protection workforce is dependant on the willingness of the system to transform, pivoting from Western-centred structures to authentic kaupapa Māori practice. The testimonies of the Māori HPOs show the potential they carry in shifting the system, to lead, protect and uplift public health in ways that honour whakapapa and strengthen the collective wellbeing of our communities.

By embedding clearer pathways, recognising mātauranga Māori as essential expertise and enacting genuine partnership under Te Tiriti, NPHS can grow a workforce that is better equipt to meet the needs of the communities they serve.

Chapter 5: Conclusion

This thesis set out to understand how the Māori Health Protection workforce can be developed and expanded by listening to the experiences of previous and current kaimahi Māori Health Protection Officers (HPOs). Through exploring the pathways into the profession, the factors influencing retention, and the role of cultural capability, this research has highlighted both the strengths Māori bring to Health Protection and the structural barriers they continue to face.

Across the kōrero, one truth remained constant: Māori do not enter or remain in Health Protection because of the system, they do so despite it. Their journeys are driven by whakapapa, whanaungatanga, kaitiakitanga, and a deep desire to contribute to the wellbeing of their communities. Yet the systems they navigate are grounded in Western frameworks that marginalise mātauranga Māori, inconsistently uphold Te Tiriti, and fail to provide culturally safe work environments.

5.1 Key Findings

Participants' pathways into Health Protection were shaped by accident rather than design. Whakapapa and kaitiakitanga motivated them; whanaungatanga guided them. Tailored opportunities like scholarships, Māori-specific trainee roles, and on-the-job learning were essential enablers. However, the invisibility of the profession and the opacity of designation and qualification pathways created significant barriers.

Retention was determined not by individual resilience but by organisational culture. Where leadership demonstrated manaakitanga and cultural humility, Māori HPOs flourished. Where cultural safety was inconsistent, cultural labour was unevenly distributed, or racism occurred, Māori kaimahi faced burnout, isolation, and role conflict.

The cultural capability of non-Māori staff was a defining influence across the entire pipeline. Strong cultural capability created safety, belonging, and opportunities for genuine practice. Weak capability generated cultural taxation, racism, and structural inequities that ultimately undermined retention.

To expand and sustain the Māori Health Protection workforce, incremental improvements are not enough. The findings make clear that genuine change requires it to be kaupapa Māori by design, embeds Treaty-based workforce structures, demands systemwide cultural capability and has visible, accessible and equitable pathways

A truly sustainable Māori HPO workforce will emerge when the profession is reframed as an expression of mana motuhake, kaitiakitanga, and the protection of whakapapa values that Māori already bring to the role, and which elevate the quality and integrity of Health Protection for all.

5.2 Limitations

This study offers critical insights however must be understood within its limitations as follows

1. Small sample size: Seven participants provided deep kōrero, but findings cannot represent all Māori HPO experiences.
2. Lack of contemporary workforce data: No centralised dataset for Māori HPOs restricts understanding of national trends.
3. Scope: This study focused solely on Māori HPOs, not including managers, or wider public health staff.
4. Political and structural context: The research took place during major health system reforms, which may have influenced experiences.
5. Researcher positionality: As a Māori HPO and Senior Advisor, my perspective shapes interpretation despite reflexive practices.

5.3 Areas for further research

Based on the findings within this thesis, researchers could further explore how qualification pathways can be Co-designed and Māori-led.

Based on a major limitation in the literature, research into the improvement of National Māori public health workforce mapping will help understand the true capacity of the workforce while also creating evidence for accountability of the system in their efforts to increase the workforce.

While literature and this thesis has identified cultural capability as a crucial factor in retention, further research into the development of these capabilities for non-Māori kaimahi will shift the culture while also creating the opportunity to begin grounding the health protection profession in Māori worldviews.

5.4 Reflexivity and Researcher Positioning

My own pathway into Health Protection was guided by whakapapa, kaitiakitanga, and whanaungatanga. These experiences align closely with those of the participants and strengthened the kaupapa Māori framing of this study. While this insider positioning enhances cultural integrity, it also requires careful reflexivity to avoid projecting personal experiences onto the data. Throughout the research, journaling, supervision, and peer discussion ensured that the voices of participants remained at the centre.

5.5 Closing statement

This thesis began with *Ko Wai Au*, a journey of whakapapa, reconnection, and the search for identity. That journey has woven itself through every stage of this research, shaping how the work was approached, how the kōrero was held, and how the findings were interpreted. The stories of kaimahi Māori who walk the same tightrope between systems built on Western logics and responsibilities grounded in whakapapa echo the questions that guided my own path: *Where do I stand? How do I serve? How do we protect our people and our whenua in ways that honour who we are?*

Through this kaupapa, the research has shown that Māori entry into Health Protection is not determined by system-designed pipelines but by whakapapa, whanaungatanga, and a deep, inherited sense of kaitiakitanga. It has shown, too, that Māori remain in the workforce when they experience cultural safety, leadership grounded in manaakitanga, meaningful inclusion of mātauranga Māori, and an environment where they can bring their whole selves to the role. Conversely, it has demonstrated that cultural labour, racism, and Western-centred structures continue to undermine Māori wellbeing, identity, and retention.

By listening to the lived experiences of Māori HPOs, this research has answered the central question: **How can the Māori Health Protection workforce be developed and**

expanded? The answer is clear. It requires transformation, not of Māori, but of the system. It requires redefining what a Health Protection Officer is, redesigning qualification pathways to reflect Indigenous knowledge and Treaty practice, creating deliberate and kaupapa-aligned recruitment pipelines, strengthening relational and cultural infrastructure, and embedding accountability for cultural capability and equity at every level.

In many ways, this thesis marks the transition between my own journey of reconnection and the collective aspirations of those who shared their stories. Their kōrero reaffirms that the strength of our workforce lies not only in technical expertise but in whakapapa, tikanga, and the relational responsibilities we carry as descendants of Papatūānuku and Ranginui. The future of Health Protection depends on recognising, resourcing, and protecting that strength.

As this research closes, the path forward becomes clearer: a Health Protection system that honours Te Tiriti, values Māori leadership, upholds mana motuhake, and creates conditions where Māori can thrive as kaitiaki, practitioners, and Crown partners. The work ahead remains urgent, but it is also filled with potential—anchored in the voices, resilience, and collective vision of those who walk this path.
I close with a whakataukī that reflects both the kaupapa of this thesis and the direction it calls us toward **"He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata."** *What is the most important thing in the world? It is people, it is people, it is people.*

This work has always been, and will always be, for our people for our whakapapa, our whenua, and the generations yet to come.

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Appendices

Appendix 1: Audit Trail of Literature Review

Appendix 2: Expression of Interest Advertisement

Appendix 3: Letter of Invitation

Appendix 4: Consent Form

Appendix 5: Interview Schedule

Appendix 6: Interview Transcripts

Appendix 7: Glossary of Māori Kupu