



Te Aronga-a-Hine

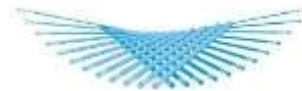
Consolidated Summary of Evidence
and Recommendations
September 2020



TE RAU ORA



TE RAU ORA
Strengthening Māori Health and Well-Being



**COUNTIES
MANUKAU**
HEALTH



Tupara, H., & Tahere, M. (2020). Te Aronga-a-Hine: Consolidated Summary of Evidence and Recommendations - September 2020. Wellington, NZ: Te Rau Ora.

ISBN: 978-0-473-54791-2
Publication Date 11/2020

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Introduction

This consolidated report summarises evidence and recommendations arising from Te Aronga-a-Hine (the Project) which was commissioned by the Ministry of Health (MoH) in Aotearoa New Zealand (Aotearoa). The purpose of the Project was to develop an evidence base that informs workforce priorities with a focus on Māori women, babies, children and whānau. Led by [Te Rau Ora](#), in partnership with [Ngā Māia Māori Midwives o Aotearoa](#) (Ngā Māia) and [Counties Manukau District Health Board](#) (Counties Manukau Health) (the Partners) the Project was commenced in 2019. The Partner leads were Dr Kahu McClintock (Te Rau Ora), Jean and Beverley Te Huia (Ngā Māia), and Heather Muriwai (Counties Manukau Health). The Project emerged as seven outputs, which are:

1. Rapua te Aronga-a-Hine, The Māori Midwifery Workforce in Aotearoa: A literature Review - February 2020 (Rapua te Aronga-a-Hine).
2. Whaia te Aronga-a-Hine, Ngā Māmā Report 2020 (Whaia te Aronga-a-Hine Ngā Māmā).
3. Whaia te Aronga a Ngā Kaiwhakawhānau, The Māori Midwifery Workforce in Aotearoa Ngā Kaiwhakawhānau Māori - June 2020 (Whaia te Aronga a Ngā Kaiwhakawhānau).
4. Kimihia te Aronga-a-Hine, The Māori Midwifery Workforce in Aotearoa: Workforce Report 2020 (Kimihia te Aronga-a-Hine).
5. Te Aronga-a-Hine Māori Midwifery Symposium (the Symposium) and Proceedings.
6. Making Sense: Consolidating evidence of the needs of the Māori midwifery workforce and Māori women receiving midwifery services (Making Sense).
7. Te Aronga-a-Hine: Consolidated Summary of Evidence and Recommendations - October September 2020.

This report primarily draws on research outputs 1-4, and it is organised in two parts. The first part provides a brief synopsis of outputs 1-4, although readers should refer to the actual documents for detailed information. The second part of this report consolidates the recommendations from outputs 1-6, which have been affirmed by anecdotal evidence from Māori midwives who have read the reports, some of whom attended the Symposium.

International awareness of cases of Novel Coronavirus (COVID-19) in Wuhan China occurred in 2019. The first case of COVID-19 in Aotearoa was identified on 28 February 2020 and it was publicised by the MoH in a media release that day.

An alert system was introduced by the government in Aotearoa which included a complete lockdown of the country in mid-March 2020, to prevent transmission of the contagious virus. Businesses, schools, and most retailers were required to close down until further notice. Residents were asked by the government in Aotearoa to stay home (stay in their bubble). The effect of the COVID-19 restrictions had a resulting impact on the Project, which is reflected in the data gathering methods and timing of the outputs. The first output, Rapua Te Aronga-a-Hine was in its final stages of completion at the same time the first case of COVID-19 in Aotearoa was known.

Te Aronga-a-Hine outputs confirm te Tiriti o Waitangi (Te Tiriti) is fundamental for radical and transformational changes to the inequitable health system that has persisted in Aotearoa decades. Te Tiriti mandates the relationship between tangata whenua and the Crown, and therefore, the constitutional relationship and obligations of midwives as agents of the Crown. Embedding te Tiriti into the psyche and actions of government, of health services and the midwifery profession, is the most significant factor that will ensure Māori women, babies, children, their whānau, Māori midwives and the wider Māori health workforce, are equals with their Tauwiwi (non-Māori) citizens and colleagues.

Throughout this report both the Treaty and te Tiriti are used, but the terms are not used synonymously. Te Tiriti is used when a source document has referred to te Tiriti and vice versa when the Treaty is referred to in a source document. This document privileges te Tiriti as an affirmation of the Māori language version and the intent of the Māori

signatories. Readers of this report should consult further information to understand the history and political debate behind the two language texts.

Part One: Te Aronga-a-Hine Project Outputs

1.1 Rapua te Aronga-a-Hine

Introduction

Te Rau Ora, on behalf of the Partners, commissioned [Tieki Consultancy](#), to undertake a literature review to establish an evidence base that describes the current Māori midwifery landscape and the nuances of the workforce, to inform the next steps of the Project. Rapua te Aronga-a-Hine was completed in February 2020 and authored by Dr Hope Tupara and Megan Tahere.



Dr Tupara, the Reikura – Director and Principal Consultant of Tieki Consultancy, has been a midwife for 25 years having practised as a self-employed Lead Maternity Carer (LMC). She currently supervises Māori doctoral candidates and is the Co-Chairperson of the Midwifery Council of New Zealand’s Aotearoa Midwifery Project Collaborative Reference Group to lead a review of the midwifery regulatory framework in Aotearoa. She has extensive experience in research, midwifery education, health governance and regulation, and in Māori development as an iwi Treaty Settlement Negotiator, iwi Chair, Technical Advisor to the Iwi Chairs Forum, and a Ministerial Advisor on Treaty issues. In 2004 she was m by Te Rau Ora (formerly Te Rau Matatini) to co-author a publication titled: [In the Context of Midwifery Practice: Recognition and Management of Mental Health](#).

Megan Tahere, the Manu Manawakōkōpu – Senior Consultant at Tieki Consultancy, is also an experienced midwife having practised mainly in the District Health Board (DHB) primary and secondary care environments. She has broad experience in clinical, leadership, management, education, governance, and advisory roles. Megan is currently a doctoral candidate in the Massey University Te Pūmanwa Hauora PhD programme at the Centre

for Hauora and Health in Wellington, supervised by Dr Tupara, and the Service Development Manager – Child, Youth and Maternity at Waikato DHB.

Summary

The opportunity to undertake the first systematic analysis of the Māori midwifery workforce and unbundle the multiplexity of the midwifery landscape in Aotearoa, in which Māori midwives are positioned, naturally took Rapua te Aronga-a-Hine well beyond the brief of being a literature review. The link between midwifery education, the midwifery workforce, and maternity outcomes is highlighted and made explicit in Rapua te Aronga-a-Hine. Over a ten-year period from 2008 to 2018 there were 1,445 Māori enrolled in a midwifery programme and only 230 completed, which equates to an 84% attrition rate. This attrition rate is abhorrent as it translates to a loss of 1200 potential Māori midwives. If these 1200 Māori midwifery students were retained and graduated from a midwifery programme the Māori midwifery workforce in Aotearoa today could potentially be as high as 1,517 or 34.3% of the overall national midwifery workforce.¹ The actual number of Māori who did commence a midwifery programme during the 10 year-period from 2008 to 2018 is not known because it was not possible to access the data. Anecdotal evidence from midwifery educators in Aotearoa indicates that attrition is benchmarked by comparing rates across the five midwifery schools. By comparing attrition rates, midwifery schools are using each other's attrition rates to determine their success, which is a flawed benchmarking method for Māori students. This method positions blame for attrition on the students' failing rather than on the failings of the midwifery schools and programmes they offer. A strengths-based approach to measuring success, is for midwifery schools to focus on transparency of the pipeline between enrolment, commencement, retention, and completion rates whilst undertaking a Kaupapa Māori approach to annual critical analysis of data and student and staff experiences.

Given that all midwifery schools and programmes are located within mainstream (Tauwiwi) tertiary education institutions and are led by Tauwiwi, and the majority of educators are

¹ The MCNZ reported that there were 3,226 midwives with an APC in Aotearoa in 2017. Of these midwives, 317 (9.83%) self identified as Māori. Take 3,226 and add the loss of 1,200 Māori midwifery students in 2018 to 317 and this equates to 4,426. Take 317 Māori midwives and add 1,200, this equates to 1, 517 which is 34.3% of 4,426.

Tauiwi, it is unlikely that particular issues impacting on Māori attrition rates will be identified and addressed in a sustainable way. The nature of midwifery attrition rates for Māori is an important area for future research. It is useful to understand what happened to those who left and why; how far they progressed through midwifery education, and what kind of support from the midwifery school, may have helped them to complete the programme. Furthermore, whether they incurred student debt on their departure from a midwifery programme and if so, how much debt and what has the impact of that debt had on their long-term wellbeing. Low numbers of Māori graduates coming out of midwifery programmes from 2008 to 2018, has directly impacted the Māori midwifery workforce. Low numbers of Māori midwives, means there is reduced choice for Māori women, and in some areas of the country, no choice of a Māori midwife, available for Māori women seeking a Māori midwife to provide their maternity care.

Other avenues for research identified in Rapua te Aronga-a-Hine include the extent and depth of racism, discrimination, and bias occurring across the profession. Information from four years of annual practising certificate (APC) renewal information collected by the Midwifery Council of New Zealand (MCNZ) shows Māori midwives gave racism and bullying as reasons for leaving the profession, which coincides with historical and ongoing anecdotal information from Māori midwives. Experiences of racism, discrimination and bullying were also expressed verbally by Māori midwives who have worked in midwifery education, and it is both sources of evidence, about negative experiences of workplace environments by Māori midwives, that is concerning, because the work environments could also be manifesting as unhealthy settings for women and babies using maternity services.

The literature review found evidence of workforce entry and exit patterns of Māori midwives that have some differences to that of non-Māori midwives. That Māori midwives leave and re-enter the profession differently to their Tauiwi colleagues, has never been highlighted or investigated before. Māori midwives tend to be younger than the average age for all midwives. For the years 2015 to 2019 the average age of a Māori midwife was 43 years compared to the average age for all midwives at 47 years for the same period. The average time that Māori midwives spent in practice between 2015 to 2019 was 12

years, which is 3 years less than the average time spent in the midwifery workforce by all midwives during the same period.

Research is needed to better understand the demographic of Māori midwives and their needs to enhance their wellbeing and retention in the profession. The undertaking of such research would provide insight into what initiatives could be co-designed with Māori midwives and implemented by the MoH and DHBs to develop a pipeline approach to not only the recruitment, but retention of Māori midwives, beyond the identified average length of service. Ensuring that Māori midwifery students have experienced Māori midwives available to choose from for practice placements during their training, is also significant. New graduate Māori midwives should be able to choose to be mentored by their more experienced Māori colleagues and to join practice teams comprising Māori midwives, which is critical to the future state of the midwifery profession. A locality-based approach to workforce development to meet the demand of the projected Māori birthing population is another important research avenue. Collaborating with iwi to understand their aspirations for whānau will assist in growing a midwifery workforce that aligns with the diverse, current, and future needs of Māori communities. Workforce modelling data shows the forecasted increase in the number of Māori midwives needed up to the year 2029, to reach the workforce growth target of the MoH.

The collective comments by Māori midwives raises questions regarding the general attitudes within the midwifery profession towards Māori colleagues and equity in recruitment processes. There are no Māori midwives across all the top tier midwifery leadership positions in the country including all midwifery schools and the 20 District Health Boards (DHBs) in the country. Existing midwifery leaders are being observed moving from one DHB to another, despite under-performance around increasing recruitment and retention of Māori midwives and improving Māori health outcomes. Since the publication of *Rapua Te Aronga-a-Hine*, the authors are aware of four experienced Māori midwives who applied for midwifery leadership positions and none were appointed despite them all being suitably qualified and experienced for the roles. In one situation, the Māori midwife had a Master's degree, which was the minimum qualification required for the role, and yet the successful Tauwiwi applicant did not. One Māori midwife applied

for a tertiary hospital leadership position with 10 years of tertiary hospital and Māori leadership experience, and yet the successful applicant had no tertiary hospital leadership experience. These examples indicate that 'non-transparent' criteria appear are being applied to appointment processes.

The under-representation of Māori midwives across all areas of the profession means the capacity of Māori midwives to influence changes to the profession, is severely hindered. The cumulative effect of an under-represented Māori midwifery workforce means that there is reduced potential for Māori voices to be heard and Māori are not part of critical leadership decision making where the status quo is more able to be challenged or changed. The current situation does not allow the profession to benefit from the views or perspectives of its indigenous midwives and the indigenisation of the midwifery landscape as a result.

As of 2019, approximately 9.83% of practising midwives in Aotearoa identified as Māori as their first (n=197 or 6.11%), second (n=119), or third (n=1) ethnicity. Such information is critical for workforce planning because it provides some indication of how the Māori midwifery workforce perceive themselves. However, what influences this self-perception and how it impacts the Māori midwifery workforce and wider profession has not been investigated. Understanding why midwives self-identify as Māori as their first ethnicity in comparison to those who self-identify as Māori as their second or third ethnicity and what this means for each midwife will assist in charting our course for workforce development. Midwives who live as Māori, may be those who selected Māori as their first ethnicity, and midwives who identify as Māori as their second or third ethnicity, meaning that they could associate more strongly with, and live, another ethnic identity. If this were found to be accurate, midwifery workforce planning would be faced with two challenges with respect to ethnicity. One is growing the number of Māori midwives. The other is growing the number of Māori midwives who Māori women in the community will connect with, because a midwife who has Māori as part of their identity but has never lived as Māori, could struggle in the same way as Tauīwi, to connect at a cultural level with other Māori women who live as Māori. These areas of the Māori midwifery profession are uncharted and worthy of investigation from both a workforce and consumer perspective.

The competence of midwives to properly meet the needs of Māori women is also questioned in Rapua Te Aronga-a-Hine. There is no compulsory mechanism in place to monitor or review the cultural competence of midwives. At the time of preparing this report, midwives' regulatory body, the MCNZ, is in the throes of reviewing the midwifery regulatory framework. For Māori, the review provides an opportunity to revisit the framework that is in place and address current concerns about the rigour of the process and methods being used to assess and address cultural competence of midwives.

Systemic barriers identified in Rapua te Aronga-a-Hine, prevent Māori midwives from being appointed to leadership positions across the maternity sector. The creation and implementation of Māori midwifery positions at all levels of the profession, including the MoH, MCNZ, NZCOM, Midwifery Employee Representation and Advisory Service (MERAS), Midwifery and Maternity Providers Organisation (MMPO), and the DHB environment using a Tiriti-led approach to organisational structure and operation, is long overdue. These positions must be defined and developed by Māori and have position descriptions that prioritise Māori knowledge, experience, and professional development. The roles must be appropriately scoped to ensure Māori midwives are recognised for the added value they inject into the profession and that they are remunerated accordingly. Advancement of the Māori midwifery profession in a direction that will achieve equality for Māori midwives, and contribute to reducing Māori health disparities and achieve equity for women, babies, children, and whānau must be Tiriti-led and multifaceted if we are going to see expected gains in our lifetime and set a thriving future state for generations to come.

The most profound issue by far, is the absence of an authentic Tiriti-led partnership between Māori and Tauwiwi midwives within the profession and with Crown agencies. The discourse that midwives work in partnership with women is embedded in professional and regulatory frameworks for midwifery, yet Māori midwives seek a profession and health system that is committed to being Tiriti-led whereby the power balance is reset and Māori and Tauwiwi midwives are themselves equal Tiriti partners who work in a health system whereby Māori women are treated as equal citizens.

Conclusion

A commitment to a Tiriti-led profession is the single most important challenge for the midwifery profession in Aotearoa in the 21st century. As a partnership framework for indigenous midwives and Tauwiwi colleagues, te Tiriti provides a pathway for a future direction for midwifery that honours the unique cultural context of Aotearoa. The midwifery profession has reached an impasse. Midwifery leaders need to look past any previous grievances and put aside their organisational agendas and egos, because the needs of Māori women and babies is too dire, not to act now.

1.2 Whaia te Aronga-a-Hine Ngā Māmā

Introduction

Talking to Māori women who use midwifery services was a deliberate part of the design of Te Aronga-a-Hine from the outset. Beverly Te Huia led and authored this output of the Project.

Beverly is a midwife with over fifteen years practice experience and having worked for a Māori health provider since 1996 she is aware of the struggles and the strengths that contribute to better health outcomes for Māori. She is the former Chairperson of the Ngā Māia Board of Trustees and has experience in Māori health leadership and management roles designing and implementing integrated primary care models, and midwifery advisory roles including the development of childbirth education tools in Mongolia. Beverly developed Bio-Oil Lanomint for breastfeeding women, and she is a licensed pilot, beekeeper, and outdoor education instructor.



Twenty-five women were recruited for the qualitative research undertaken in Whaia te Aronga-a-Hine Ngā Māmā to understand the experiences of maternity care Māori women received. In total, 19 of the women who participated in this research were interviewed and they had experience of midwifery care in Counties Manukau, Hamilton, Hastings, Wairoa, and Waipukurau. The women were recruited through midwives, nurses, kaiāwhina, and whānau and they were asked questions according to the following three themes.

1. Whom they sought and received maternity care from, such as midwives, doctors, or the hospital. The ethnicity of their carer's, and what made that experience successful and disappointing.
2. What were their expectations of maternity care, if any, and what was important to them before, during, and on reflection of their experience.
3. What is missing from maternity care that would be helpful.

Interviews began on 9 March 2020 and progress was interrupted because of the impact of COVID-19.

Summary

Nineteen women were interviewed and they had experience of maternity services in the following areas: Hastings (n=6), Wairoa (n=2), Waipukurau (n=1), Counties Manukau (n=4), and Hamilton (n=6). The ages of the women ranged between 15 and 44 years old with 72% of the women aged between 20 and 34 years of age. The majority (95%) of women self-identified as Māori and the remainder self-identified as Samoan/New Zealand. Of the women interviewed, 26% had experienced one pregnancy, while the remainder had given birth for their second or subsequent baby. Just over half (58%) of the women changed their LMC either during their pregnancy or with a subsequent pregnancy and 64% of these women changed LMC because they moved to another area.

Most women had a Māori midwife and some wanted a Māori midwife but they could not access one. One woman was not concerned about the ethnicity of the midwife. Of the women interviewed 95% felt it was important to have a Māori midwife because they felt more comfortable with a midwife from their own culture, although they had difficulty elaborating why.

The following are some of their comments.

- “Māori midwives are just more – I’m just more comfortable.” Māmā 2.
- “I felt more comfortable cause she was in here and stays to me – I’ve got someone coming in, is that all right?” Māmā 4.
- “Well for me, having someone the same culture as me, it made me feel comfortable.” Māmā 4.
- “Yeah, it’s more comfortable.” Māmā 8.
- “It’s like the stars aligned at that point, and we jumped in straight away with her aye.” Māmā and Pāpā 7.
- “I deliberately chose a Māori midwife.” Māmā 1.

Women identified that having a maternity carer that respects their culture, values, and background influences their choices of LMC and most had a preference for a Māori midwife because they felt safe, understood, and trusted a Māori midwife. Some said:

- “It's cause you have a better understanding of your own people.” Māmā 4.
- “A Māori midwife would kinda know. She would just know and be able to give me information that I need. And they would understand you better. I feel that if you are able to understand that person better then you are able to help that person better.” Māmā 2.
- “I had a really good birth with my first baby. So I didn't realise that was because of the care that I had with my Māori midwife. So what I did, I wasn't bothered the next time.” Māmā 8.
- “I felt safer knowing my midwife was there. Because when I went for surgery and she wasn't there, I cried for my mum.” Māmā 6.
- “There is understanding already through her culture and their backgrounds.” Māmā 8.
- “I didn't really know what to expect. I just let her do it to be honest.” Māmā 3.
- “You should be able to get this and that cause your Māori and you need it.” Māmā 6.
- “Like I'm so sure that in their studies they do practice Māori health models. They have papers on it I'm sure. It's like with anything and to uphold the Treaty and stuff they got to do it. And so, you have done all this study on it, but for what? It's not within their practice. For everyone we had, we can't remember anyone that upheld that. Yup, they didn't uphold that. I know if we had our Māori midwife there, because of her level and she knows a bit more, they may have treated us differently aye.” Māmā 8.
- “I trusted the Māori midwife to be culturally appropriate.” Māmā 1.

Most women (63%) sought their midwife by word of mouth from whānau and women's choices were influenced by the experience of other whānau and they would often choose the same Māori midwife.

Most of the women interviewed had experienced racism within the secondary care hospital environment or other areas like radiology, the laboratory, or antenatal clinics. Just over 30% experienced racism from their midwife, which was a further reason they changed LMC.

Figure 1 shows the range of comments women gave to express their experiences of racism.²

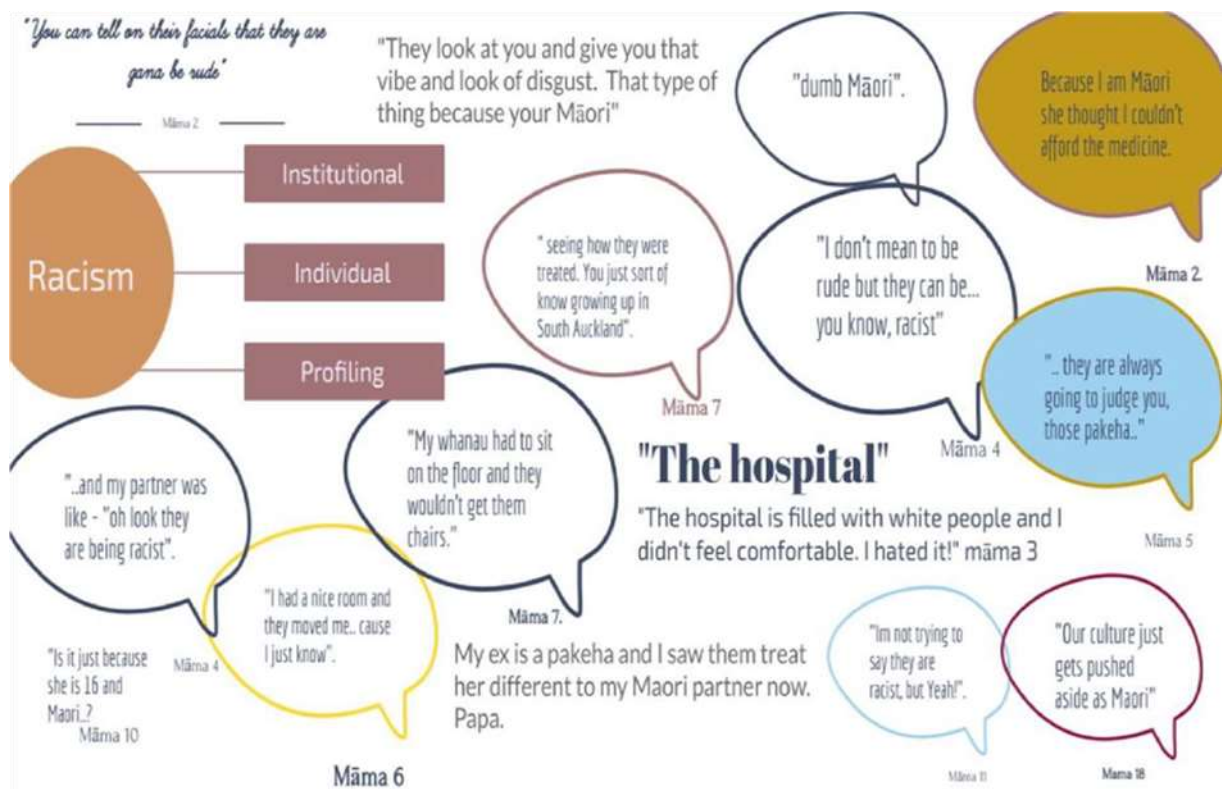


Figure 1: Expressions of racism

The women described a range of emotions and feelings they had about the hospital setting, such as the following:

- "I feel like I was like borderline racist towards her too. Cause I was like – I don't like you cause I know that you can't give me what I want." Māmā 7.
- "They had really good intentions, but it wasn't real." Māmā 8.

² Te Huia, B. (2020). Whaia Te Aronga-a-Hine – Ngā Māmā Report 2020 Ngā Maia, Māori Midwives. Aotearoa. New Zealand. Published September 2020, figure 14, pp 40. ISBN 978-0-473-53891-0. © Te Rau Ora

- “You just always feel uncomfortable.” Māmā 8.
- “So mums been in the mental health care for a while with Counties Manukau. So just knowing how they are treated. You just sort of know growing up in South Auckland.” Māmā 7.
- “Yeah, it feels like I'm in the category of – you don't deserve it; you're not good enough, like at the doctors.” Māmā 6.
- “You just sort of give up in the end.” Pāpā.
- “But you don't go in there and tell them what type of education you have had so that you get treated a bit differently, but honestly, you just get treated like you are dumb and you don't know.” Māmā 8.

Their fears were exacerbated by other feelings captured in Fig 2.³

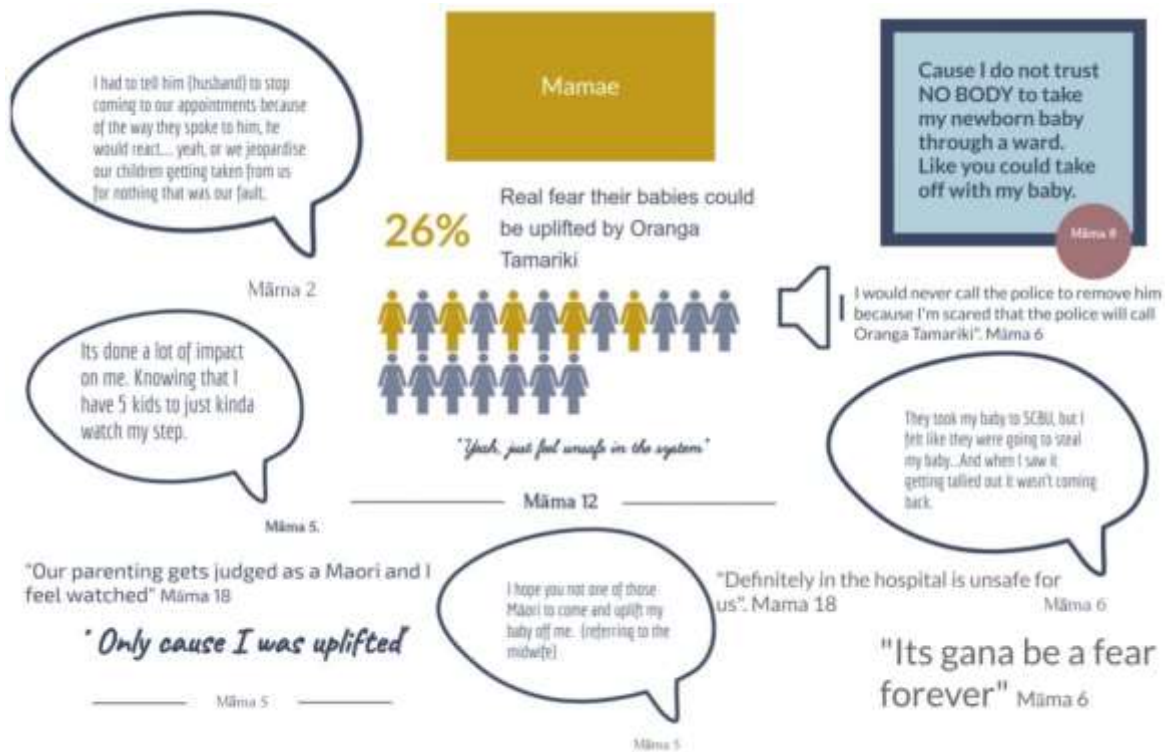


Figure 2: Expressions of fear

³ Te Huia, B. (2020). Whaia Te Aronga-a-Hine – Ngā Māmā Report 2020 Ngā Maia, Māori Midwives. Aotearoa. New Zealand. Published September 2020, figure 15, pp 41. ISBN 978-0-473-53891-0. © Te Rau Ora

All of the women supported the inclusion of tikanga Māori throughout their pregnancy and birth journey. Some of them relied on their Māori midwife, but most felt it was the responsibility of their whānau to carry out many of the traditions with their Māori midwife guiding them. About 25% of the women had experienced hapū wānanga.

From the women 63% of the women interviewed needed more social support than the midwife was able to provide. Some of the comments they said were:

- “I think Māori need more help. That's the care that I mean. They don't really get much help. They get the minimum of care, I think. Some can't go to places or afford things for their pregnancy. They maybe need the help to point them in the right direction, and you know, just ongoing care when they check-up. I.e. Are you OK? To tell them they are OK, your appointments next week. Do you need a ride, that type of thing.” Māmā 2.
- “I just feel and I'm sure that there is a lot more that can be offered to them, but they just give them that, and that's it. They don't get to choose.” Māmā 2.
- “It was hard, really hard. Especially when you are pregnant for the first time, or you're pregnant, and you have other kids like under 3 trying to get to the appointment and be pregnant with two babies. They don't help you. You're at the door with your two babies in a pram trying to open up the door, and they are like sitting at the desk watching you.” Māmā 2.
- “Yeah, I need heaps of support. I haven't got a carer and have all these problems with agencies.” Māmā 5.
- “The midwife only does so much, but I need more than that.” Māmā 9.

Conclusion

Women interviewed for this research spoke of a range of experiences with some common findings. The inability to choose a Māori midwife was raised by a number of women. Their experiences within the hospital settings, but also during their engagement with other maternity services was often negative. There was unanimous consensus for tikanga Māori and culturally tailored Kaupapa Māori antenatal education, and information, and choices whereby their whānau are included and actively engaged in their pregnancy and childbirth journey. The women attributed their ability to be able to be Māori, was more likely to occur with a Māori midwife.

1.3 Whaia te Aronga a Ngā Kaiwhakawhānau Māori

Introduction

Whaia te Aronga-a-Hine Ngā Kaiwhakawhānau sought views from Māori midwives, and was conducted by Jean Te Huia.

Jean is currently the Chief Executive Officer (CEO) of Ngā Māia.

She has been a nurse and midwife for 30 years and she was the first Māori woman to graduate with a Master's degree in nursing from the Eastern Institute of Technology in Hawkes Bay. Jean founded Choices: Kahungunu Health and Community Services located in Hawke's Bay, but her participation on national advisory committees has enabled her expertise to influence



national policies. Her ongoing concern with the discriminatory practices experienced by Māori women seeking maternity care has been a prime motivator of her involvement in the Mana Wahine kaupapa inquiry currently lodged with the Waitangi Tribunal.

Māori midwives around the country were engaged with to understand their views of working in the maternity system, challenges for them in the health system, and specific improvements to support them as Māori practitioners. In order to understand the views of Māori midwives a set of questions was developed, based on themes derived from

workshops at Ngā Māia Hui-a-Tau held in Northland from 21st October until 23rd October 2019. The questions for the design of Whaia te Aronga-a-Hine Ngā Kaiwhakawhānau Māori, were:

1. Describe your understanding of a Māori midwife.
2. What are the challenges for you to practice as a Māori midwife?
3. What changes in Midwifery Practice would better support you in your role as a Māori midwife?
For you? B) Your client?
4. What are your professional development needs for the future?

Data answering the four questions was collected from 102 Māori midwives, and of those midwives, 63 responded by way of an online survey, 35 midwives engaged in one of four focus group hui held in Hastings, Napier, Palmerston North, and Hamilton. Four midwives had a phone interview.

Summary

The findings of the kaiwhakawhānau research is summarised as follows.

Question 1: Describe your understanding of a Māori midwife?

Of the midwives who responded, 72.06% identified as Māori, and the majority of midwives (63.24%) identified a need to re-connect, re-establish and support whānau Māori through tikanga. Midwives said:

- 'Maintain Te Ao Māori values and acknowledging one's whakapapa' • 'I am Māori first and foremost. I am Mana Wahine and I am a midwife'.
- 'A Māori woman, trained as a midwife'.
- 'Being of Māori descent, understanding the tikanga of mātauranga birthing'
- "Acknowledging Te Ao Māori tikanga of birthing, as a Māori midwife'.

Question 2: What are the challenges for you to practice as a Māori midwife? For yourself? For the needs of your client?

In response to question three, the leading three challenges midwives identified for themselves as Māori midwives, are racism (61.7%), colonisation (48.53%) and judgement by others (32.35%). Comments by midwives included:

- “Racism, colour of my skin, my surname, not being taken seriously, my clients undermined, undervalued, working defensively
- “They blacklisted me and her (pointing toward her colleague), we’ve been midwifery partners for over ten years, and we still get treated like that...”
- “The system doesn’t respect, trust or advocate for me as Māori, even though I have been a midwife for 20 Yrs. It is designed to suppress me and our Māori knowledge”.
- “It’s expected of me to be knowledgeable about kaupapa Māori and use that knowledge to sit at various tables as the be all and end all of things Māori. It is expected that I will open meetings with karakia and song, bless birthing rooms, but my traditional birthing methods are questioned.”

Midwives described a range of experiences for whānau in their care.

- “They got no support in there...racism...institutional racism is embedded deeply within this area...which makes it unsafe for our women...which also makes it unsafe for us...harassment and constant horizontal violence by colleagues and DHB...cold...uncaring policies that disrespect whānau, wahine, and negatively impacts on whānau for generations”.
- “Every day is different. A planned day can change in seconds...Our clients require more care... at the DHB... pakeha midwives are hostile...Māori staff make you feel supported.. Even when they are just the care-associates...we need more Māori Midwives in there...at least then we won’t have to worry about our women.”
- “She yelled at me in the corridor, ‘Hey, Blah Blah, you’re in trouble again! ‘What for this time?’. Because you gave that woman a \$30 travel voucher.’ ‘What’s wrong with that?’ Well, she already got one when she left Wairoa last week!’...’But she needed to get home! Its better she goes home then stays another night here!...

- It will cost the DHB more than \$30 for her to stay another night!...So, the DHB is saving money, aren't they?' ... Yeah, but that's not the point. You're only allowed to give them one petrol voucher..."
- "Māori women have to fight for everything they need...sometimes against each other...Māori midwives are especially disadvantaged because no one fights for us. No one stands up for us as Māori...We are constantly challenging the system and trying to make it better for us as Māori midwives ...and when you do stand up and fight, you are labelled a radical, a bully, and a trouble maker. You can't win. And when those few of us who stand up and fight can't win, then our families don't win, our Māori Mums don't win, and our Māori babies don't win, and we remain at the bottom of the social order... being constantly blamed for our lack of health gains."

Question 3. What changes in Midwifery Practice/Workforce would better support you in your role as a Māori midwife?

Māori midwives spoke of their frustration of providing midwifery care that has become more descriptive and prescribed, dominated by medical interventions, that offer little or limited opportunity to work in partnership with hapū Māori māmā. They recognised the need for Kaupapa Māori professional review and a dissatisfaction with their midwifery scope of practice, identifying themselves as being under-utilised in the community, where little evidence is known about their roles and responsibilities, particularly in sexual and reproductive health care for whānau Māori.

Of midwives who responded, 34.33% felt more Māori midwives are needed to better support them, 29.85% felt culturally safe practice was a priority and 23.8% felt Kaupapa Māori frameworks were important to support their role. Some comments made by Māori midwives were:

- "And this pakeha midwife said, I don't even know why they keep having kids? They can't even look after the ones they've got now! They should be sterilised!..."

- I've seen these midwives from overseas sitting at the computer, answering questions on the Treaty: a tick box. When they are finished, they're supposed to be culturally safe to work with whānau?"
- "I think it is imperative we have our own ways of learning and our own ways of knowing to be able to teach those young girls.... And that is completely missing out of the New Zealand psyche of maternity care, out of midwifery care."
- "Yes why do we have to be called midwives, and not Tāpuhi? We should be defining the role of Tāpuhi, and then as Māori we have the right to determine what that is! What that looks like for ourselves as Tāpuhi, and how that would look like for our whānau..."

Question 4. What are your work development needs for the future?

Māori midwives attributed high value to Kaupapa Māori programmes with 40.3% of respondents giving Kaupapa Māori programmes the highest priority to meet their needs. This was followed by 32.9% who valued Māori midwifery wānanga and 26.92% felt more funding was needed to support their needs.

Some comments were:

- "Māori midwives can make a positive differences for Māori whānau, who have been intergenerationally marginalised..."
- "More Māori midwives in the motu, supporting each other."
- We need to be resourced properly, identify more Māori midwifery leaders into Governance and authorities roles, have our basic human rights met, they need to honour the treaty..."
- "The MSR is a pakeha construct, why should we have to explain to pakeha how we work?"

Conclusion

There are five recommendations concluded in Whaia te Aronga-a-Hine Ngā Kaiwhakawhānau Māori.

They are:

1. Government Review and Organisational Development

The development of a Ngā Māia Workforce Development Plan.

2. Workforce Development

Ngā Māia seeks to be the 'preferred' Māori midwifery voice in Aotearoa and aims to co-design clinical and cultural policy frameworks using a bi-cultural partnership model. Develop opportunities and options for Ngā Māia.

3. Recruitment and Retention

Ngā Māia aspirations are broad and include building a sustainable workforce that includes professional development needs specific to Māori succession planning and supports the growth of Māori leaders.

4. Training and Development

Ngā Māia will co-design and coordinate Māori birthing and maternal child-health education programmes within whānau, including development of education curriculum that fits the New Zealand qualifications Accreditation (NZQA) framework and connects with existing Māori nongovernment organisations, kura kaupapa and wānanga schools of learning.

5. Information, Research and Evaluation

Development of a research agenda and provision of facilities for conducting research that addresses the questions of diverse Māori whānau realities and includes collaboration with other Māori organisations.

The recommendations align to the needs for Māori, found from the companion reports for the Project. Major transformation is needed from a Tiriti-based position, to ensure that all health policies, programmes and workforce development favours Māori women, babies, children and whānau.

1.4 Kimihia te Aronga-a-Hine

Introduction

Kimihia te Aronga-a-Hine quantitative survey was led by Te Rau Ora under the guidance of Dr Kahu McClintock.

Dr McClintock has been working in health for almost 30 years and she is currently the Research Manager of Te Kīwai Rangahau, Te Rau Ora's research and evaluation unit. Dr McClintock leads and collaborates on multiple projects that work toward improving the wellbeing of Māori. Dr McClintock



also sits on the Waikato District Health Board Iwi Māori Council, the Waikato District Health Board Governance Board Acute Mental Health, is a member of the National Ethics Advisory Committee. Kahu is also the managing editor of the Journal of Indigenous Wellbeing Te Mauri-Pimatisiwin, and recently finished a nine-year run of representing her marae on Te Whakakitenga o Waikato (Waikato-Tainui tribal council).

Rachel McClintock (Waikato/Maniapoto, Ngāti Mutunga and Ngāti Porou) is a Researcher at Te Rau Ora. She has a background in Kaupapa Māori community based research and evaluation, with experience of research with Māori whānau (families) and communities, across areas such as youth development, mental health and wellbeing, gambling, palliative care, intergenerational communication, and suicide prevention. Rachel holds a BSocSc (Psychology), PGDipPH, and has submitted her thesis in the Masters of Public Health, Auckland University.

Sue Stephens (Waikato/Maniapoto and Ngāti Porou) is a Researcher at Te Rau Ora based in Hamilton, Aotearoa/New Zealand. Sue has a background in tertiary education with experience in evaluation, analysis, database management, data assessment, project management and administration. She holds a Postgraduate qualification in Management. Sue's professional expertise is in Research: Whakapapa and whānau histories, Support Māori Development: Te Reo Māori in Kohanga reo, kura kaupapa and

wharekura and Manaakitanga: Prioritising Kuia/Kaumātua and Mokokopuna, and intergenerational living.

Te Rau Ora conducted additional research by way of a survey, to collect information from the wider Māori health workforce involved in services to Māori women, babies, children and whānau. The prominence of Māori midwives in the maternity sector is acknowledged, however, midwives work in a health system that includes other professional groups and kaimahi who work with whānau. The survey was thus opened up to include other professional groups, and the results of the survey affirm some of the same issues that impact Māori midwives, but there were a few discreet issues specific to certain professional groups, which add to the broader picture of workforce needs documented in the companion reports for the Project.

The survey commenced March 2020 and ran for 8 weeks until it closed in May 2020. It was administered using the online Survey Monkey platform and it was open to adults aged 18 years and over who identified as Māori and worked with Māori mothers, babies, children and whānau.

The survey built on a method used by Te Rau Ora and reported in: [Te Iti me te Rahi, Everyone Counts. Māori Health Workforce Report, 2018](#), although the methodology was developed further in collaboration with the project partners, as well as findings from Rapua Te Aronga-a-Hine Literature review.

A total of 309 people responded to the survey that was administered Online. Respondents who answered less than 80% of the survey questions were excluded from the final analysis, which means the answers of only 235 respondents were analysed.

Summary

Respondents work in a range of professions or roles as shown in the figure.1 below:⁴

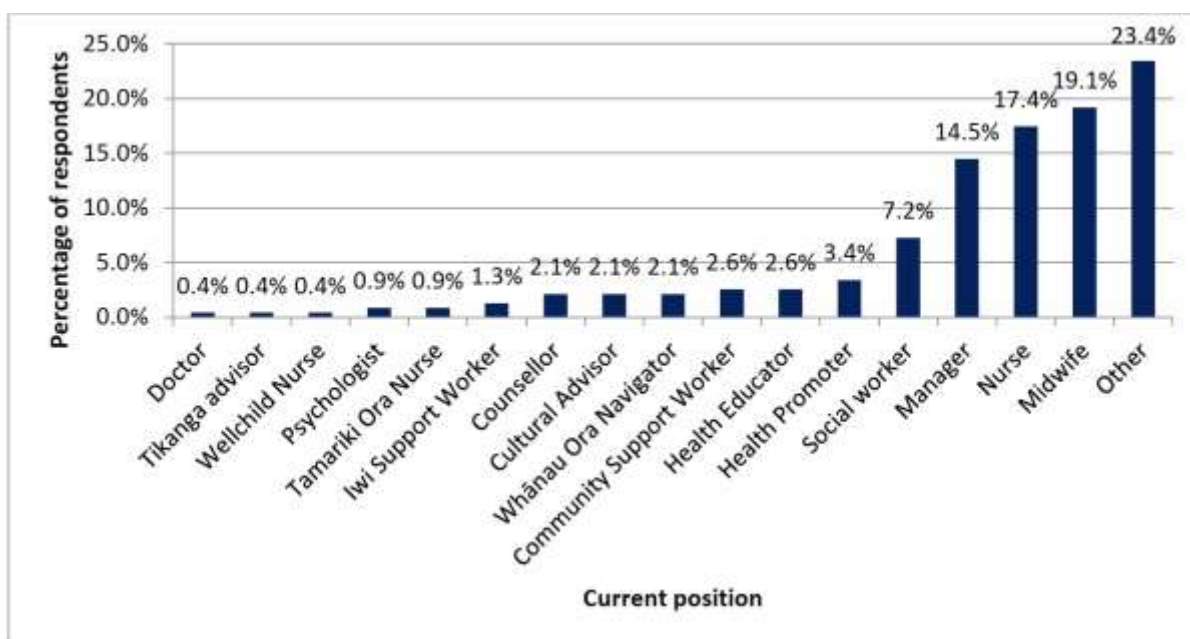


Figure 3: Current position of respondents.

Nearly 60% of the workforce has been in the health sector for 15 years or less.

Just under 50% of respondents work for a District Health Board and 35.7% work for a non-government organisation. Close to 60% of the Māori health workforce are employed by a mainstream health service.

Nearly two-thirds of the survey respondents were asked about the Treaty of Waitangi during their initial recruitment interview and just 59.6% recalled being tested or asked about cultural competence.

Just under 75% of all respondents in the survey had a minimum of an undergraduate degree. About 30% of all respondents were studying. Of those studying, 19.4% were studying towards an undergraduate degree and over 50% are studying towards a

⁴ Refer fig 14, page 20 - Kimihia te Aronga-a-Hine, The Māori Midwifery Workforce in Aotearoa: Workforce Report 2020

postgraduate qualification. These figures indicate that the Māori health workforce is becoming highly skilled. The increasing fluency of the Māori health workforce in health systems literacy, means they increasingly understand the importance of professional development and what it should look like to be credible and effective as Māori providing services to Māori communities. Critical areas for ongoing learning were identified in the survey shown in Figure 2.

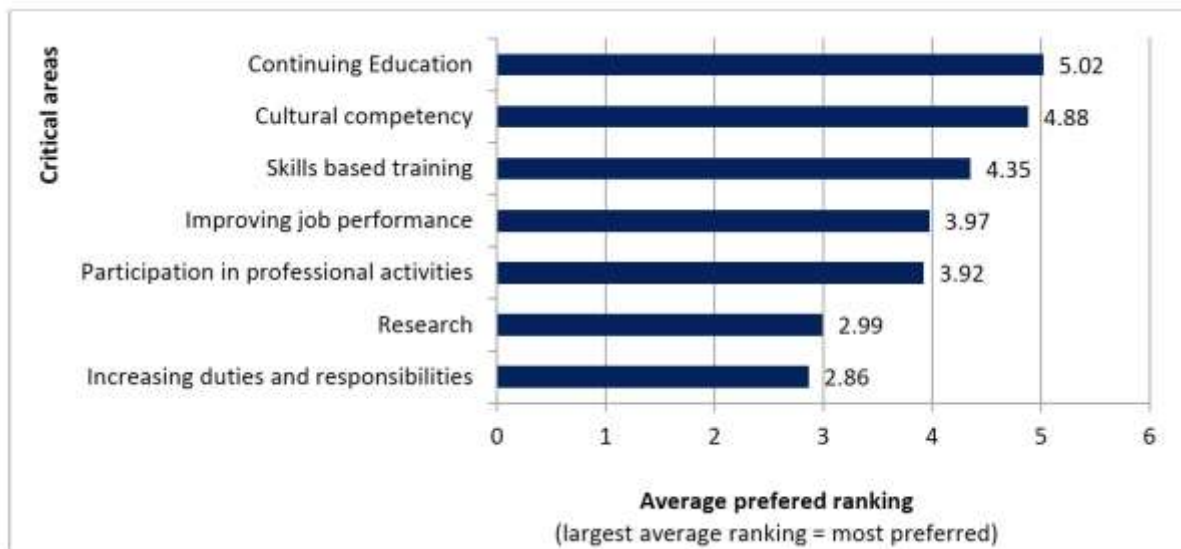


Figure 4: Critical Areas for Professional Development

Key factors identified to impeded or encourage workplace satisfaction are:

- Having a professional development plan in place that is tailored to the needs of the Māori workforce
- Employer support to engage marae/hapū/ iwi, and
- Having cultural supervision in place.

Conclusion

The report discusses a number of opportunities which are reiterated by all reports for the Project.

Recommendations come in two sections:

Pre-employment

Recruitment - Each of the following roopū must work together in a partnership and in a coordinated way:

- Health Workforce New Zealand
- Training institutions
- Iwi/ Community

Retention - Each of the following roopū must work together in a partnership and in a coordinated way:

- Health Workforce New Zealand
- Training institutions
- Iwi/ Community

Employment

Recruitment and Retention

- The Treaty of Waitangi is embedded
- Cultural competencies of health workers expected

Retention

- Have a professional development plan in place.
- Have cultural supervision in place.
- Provide dedicated leadership pathways.
- Employer support to engage marae/hapū/iwi/ Te Ao Māori
- Remuneration aligns with employee contribution.

1.5 Te Aronga-a-Hine Māori Midwifery Symposium

Hosted by Counties Manukau Health on July 28, 2020, at Ko Awatea, Middlemore Hospital. Organised by Heather Muriwai, Clinical Lead Advisor – Māori Midwifery (Māori Health).

The Symposium was preceded by a hui at Manurewa marae on Monday 27th July 2020, of Māori midwives from around the motu, that was facilitated by Heather and Kataraina Pipi.



The Symposium was opened by Hon Nanaia Mahuta and facilitated by Kataraina Pipi. Te Aronga-a-Hine researchers and guests presented in the following order:

- Dr Hope Tupara and Megan Tahere
- Beverley Te Huia
- Jean Te Huia
- Dr Kahu McClintock, Rachel McClintock, and Sue Stephens
- Hinewirangi Morgan
- Dr Naomi Simmonds
- Dr Maria Baker

1.6 Making Sense: Consolidating evidence of the needs of the Māori midwifery workforce and Māori women receiving midwifery services

Te Rau Ora arranged a feedback hui to representatives of the MOH as the funder of Te Aronga-a-Hine, which took place on 20 August 2020, at Te Rau Ora Kaiwharawhara Wellington office. MOH representatives present were Abby Hewitt (Maternity Team), Kiri Dargaville (Equity) and Ramai Lord (Senior Advisor, Nursing). Heather



Muriwai, Megan Tahere and Dr Kahu McClintock attended by Zoom. Dr Maria Baker and Hope Tupara were present at the venue with MOH staff.

Dr Hope Tupara and Megan Tahere prepared a power-point presentation titled "Making Sense", based on consolidated findings of Te Aronga-a-Hine, and a discussion ensued, with a request for ongoing commitment from MOH for further engagement to progress recommendations to correct inequities in the maternity system.

Part Two: Consolidated Themes and Recommended Actions

Rapua Te Aronga-a-Hine identified significant barriers to revolutionise the maternity landscape for Māori. Many of the challenges are reiterated in the research summarised in this document, which have since been reaffirmed anecdotally by Māori midwives, Māori women and the wider Māori health workforce. Despite the obstacles in the way of change, there are opportunities. Common themes arose from the outputs of the Project and they are aligned to the bold proposals recommended for Maori health and wellbeing, by the review of the Health and Disability System 2020. The themes are not new. For Māori midwives, this is one of many times they have recorded their worries, their frustrations, and their aspirations. They are unlikely to desist pressure on the profession, on the government and policy makers. Underpinning the entire change process is the

commitment by government to become a Te Tiriti partner in every sense of the word and aspirations of rangatira who signed Te Tiriti in 1840.

A revolutionary reset is required to correct the unequal and inequitable position of Māori women and Māori midwives. For many years, Te Tiriti, as a founding document of Aotearoa with its principles (partnership, participation, and protection), have for Māori, remained as words on paper with no practical substance. This has been affirmed by all the Te Aronga-a-Hine reports.

The disproportionate preference of Tauwiwi appointments to influential and leadership positions in comparison to Māori is observed across all levels of the health sector. The Ministry of Health (MoH) comprises a maternity team of which Tauwiwi have been appointed to all positions. This provides an example of the systemic inequality experienced by Māori midwives.

The MCNZ is established under the Health Practitioners Competence Assurance Act 2003 (the Act). The principal purpose of the Act is to protect the health and safety of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.⁵ The MCNZ has neglected its responsibility to protect the health and safety of Māori women because it has failed to implement recertification requirements that ensure all midwives are competent to work with whānau Māori. Representation on the MCNZ is dominated by Tauwiwi, and consequently Māori as a Tiriti partner do not have an equal voice.

The systematic preference for Tauwiwi appointments to the MCNZ by the Minister of Health undermines the ethos of Te Tiriti, highlights the absence of a Tiriti framework for appointment to regulatory authorities, and disadvantages the decision-making capacity of the MCNZ by restricting the Tiriti partner perspective to one or two Māori appointees.

⁵ <http://www.legislation.govt.nz/act/public/2003/0048/latest/whole.html#DLM203319>

The MCNZ launched its review of their regulatory framework in May 2020. The appointment of both a Māori and a Tauīwi midwife to co-chair positions in the Aotearoa Midwifery Collaborative Reference Group is a positive step by the MCNZ towards adopting a Tiriti-led review process.⁶ This also provides the MCNZ with the opportunity to undertake a thorough examination of their organisational and operational practices and to prioritise embedding and implementing a Tiriti-led regulatory framework to assist with achieving equality and equity for Māori women and Māori midwives in Aotearoa.

The Partnership Model of Midwifery Practice states, “New Zealand women’s recognition of partnership under the Treaty, has facilitated their understanding of, and their demand for, midwifery as a partnership” (p.12).⁷ The NZCOM publication, *Continuity of Midwifery Care in Aotearoa New Zealand*.

Partnership in Action, states, “Te Tiriti recognises the unique place and status of Māori as the Indigenous people of Aotearoa New Zealand...The partnership model of midwifery, along with cultural safety and competence, has developed out of the history and context of New Zealand and, in particular, the model of relationship that is at the heart of Te Tiriti o Waitangi” (p.31).⁸

The Treaty of Waitangi was specifically referenced in the 2005 edition of the NZCOM *Midwives Handbook for Practice* (p.14).⁹ The removal of this paragraph from the latest 2015 edition (p.17)¹⁰ demonstrates a blatant contempt for Māori, disregards the principle of partnership with Māori under Te Tiriti, and discredits the foundation of the Partnership Model of Midwifery Practice. Despite the profession’s claim that the Partnership Model of

⁶ <https://www.midwiferycouncil.health.nz/aotearoa-midwifery-project/te-r%C5%8Dpu-pou-herengacollaborative-reference-group>

⁷ Guilliland, K., & Pairman, S. (1995). *The midwifery partnership: A model for practice*. Wellington, NZ: Victoria University Press.

⁸ <https://indd.adobe.com/view/9f196f31-57d3-4124-9c77-936a0d65dca6>

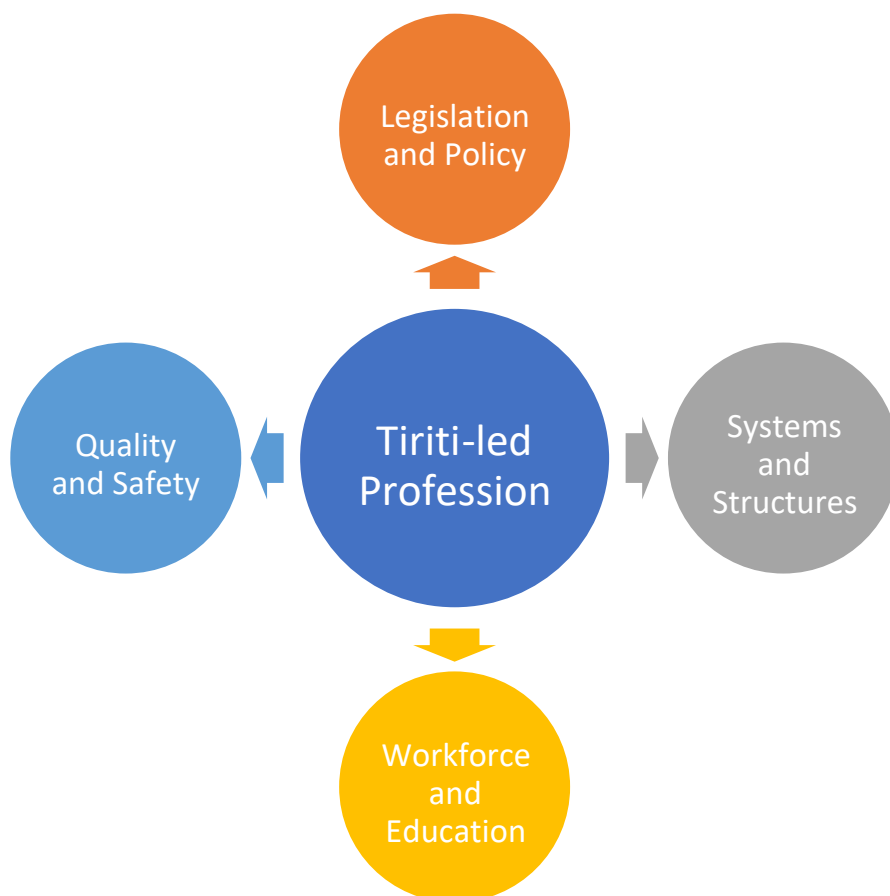
⁹ New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa. (2005). *Midwives Handbook for Practice*. Christchurch, NZ: New Zealand College of Midwives.

¹⁰ New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa. (2015). *Midwives Handbook for Practice*. Christchurch, NZ: New Zealand College of Midwives.

Midwifery Practice is underpinned by the sharing of power and equality, Te Aronga-a-Hine reports provide evidence to the contrary.

The Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, WAI 2575 Waitangi Tribunal Report 2019 (The Hauora Report) recommends operating under a Tiriti framework is necessary to address inequality and inequity. Commitment to Te Tiriti should be stated expressly in all documents that make up the policy framework of the primary health system; the strategies, the plans, and the so-called lower level documentation.¹¹ Figure 5 highlights the depth of work required to embed Te Tiriti across the profession, including the connections to government and the wider health system and professional structures.

Figure 5: Embedding Te Tiriti: A 360 degree approach



More specific recommendations arising from Te Aronga-a-Hine outputs singularly and collectively are captured in tables 2-4

¹¹ https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

Table 1: Rapua Te Aronga-a-Hine recommendations

Te Aronga-a-Hine Project Output	Recommended Action Areas			
	Legislation and Policy	Systems and Structures	Workforce and Education	Quality and Safety
Rapua te Aronga-a-Hine	<p>Embed Te Tiriti into all government legislation</p> <p>Develop measurement frameworks to monitor the implementation of Te Tiriti legislation and policy and create accountability mechanisms.</p> <p>Incentivise funding for improved health outcomes.</p> <p>Embed equality for Māori.</p> <ul style="list-style-type: none"> - Uphold Māori Data Sovereignty. - Change the perception of Māori philosophy. - Mātauranga Māori and Māori values at the core. 	<ul style="list-style-type: none"> - Achieve equality for Māori. - Create Te Tiriti-led partnerships. - Embed and implement a Te Tiriti-led profession. - Conduct a review of the MCNZ cultural competence framework. - Challenge the status-quo to achieve system equity. - Fair and deliberate investment in Māori midwifery. - Reconciliation of grievances, restoring a 'clean slate' for the profession to build upon. - Conduct a national systematic review of maternity services in Aotearoa to understand: <ul style="list-style-type: none"> - Consistency and/or variance of investment in service provision across the country. - Adequacy of services for Māori women. - Level of inequity that exists. - How we could disinvest and invest to achieve a sustainable health and disability system and achieve budget stability. 	<ul style="list-style-type: none"> - Establish a Māori midwifery school. - Fund and support the undertaking of Māori midwifery and childbirth research by Māori to build on the Māori childbirth body of knowledge. - Build Māori midwifery leadership capacity. - Cohort approach to recruitment and retention. 	<ul style="list-style-type: none"> - Comprehensively analyse maternity service data and performance to affect revolutionary change. - Accountability for decisions and actions. - Transparent and authentic communication. - Shared guardianship of birthing outcomes. - Uphold professional integrity. - Continually critique, develop, and refine the way we work. - Optimise the First 1,000 Days for each child in Aotearoa by focusing on a healthy mother, a healthy pregnancy, and a healthy early childhood. - Develop and implement a comprehensive First 1,000 Days model of care that takes a systems view, prioritises whānau ora, and offers a suite of care initiatives that achieves equity for Māori, and is locally responsive, strengths based, and systems orientated.

Table 2: Recommendations from Ngā Māmā and Kaiwhakawhānau Māori

Te Aronga-a-Hine Project Output	Recommended Action Areas			
	Legislation and Policy	Systems and Structures	Workforce and Education	Quality and Safety
Whāia te Aronga-a-Hine Ngā Māmā	Strengthen the presence of Te Tiriti and the principles of partnership, protection, and participation.	<p>Conduct an inquiry into human rights breaches occurring in maternity services.</p> <p>Conduct an inquiry into breaches of the Code of Health and Disability Services Consumers' Rights occurring when whānau Māori engage in maternity services.</p>	<p>Increase the Māori midwifery workforce to meet the demand of Māori birthing women.</p> <p>Workforce plans to increase the capacity for a match between the ethnicity, cultural identity, and world view of the midwife and woman</p> <p>Embed anti-racism education</p>	<p>Improve whānau experience across the health sector.</p> <p>Embed tikanga Māori. Culturally tailor pregnancy and parenting education.</p> <p>Provide a suite of social supports in addition to midwifery care.</p>
Whāia te Aronga a Ngā Kaiwhakawhānau Māori	<p>Affirm Te Tiriti relationships.</p> <p>Protect Māori birthing and childrearing knowledge and practices.</p> <p>Co-design clinical and cultural policy frameworks with Māori midwives.</p> <p>Invest in the Māori midwifery profession.</p>	<p>Embrace Te Tiriti across the health sector.</p> <p>Review the Ngā Māia Trust governance and organisational structure.</p> <p>Establish and affirm a Tiriti-led relationship between Māori midwives and the MCNZ and NZCOM.</p> <p>Develop and implement kaupapa Māori orientation processes and procedures.</p>	<p>More in-depth research into the needs of Māori midwives to inform development of a Māori miwifery workforce strategy</p> <p>Support the development of kaupapa Māori education.</p> <p>Invest in different pathway for Māori leadership capacity, and postgraduate study.</p> <p>Remunerate the added value that Māori professionals bring to the workforce</p> <p>Develop and implement a tuakana teina mentoring model</p>	<p>Review and update the Tūranga Kaupapa education framework.</p> <p>Establish a strong public image of Māori midwifery and Māori birthing and childrearing practices.</p> <p>-</p> <p>Develop a Māori midwifery research agenda that includes identifying the needs of whānau.</p> <p>Develop and implement a kaupapa Māori MSR framework.</p> <p>Integrate kaupapa Māori and tikanga Māori into all practice settings.</p>

Table 3: Recommendations from the Māori Health Workforce Survey

Te Aronga-a-Hine Project Output	Recommended Action Areas			
	Legislation and Policy	Systems and Structures	Workforce and Education	Quality and Safety
Kimihia te Aronga-a-Hine	Incorporate Te Tiriti into workforce recruitment and retention processes	Employers value and actively demonstrate marae, hapu and iwi engagement The cultural needs of the Māori health workforce is acknowledged and comprise options in individual professional development frameworks	Provide for professional development opportunities for Māori include te reo Maori and Māori focussed training. Acknowledge the added value of the Māori workforce and reflect this in salary remuneration Dedicated Māori leadership pathways for the health workforce are supported and funded Cultural supervision is a compulsory component of professional development plans.	The Māori health workforce is culturally competent to work with whānau Māori The health workforce is culturally competent to work with whānau Māori.

Conclusion

Te Aronga-a-Hine has helped to put a spotlight on the Māori midwifery workforce and the wider Māori health workforce engaged with providing services to Māori women, babies, children and whānau, that has not been done before. The realities of persistent and long-standing workforce inequities expressed anecdotally by Māori midwives are confirmed by all the outputs of Te Aronga-a-Hine.

Inequities faced by Māori midwives in the profession and those Māori working in the health system, mirror experiences by Māori women using maternity services and more broadly, health services. The discrimination felt by Māori midwives and Māori women show up consistently as poor education, workforce, and health outcomes, which are exacerbated by a disconnected and siloed health system in Aotearoa which favours the dominant population and people in positions of power.

Te Aronga-a-Hine has initiated the beginning journey for even further work. The recommendations provided in this summary document, are based on four reports, feedback from the Māori Midwifery Symposium, and ongoing discourse amongst the Māori midwives since, all of which point to an urgent need to correct the inequalities. The Māori health workforce such as Māori midwives desperately need backing from the health system and leadership of Aotearoa to help lift whānau wellbeing starting now.

References

McClintock, K., Stephens, S., & McClintock, R. (2020). Kimihia te Aronga a Hine Workforce Survey Report 2020. Te Kīwai Rangahau, Te Rau Ora. ISBN: 978-0-473-53486-8. Available online at: <https://terauora.com/>

Te Huia, B. (2020). Whaia Te Aronga-a-Hine – Ngā Māmā Report 2020 Ngā Maia, Māori Midwives. Aotearoa. New Zealand. Published September 2020. ISBN 978-0-473-53891-0. © Te Rau Ora.

Te Huia, J. (2020). Whaia te Aronga a Ngā Kaiwhakawhānau Māori: The Māori Midwifery Workforce in Aotearoa. Te Rau Ora. Published September 2020. ISBN 978-0-473-53819-4. © Te Rau Ora.

Tupara, H., & Tahere, M. (2020). Rapua te Aronga-a-Hine: The Māori Midwifery Workforce in Aotearoa, A Literature Review - February 2020. Wellington, NZ: Te Rau Ora. ISBN: 978-0-473-53501-8. Published International Midwives Day, 5 May 2020.

Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*. Wellington: Waitangi Tribunal. URL: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf (accessed 30 May 2020).