## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgment</td>
<td>1</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>2</td>
</tr>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>Results</td>
<td>2</td>
</tr>
<tr>
<td>Background (literature)</td>
<td>4</td>
</tr>
<tr>
<td>Te Tiriti O Waitangi</td>
<td>4</td>
</tr>
<tr>
<td>Colonisation</td>
<td>4</td>
</tr>
<tr>
<td>Health Inequity</td>
<td>5</td>
</tr>
<tr>
<td>Wahine Māori</td>
<td>6</td>
</tr>
<tr>
<td>Whānau – The Medicalisation of Childbirth</td>
<td>7</td>
</tr>
<tr>
<td>Midwifery Model</td>
<td>8</td>
</tr>
<tr>
<td>Access</td>
<td>9</td>
</tr>
<tr>
<td>Adoption and Child Youth and Families</td>
<td>10</td>
</tr>
<tr>
<td>Grievance and Treaty claims</td>
<td>11</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>13</td>
</tr>
<tr>
<td>Chapter 2: Methodology</td>
<td>15</td>
</tr>
<tr>
<td>Recruitment</td>
<td>15</td>
</tr>
<tr>
<td>Participants</td>
<td>16</td>
</tr>
<tr>
<td>Questions</td>
<td>16</td>
</tr>
<tr>
<td>Analysis</td>
<td>17</td>
</tr>
<tr>
<td>Chapter 3: Results</td>
<td>18</td>
</tr>
<tr>
<td>Demographic indicators</td>
<td>19</td>
</tr>
<tr>
<td>Age of Participants</td>
<td>19</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>20</td>
</tr>
<tr>
<td>Region Representations</td>
<td>20</td>
</tr>
<tr>
<td>Pregnancy and Gravida</td>
<td>22</td>
</tr>
<tr>
<td>Whāngai</td>
<td>23</td>
</tr>
<tr>
<td>Workforce</td>
<td>24</td>
</tr>
<tr>
<td>Acceptability of Care</td>
<td>24</td>
</tr>
<tr>
<td>Translation of Graph</td>
<td>25</td>
</tr>
<tr>
<td>Reasons for Change</td>
<td>25</td>
</tr>
<tr>
<td>Tāpuhi – Māori Midwives</td>
<td>26</td>
</tr>
<tr>
<td>Culturally Skilled Workforce</td>
<td>27</td>
</tr>
<tr>
<td>Accessibility</td>
<td>28</td>
</tr>
</tbody>
</table>
"Whakapapa is a series of never-ending beginnings" (Moana Jackson, 2008)

Moana Jackson explains that the stories we tell, as Māori, are not always new.

To the wāhine and whānau who shared their purakau and whakapapa so generously and freely, we humbly thank you. During the course of the research, your insight, intuition, and desires were expressed and felt so that this report could be prepared and shared, with the vision of a better future for Māori.

In sharing your purakau, you add to the sequence of traditions and tribal histories that trace the experiences of the wāhine from papatuanuku, and to you, we will always be eternally grateful.

"We do not need anyone else developing the tools which will help us come to terms with who we are. We can and will do this work. Real power lies with those who design the tools – it always has. The power is ours. Through the process of developing such theories, we will contribute to our empowerment as Māori women, moving forwards in our struggles for our people, our lands, our world, ourselves. (Irwin, 1992:5).

Nga mihi nui ki a koutou


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EXECUTIVE SUMMARY

INTRODUCTION

In response to the rising pressure on the maternity workforce and increase demands from Māori to have a health system that meets Te Tiriti obligations and address the unacceptable health inequities, Te Rau Ora in partnership with Ngā Maia Māori Midwives Aotearoa (New Zealand) and Counties Manukau Health District Health Board (DHB), were tasked by the Ministry of Health to develop the evidence base to inform health workforce priorities. The focus of which is Māori women, babies, children, and whānau (families). Rapua te Aronga a Hine: The Māori midwifery Workforce in Aotearoa, a Literature Review – February 2020 (Tupara & Tahere, 2020) was the first step by the partners to establish an evidence base that describes the Māori midwifery landscape and nuances of the workforce.

Kimihia Te Aronga a Hine Workforce Survey (Mc Klintoch, 2020), was the next step to collect information and knowledge from the workforce industry who are task with caring and meeting outcomes for maternal mothers, their babies, children and whānau.

Whaia Te Aronga a Hine Ngā Māma (Te Huia, 2020) and Whaia Te Aronga a Kaiwhakawhanau Māori (Te Huia, 2020), is the final component to this four-part series. It provides evidence with the qualitative descriptions, views, and Mātauranga (knowledge) from Māori māma and Māori midwives who have experienced the maternity care system in New Zealand and who also come with knowledge from the past which has shaped their outlook of maternity care today.

The objective of Whaia te Aronga a Hine Māma is to provide a kaupapa Māori analysis of the qualitative findings shared by Māori māma of their experience of the maternity care workforce. In conclusion, recommendations and critical priorities for change are made.

RESULTS

The findings of Whaia te Aronga a Hine Māma, identified a maternity system that provides a vastly different experience for Māori women and their whānau to that designed and built on principles of ‘partnership, protect, and participation.’
The results point to the harsh reality of a system grappling with Tiriti obligations and colonisation’ hangover’, unsatisfied workforce, workforce shortages, and a long-existing culture of cultural inappropriateness and racism towards Māori.

The sustained assimilation policies throughout generations and imposed British culture of female inferiority and male dominance have seen the diminishing and disregard of Māori women and their voices. Their muted callings have culminated in the maternity inequities experienced by Māori women, their babies, and whānau today.

Childbirth is a significant cultural event for Māori people. Māori women want Māori Midwives to care for them during this time to protect and hold this space. When they can not find a Māori midwife, they want to experience a workforce that is accepting of them and their unique difference as Tangata Whenua (indigenous people of Aotearoa). Through Te Tiriti, Māori women want to feel reassured the care they receive from health care professionals is nonjudgemental, safe of an equal level to that which is given to all other women.

Māori women want maternity carers who respect and support their cultural difference, not to provide it. They want to be acknowledged as an extension of a collective whānau unit and not as an individual seeking care in isolation and alone.
BACKGROUND (LITERATURE)

Relevant historical and contemporary descriptions concerning maternal and infant health care in New Zealand is contained in this background.

TE TIRITI O WAITANGI

Te Tiriti o Waitangi is intended to provide for a mutually beneficial relationship between Māori and the Crown. The New Zealand health system is obligated to give proper and full effect to Te Tiriti and its principles (Waitangi tribunal, 2019).

A consideration of Te Tiriti o Waitangi provides a critical context. Understanding the rights of Māori women, their pēpi and their whānau as Tangata Whenua (people of this land), the distinction between Health care, in particular, maternity health care which is defined by the New Zealand Government and its agencies and Tikanga Māori, which existed before the arrival of British explorers and their laws and as an expression of Tino Rangatiratanga is considered in this report.

COLONISATION

This report challenges the view that colonisation only lives in history and something that ended in the nineteenth century, when in fact, colonisation is underpinned by assimilative policies and practices that began in the nineteenth century (Reid, Rout, Tau & Smith, 2017). It continues today, leaving a legacy of New Zealanders grappling with truly honoring Te Tiriti. The struggle is further compounded by waves of diverse immigrants that add layers of complexity to the issue (Dawson, 2020).

New Zealand’s colonial history and compounding eurocentric policies and practices continue to impose social, political, and economic structure upon Māori as Indigenous people of Aotearoa without their consultation, consent, or choice. As such, Māori have a distinct status and specific needs relative to others in New Zealand.

“One of the most damaging effects of colonisation for Māori women was the destruction of the whānau. It was clear right from the outset that Māori collectivism was philosophically at odds with the settler ethic of individualism”. (Mikaere, 1994).

Much recent literature is devoted to the wellbeing of Māori women and their whānau (Durie, 1994; Mikaere, 2011; Pihama, 2014; Smith. 1999). They too, acknowledge the continuing health inequities linked to loss of lands, loss of self-governance, and language
resulting in the near loss of culture and traditions. This ongoing problem contributes to the disparities in the health of maternal Māori women. While indeed, colonisation brought opportunity and growth for Māori, Cram (2019) argues the short-lived prosperity is outweighed by the severe and persistent negative impacts on oranga (health and wellbeing) for Māori (Cram, William, William, Te Hui a Te Huia, 2019).

**HEALTH INEQUITY**

Health inequity, including maternal and infant health inequity, is typically measured and demonstrated by differences in health status, health outcomes, and experiences of health care across groups of demographically distinct people (Dawson, 2019). For Māori women and their babies, their health outcomes are significantly worse than those of other New Zealanders, which represents a failure of the maternity health system and does not reflect Te Tiriti commitments (Health and Disability System Review, 2020). It has long been recognized that differences in health outcomes vary dramatically as a function of clinical factors and social determinants of health.

"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognizes different people with different levels of advantage require different approaches and resources to get equitable health outcomes". (HDSR, 2020 p. 33)

In seeking to understand the reasons for differences in maternal status and outcomes, it is essential to acknowledge the journey of Māori women and their experience with maternity care in Aotearoa, and for many, these experiences are intergenerational.

Mostly, health care in New Zealand is a socialized, universal health care system, with maternity care free to all New Zealanders, from primary to tertiary level, unless a woman chooses to pay for a private obstetrician (Dawson, 2019). The key difference in New Zealand compared to many other countries is that Midwives have a significant role in Aotearoa as primary maternity care providers, with the majority of women (87% in 2017) cared for by autonomous, self-employed midwives. This rate is even higher for Māori women at (92%) (Tupara & Tahare, 2020, p21).

This midwifery-led model is often promoted as the 'gold standard' for maternity care and was also touted as a significant contributor to reducing inequity during the 1990s reforms. However, inequity issues in maternal morbidity studies have persisted, and over-representation of poor maternal outcomes for Māori continues (Dawson, 2019).
In 2017 Māori women made up 25% of all women who gave birth in New Zealand despite only being 8% of New Zealand's population, and despite an overall decline in total births, the Māori birth rate continues to grow. The projected Māori population growth rate is an average increase of 1.4% annually with a projected Māori population of 827,230, and a birth rate of 26% of the total births by 2030. The drivers for this increase for Māori include a higher fertility rate of 2.34 compared with 1.92 for New Zealand. Another contributing factor is that the Māori population has a younger age structure, with a large population within the reproductive ages of 15-44 years, and Māori have more babies than non-Māori. Combined, this provides a built-in momentum for future population growth (MOH, 2015).

However, their experiences of maternity and infant care are far different from others in Aotearoa. Māori women and their pēpi are over-represented in health inequities and adverse or sub-optimal maternity outcomes. Also, Māori women and whānau continue to experience persistent inequities across socioeconomic determinants of health and risk factors that impact on their wellbeing throughout the maternity continuum. (Tupara & Tahere, 2020).

The ninth annual report by Perinatal and Maternal Mortality Review Committee (PMMRC) (2015) identified that Māori had significantly higher rates than non-Māori in; perinatal related deaths, stillbirth, and neonatal deaths, intrauterine growth retardation (IUGR), premature birth and antepartum haemorrhage (PMMRC, 2015). Māori infants also die more frequently from sudden infant deaths and low birth weight than non-Māori children (Abel & Tipene-Leach, 2013). They are also less likely to receive life-saving treatment because they are Māori (PMMRC, 2015), which is associated with 'institutional bias or implicit biases' or understood by others as 'Institutional racism.'

Rumball-Smith (2012) analyzed the relationship between maternal outcomes and process of care, including rates of cesarean section, induction of labor, instrumental vaginal delivery, and epidural analgesia and discovered that Māori women all had lower intervention rates despite being at higher risk of poor outcomes in pregnancy (Dawson, 2020).

This narrative of health inequity focuses on the assimilation of Māori into colonial models, and not surprisingly, it also intersects or converges with other contributory factors such as government policies and practices. The maternity care system is part of a much more extensive network of assimilation driven by government policies and practices that
contribute to the development of Māori – Pākeha disparities in health. This report concurs with Cynthia Kiro’s (2001, p78) view that ‘what affects the health of Māori lies more outside the gambit of the health sector than within it,’ and thus extends a wide-ranging account of how colonial history and continuing assimilation policies have formed the backdrop to maternity care experienced by Māori in Aotearoa.

WHĀNAU – THE MEDICALISATION OF CHILDBIRTH

Before the 1904 Midwives registration Act, Māori birth was a ritual performed within the safety and support of Te Ao Māori. The knowledge of birthing and whakapapa passed down and between, through Ori Ori (ancient chants) even before conceptions, laying before the baby their future. These traditions and knowledge, both practical and spiritual, helped to guide birth outcomes for Māori (Tikao, 2014).

The Midwives Act (1904) provided for the registration of midwives and gave to the establishment of State maternity hospitals and for the training of midwives within them. At this time, there was no official record of data for Māori birthing, and giving birth within these facilities was not free, and so the majority of birth were performed at home. For the next 30 years, Māori continued to practice tāpuhi (midwifery practice) within their homes while Pākeha birthed in institutions (Clarke, 2012).

In 1908, the Tohunga Suppression Act was passed out of concern over the practices of some Tohunga. It was a critical contributory factor to the loss of traditional Māori birthing practices as it effectively outlawed Māori childbirth practices (Sweetman, 2013).

By 1925 the Nurses and Midwives Act formalized the courses of training and approved the institutions of training and hospitals. That Act also provided a penalty for persons not so registered carrying out the duties of a midwife or maternity nurse (Maclean, 1932). At the same time, 58% of births were occurring in hospitals; however, this cannot be verified as fewer the 60% of Māori registered their birth (Banks, 2000).

Harris et al., (2007) has captured the birthing experience of two Māori women from that time, which support Māori birth practices retained within their hapū boundaries, amongst their kin. Over the next 50 years, there was a steady movement of birth from Whenua Māori into hospital institutions, and by 1938 Hospital births represented 87% Pakeha and 18% Māori.

At the same time, advancements were being made within the medical field in science and technology, including pain relief. Women were encouraged by their doctors to give
birth in the safety of a hospital. When Māori women were slow to move into hospitals to birth, the State began to link eligibility for benefits to birth registration, which had to be done at hospitals with doctors in attendance. Over the following three decades, Māori birthing became almost entirely institutionalised, so that by 1967, 95% of Māori births occurred in the space of the hospital. The marginalisation of mana wāhine existed in a very material sense, forcing many Māori women to birth in foreign spaces. (Simmons, 2014)

The Introduction of the Nurses Act 1971, effectively ended any remaining autonomy enjoyed by Tapuhi and midwives by making it an offense to carry out ‘obstetric nursing’ (Harris, 2007 & Sweetman, 2013).

The Amendment to the Nurses Act (1990) turned autonomous Midwifery practice back around. Still, it was too late for Māori as the knowledge of childbirth, and the confidence in their traditional methods had vastly diminished.

**MIDWIFERY MODEL**

The Lead Maternity Carer (LMC) model in Aotearoa is led by primary care midwives, providing continuity of care within a partnership model. The midwifery partnership model is aligned with the principles of partnership, protection, and participation in the Treaty of Waitangi (Guilliland & Pairman, 2010).

The midwifery-led continuity model is often promoted as the gold standard for maternity care for low-risk women, who report fewer interventions and higher satisfaction than with other models such as medical-led or shared care (Sandall et al., 2016). It is also touted as a significant contributor to the reduction of inequity, even so, maternal health inequity persists in outcomes, care processes, and Māori women's experience within this model (Dawson; 2019).

Dawson (2019) points to underlying power imbalances between clinician and patient relationship as a mechanism associated with persistent inequity and, therefore, cannot be relied on in practice. “This is often exacerbated when the clinician is from a dominant and privileged group and the patient from a vulnerable population” (Dawson, 2019 p. 8).

The stories of Māori māma in this report ameliorate these findings and support Ratima & Crengle (2013), Kenney (2011), Te Huia (2015), Lawton (2014) that Māori women prefer a maternity carer of their ethnicity/cultural background. Reasons for this include cultural compatibility and understanding, and an equal partnership with the midwife. (Ratima & Crengle, 2013; Kenney, 2011; Te Huia & Wepa, 2015; Lawton, 2014).
However, this glaring gap of inequities for Māori women points to more severe systemic failures of a maternity system and the professional bodies that represent them. The midwifery model and the partnerships which developed between the different organisations and groups that provided the political clout which brought about change, continues to be relevant today. Failure to consider the proper place of Te Tiriti and Māori as having a lead role has occurred since its inception. The midwifery professional bodies, New Zealand College of Midwives, Midwifery council of New Zealand overarched by the Ministry of Health, have shelved, impeded, and under-resourced for the proper inclusion of an independent Māori voice. For example, the current co-design discussions around equity are promoted as a partnership model between the NZCOM and MOH (MOH, 2020). Nga Māia Māori midwives referred to by maternity professional groups as the national Māori Midwives collective to affirm Māori knowledge (Grigg, 2012) have been excluded from the current discussions which may ultimately have an impact on the future model and direction of maternity care in New Zealand and the way Māori women experience this care.

The literature review has identified Ngā Māia representation on various professional committees and boards as limited by its capacity and capability amongst its members in governance, regulation, disciplinary procedures, peer review, research, advisory, and education roles. The low number and significant under-representation of Nga Māia Māori midwives at all levels of the midwifery profession often results in narrow and superficial consultation with Māori midwives that see the broader view of the cohort excluded. This continued resistance to acknowledging Nga Maia as a political authority to assert change ignores the Ministry of Health, New Zealand College of Midwives and Midwifery Council of New Zealand’s commitment to te Tiriti and denies Māori their rightful place.

**ACCESS**

For vulnerable populations, especially Māori, the choice of maternity carer is vital for achieving the best outcome. Currently, there are few alternatives to lead maternity care for women to choose from, and the literature indicates that there are substantial differences in how access to maternity care is sort (Tupara & Tahere, 2020). Navigating the system to engage with care is challenging, and there exists a variety of barriers, including economic and geographical location. Cultural factors are also identified by Cram (2013) as a barrier for young Māori women in engagement with the maternity care system. However, systemic issues leading to workforce shortages mean women have fewer midwives to select from, making it difficult to find any LMC at all (Dawson, 2019).
This acute maternity workforce shortage is severe in rural areas (NZ College of Midwives, 2016); thus, the geography where there is no or limited local service available due to the LMC shortage, in turn, restricts the choice of career, disadvantaging Maori women. For instance, Lawton et al. (2013) found that young Māori women would give up looking for a midwife if calls were not returned, or the first midwives they approached had full caseloads. Women in rural areas may need to travel to main centers to access specialist care during antenatal checks or epidural anesthesia during labour. Travel associated with specialist care has an economic cost for women.

Also, the difficulty in accessing available services and social issues such as problems with child care, accessing transport, and having to attend clinic visits rather than home visiting is more commonly experienced by Māori women (Tupara & Tahere, 2020 & Dawson, 2019).

ADOPTION AND CHILD YOUTH AND FAMILIES

In July 2019, Māori gathered for a ‘Hands off our tamariki’ hikoi to Parliament. Those on the hikoi called for a change to the child welfare system where Māori tamariki are over-represented and where uplifts of Māori babies soon after their birth have increased over the previous 3-5 years. In 2018, 283 babies were taken into care, with three Māori babies uplifted each week (on average) and a disproportionate number of Māori babies in the welfare system (Peacock, 2019).

Such criticisms of the treatment of Māori whānau within our state-sponsored welfare system are not new. The migration of Māori to urban centers after the second world war brought whānau into contact with a state-sponsored child welfare system that did not recognise the role of whānau in the raising and care of children (Duncan & Worrell, 2000; Libesman, 2004). Legislation enacted (e.g., Adoption Act 1955) during the time side-lined Māori beliefs and practices and further disadvantaged Māori within this monocultural child welfare system (Love, 2006; Mikaere, 2002) and successive governments ‘refused to allow a traditional parallel system to continue to exist’ (Pitama S., 1996). A consequence for Māori was the widespread use of an intervention of last resort—child removal—by a child welfare system unwilling to recognise its own systemic racism, let alone the intergenerational trauma wrought by colonisation on Māori whānau (Love, 2006).

This history of child welfare in Aotearoa, New Zealand, has vast repercussions. The over-representation of Māori in state and non-whānau care impacts on whānau, hapū, iwi and
Māori communities, in addition to Māori birthing parents (Love, Makarinin, Waldegrave, Nguyen, & Makarini, 2019).

For those birthmothers who did have children taken from them, the emotional and psychological effects have been severe and hindered not only the progress of the birth mother and child but also the hapū. The emotional effects encountered included grief, depression, anger; however, the most detrimental is the effect of such loss on one’s spirit (Pitama, 1996 pp. 13-14).

While this report is primarily about the maternity workforce in Aotearoa, changes to the Children, young persons, and their families legislation Act have legitimised the fear of Māori women’s trauma from her intersection with the New Zealand Child welfare system is causing an immense distrust in maternity system, and maternity care workers labeled ‘watchdog’ for the State.

GRIEVANCE AND TREATY CLAIMS

The numerous Te Tiriti claims and claimants are a testimony of the dissatisfaction and massive upheaval Māori are forced into. Often Te Tiriti claims through the Waitangi Tribunal are brought about only after exhausting all other avenues to bring about positive reforms to support Māori. The tribunal process is long and enduring, and often claimants die waiting to be heard.

Of particular relevances, the Mana Wahine, Maternal health, uplifting of Māori children’s treaty claims speak of the lost generations which Māori women have endured by the persistent attacks on their traditions and cultural practices. "A perusal of the extensive writings on the Treaty reveals that the status, existence, and rights of Māori women guaranteed under the Treaty has never been addressed not actively protected through legislation. It is perhaps this issue which has been the motivating influence behind Māori women’s “mana wahine” claim to the Waitangi Tribunal” (Sykes, 2000).

These claims assert the Crown’s actions and policies have systematically discriminated against Māori women and deprived them of their spiritual, cultural, social, and economic wellbeing, which were entrenched in Māori traditions and which is protected by the Te Tiriti o Waitangi (Johnston & Pihama, 1994).

Stage one of the Health Services and Outcomes kaupapa inquiry through the Waitangi Tribunal, better known as the Wai 2575 claim, acknowledged that the health of Māori had not improved despite health reforms targeting this issue. During the two-week hearing at
Ngārawahia Marae, the nation heard, and the Crown acknowledged that the health system was failing to ensure equitable health outcomes for Māori.

Director-General of Health, Dr. Ashley Bloomfield, stated:

"The State of health for Māori is unacceptable, and it is the core business of the New Zealand health and disability system to respond effectively—as required by the New Zealand Public Health and Disability Act (2000). There is still considerable work needed to achieve equitable health outcomes between Māori and Non-Māori. This has been an ongoing issue for the primary health care system and one that is not acceptable or tolerable." (Waitangi Tribunal, 2019)

What was interesting, from the Tribunal perspective, was that the Director-General was repeating in 2018, nearly word for word, a statement published in 2006 in the Māori Health Chart Book. (Waitangi Tribunal, 2019)

Despite the key priority set in 2006, the evidence is that this situation has not measurably improved. Despite attempted reforms and readjustments since 2000 intended to deal with inequities, and despite government policy statements and reports acknowledging failure in this regard, these inequities in Māori maternal health status persisted in the nearly two decades since the Act was passed.

The Tribunal found serious Treaty breaches concerning the way the Crown holds the primary health care sector to account and reports on its performance, seeing that there were few mechanisms in place to ensure accountability to Māori health. Furthermore, the Tribunal found that the Crown fails to ensure that Māori has adequate decision-making authority and influence when it comes to the design and delivery of primary health care services (Waitangi Tribunal, 2019).
In response to the rising pressure on the maternity workforce and increase expectations from Māori to have a health system that meets Tiriti obligations and address the unacceptable health inequities, Te Ra Ora in partnership with Ngā Maia Māori Midwives Aotearoa (New Zealand) and Counties Manukau Health District Health Board (DHB), were tasked by the Ministry of Health to develop the evidence base to inform workforce priorities with a focus on Māori women, babies, children, and whānau (families). Rapua te Aronga a Hine: The Māori midwifery Workforce in Aotearoa, a Literature Review – February 2020 (Tupara & Tahere, 2020) was the first step by the partners to establish an evidence base that describes the Māori midwifery landscape and nuances of the workforce.

Kimihia Te Aronga a Hine Workforce Survey (Mc Klintoch, 2020), was the next step to collect information and knowledge from the workforce industry who are task with caring and meeting outcomes for maternal mothers, their babies, children and whānau.

Whaia Te Aronga a Hine Māma (Te Huia, 2020) and Whaia te Aronga a Kaiwhakawhanau Māori (Te Huia, 2020), is the final component to this four-part series. It provides evidence with the qualitative descriptions, views, and Mātauranga (knowledge) from Māori māma and Māori midwives who have experienced the maternity care system in New Zealand and who also come with knowledge from the past which has shaped their outlook of maternity care today.

The word ‘turbulence’ is used in the literature review to describe the history of the maternity care system in Aotearoa. While others would disagree with this description, it is evident for the Māori population of Aotearoa (New Zealand) this maternity system is far less than ideal. Māori women and their babies continue to experience inequitable maternal and infant health outcomes. Explanations for why Māori continue to suffer disproportionately to Pakeha are influenced by many factors outside the formal health system. It has been proposed that the determinants of ethnic inequalities in birth outcomes are multifaceted, which accumulates over the life course of the mother. That recognised maternal risk factors, even when considered in combination, do not account for the full extent of ethnic disparities in the birth outcome (Ratima & Crengle, 2013).
Harris et al. (2007), supports this in a review comparing Caesarian section rates of Māori and non-Māori. It was concluded that non-clinical factors might be contributing to ethnic differences, and while deprivation contributes to this difference, it does not fully explain it.

Whaia te Aronga a Hine ngā Māma, captures the experience of 19 wāhine of our maternity workforce and system. Their realities are revealed in this report and the concluding recommendations and critical priority for change.
CHAPTER 2: METHODOLOGY

The existing body of knowledge on Māori women and their experience of childbirth draws on pūrakau (traditional Māori narratives). These pūrakau contain atua (ancestral gods) and ancestors, which connect the mana of wāhine and affirms the sacredness of Māori during childbirth. They also contain epistemological constructs and cultural codes. This mātauranga (Māori knowledge) is used to connect and identify Māori peoples collective relationships to mountains, rivers, waka, oceans, lands, whānau, hapū, and iwi (extended family structures, sub-tribes, clans, and tribal groupings) of which one links themselves too (Tikao, Higgins, Phillips & Cowan, 2009).

Pūrakau are used to remind Māori women of their relationships, obligations, and responsibilities they have in retaining their cultural traditions, and it is a practice for themselves and their collective. These historical accounts and ancestral links also leave a legacy for all Māori women.

Although purākau derives from an oral tradition, it can continue to provide the stimulus to write, create, and research in culturally responsive ways. Pūrakāu as a methodology draws from and responds to the broader historical, social, and political contexts and which forms mātauranga Māori (Smith, 1999).

Purakau approach encourages Māori researchers to research in ways that not only take into account cultural notions but also enable Māori to express their stories to convey their messages, embody their experiences and keep their cultural notions intact (Lee, 2009).

RECRUITMENT

Recruitment was guided by a selective sampling frame to maximise the diversity of participants varying in age, parity, socioeconomic, and regional representation. Being Māori and having had given birth within the last 18 months was the only criterion stipulated.

The cohort was recruited from a major urban area (Auckland) Counties Manukau and Hamilton, a smaller town, Hastings and rural areas in which there exist no secondary care services Wairoa and Waipukarau.
Participants were recruited through midwives, Māori nurses, kaiawhina, and whānau members. Media advertisements through the hapū wananga web page were used in Hamilton.

Whānau members were recruited at the same time as the mothers as they were present at the mothers’ interview. Participants were given information sheets and assured of anonymity before their written consent was obtained.

<table>
<thead>
<tr>
<th>PARTICIPANTS</th>
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<tbody>
<tr>
<td>Twenty-five participants were initially recruited with an expectation that there would be those that would not be available on the day.</td>
</tr>
<tr>
<td>Six women did not make the scheduled interview time, and 19 interviews were completed. The following geographical areas represent the locations in which the participants had experienced maternity services and were interviewed.</td>
</tr>
<tr>
<td>- Hastings - 6</td>
</tr>
<tr>
<td>- Wairoa - 2</td>
</tr>
<tr>
<td>- Waipukarau - 1</td>
</tr>
<tr>
<td>- Counties Manukau - 4</td>
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<tr>
<td>- Hamilton – 6</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td>Three themes of questions were drafted, and expert opinion was sought. Rapua te Aronga a Hine (2020), the literature review, also guided the question criteria.</td>
</tr>
<tr>
<td>The themes included the following:</td>
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<tr>
<td>- Whom they had sought and received maternity care from; Midwives, doctors, hospital. About their ethnicity of the carers and what made that experience successful and disappointing</td>
</tr>
<tr>
<td>- What were their expectations of maternity care, if any, and what was important to them before, during, and on reflection of their experience?</td>
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<tr>
<td>- What is missing from maternity care that would be helpful</td>
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</tbody>
</table>
The importance of Te Ao Māori was woven throughout the questions, and the answers the participants provided.

The collected stories and experiences are based on the methodology, which is prioritised from a Māori world view.

**ANALYSIS**

The interviews were conducted and analysed by a Māori midwife, who is also the principal investigator.

Interviews took approximately 60-80 minutes. A voice recorder application using an iPhone was used to record all the interviews which were fully transcribed at a later date. Scribed notes were also made during the interviews.

Qualitative data were entered into Microsoft word and sorted by themes using Microsoft Excel to count the quantitative data.

The collected information and data were analysed, and expert opinion was sought at various stages throughout the findings.
CHAPTER 3: RESULTS

The analysis identified multiple factors that underpin Māori māma experience of the maternal health system which, also contribute to maternal health inequity in New Zealand: geographic access, political context, maternity care system, acceptability, colonialism, and cultural factors.

Nineteen Māori women were interviewed about their experiences concerning maternity care they had received. The interviews began on the 9th March and were abruptly interrupted by the level 4 COVID Rahui imposed on New Zealand.

This report has deliberately privileged the evidence gathered from interviews with māmā and their whānau. At the time of the interviews, māma shared their past, recent, and or current experiences with the maternity health care system in Aotearoa, New Zealand. Some of the māma also had previous exposure of maternity care through other whānau members who were receiving midwifery care for their pregnancy and birth.

The views of the māma and their whānau are supported by research findings from other strands of evidence, including a consideration of the Te Tiriti o Waitangi and Rapua te Aronga a Hine (Tupara and Tahere, 2020) literature review completed in the second quarter of 2020.
Figure 1 Displays the age of the participants at the time of the interview. The largest age group that participated in Whaia te Aronga a Hine māma was the 25-29 years, accounting for 28%, while the next age groups fell either side being 20-24 years accounting for 22% and 30-34 years accounting for 22%. The median age of women giving birth in Aotearoa in 2017 was 30 years. Māori women gave birth at a younger age, with median ages at the birth of 26 years, 28 years, and 30 years respectively, which is represented by the participants. Of all women under the age of 20 years who gave birth, Māori feature highly (Ministry of Health Manatū Hauora, 2019).
Figure 2 Displays the ethnicity of the women who participated in Whaia te Aronga a Hine Ngā Māma, by self-identification. Māori was the largest group accounting for 94.7% of participants, while 5% self-identified as New Zealand/Samoan.

Figure 2:

![Ethnicity Chart]

- Maori: 95 (95.0%)
- Samoan/NZ: 5 (5.0%)

Figure 3 Displays the residential address and the place of experience during the birth of their last baby of Whaia te Aronga a Hine Ngā Māma participants. The largest group represented were from the Waikato area, accounting for 31.5%. Participants from Hastings represented the second-highest group at 26.3%.

The birthrate of each district for the year 2017:

- Counties Manukau accounting for 8,276,
- Waikato, 5,320
• Hawkes Bay, which includes Wairoa and Waipukarau at 2,134

(Ministry of Health Manatū Hauora, 2019)
Information on women’s gravida is crucial in understanding her experience of maternity care in Aotearoa. **Figure 4** shows the majority (72.5%) of participants in Whaia te Aronga a Hīne Ngā Māma, had more than one pregnancy experience, while 26% represented women who had experienced one pregnancy. According to the Ministry of Health (2017) records, the proportion of Māori women giving birth for the first time was 32.4%. (Ministry of Health Manutū Hauora, 2019).
Māori mothers, grandmothers, and grandfathers, aunties, and cousins continue to find the spaces within which to assert and, where necessary, to reclaim the traditional practices of raising their children, including whāngai. This collective practice to raise their children where grandparents take an active role in the raising of their mokopuna (grandchildren) as do other relatives. "Mothering in this context is not a task reserved solely for women but requires the collective efforts of the entire whānau." (Mikaere, 1994)

**Figure 5:** The traditional Māori practice of whāngai continues to be practiced in contemporary Aotearoa, as was found. 36% of Whaia te Aronga a Hine Ngā Māma participants have experienced, either as the whāngai child or the whāngai parent this tradition.

The first pie represents the 36% of participants of Whaia Te Aronga a Hine Ngā Māma participants that experienced whāngai tradition within their immediate whānau, either as a child of whāngai or a whāngai parent. 88% of those that have experienced the whāngai tradition concerned the firstborn.

"With my eldest one, my dad came and took him from the Hastings hospital. When my dad turned up, he just looked at my Māori midwife, said 'Kia Ora, I'm Kingston’s grandfather, I'm taking him home.'" Māma 5
Midwives have a significant role in Aotearoa as primary maternity care providers. Pregnant women engaging with maternity care will encounter a midwife at some point throughout the maternity continuum, whether they are having their baby at home, a primary maternity facility or birthing center, or a secondary or tertiary hospital. In Aotearoa, the majority of women choose a self-employed midwife lead maternity career (LMC), with Māori women more likely (92%) to register with an LMC. (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020).

Māori women frequently encountered problems in securing their preferred LMC (Tupara & Tahere, 2020). This is still the case, as identified in this study.

It is crucial that Māori women are viewed within their broader social context and that midwives work in partnership with Māori women. Māori women seek a maternity service where the provision of care recognises and respects their culture (Tupara & Tahere, 2020).

Figure 6 shows that 100% of the participants of Whaia te Aronga a Hine Ngā Māma experienced midwifery care during the maternity journey. The ethnicity of LMC was identified for each birth.

Figure 6: Ethnicity of Lead Maternity Carer
TRANSLATION OF GRAPH

Baby 1
- Twelve wāhine had a Māori midwife
- Six wāhine wanted a Māori midwife but was unavailable and so settled for another LMC and or Core LMC
- One wāhine was not concerned about ethnicity

Baby 2
- Ten wāhine had a Māori midwife
- Two wāhine had a Pakeha midwife
- Three wāhine had a Core LMC
- Three wāhine wanted a Māori midwife

REASONS FOR CHANGE

The reasons for changing LMC were explored.

- **58%** of participants were identified as changing their LMC either during their maternity care or with the next episode (pregnancy) of maternity care.
  - **64%** that changed LMC was due to their relocation, of which **14%** (1 māma) insisted on traveling back to be with the whānau midwife
- **18%** of those that changed LMC, ‘dissatisfaction’ was stated as the reason
- **9%** of those that changed LMC, ‘no other option,’ was stated as the reason. Living remotely and without alternative options
- **9%** of those that changed LMC thought an LMC was of no relevance to the birth outcome. Only to change back to her first LMC with the next pregnancy

Figure 7:
95% of participants of the Whaia Te Aronga a Hine Ngā Māma study, felt it was essential to have a Māori midwife.

Figure 8:

Wāhine Māori prefer Māori midwives as their LMC. Furthermore, they want to be confident that their care provided by an LMC is culturally responsive to their needs. While many participants expressed their satisfaction captured in the statements below, they also found it challenging to articulate their real emotions about how vital a Māori midwife was for them and their whānau.

"Māori midwives are just more – I’m just more comfortable." Māma 2

"I felt more comfortable cause she was in here and stays to me – I’ve got someone coming in, is that all right?" Māma 4

"Well for me, having someone the same culture as me, it made me feel comfortable." Māma 4

"Yeah, it’s more comfortable." Māma 8

"It’s like the stars aligned at that point, and we jumped in straight away with her aye." Māma and Pāpa 7

"I deliberately chose a Māori Midwife." Māma 1
CULTURALLY SKILLED WORKFORCE

Participants of Whaia te Aronga a Hīne Ngā Māma, identified that having a maternity carer that respects their culture, values, beliefs, and background influences their choices of LMC. Māori women feel safe when their LMC is also Māori.

These findings concur with the findings of the Maternity Consumer Survey (2014) and Buchanan and Magill (2015) study.

"It's cause you have a better understanding of your own people." Māma 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." Māma 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." Māma 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." Māma 6

“There is understanding already through her culture and their backgrounds." Māma 8

"I didn’t really know what to expect. I just let her do it to be honest." Māma 3

"You should be able to get this and that cause your Māori and you need it." Māma 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". Māma 8

"I trusted the Māori midwife to be culturally appropriate." Māma 1
Despite **95%** of participants wanting a Māori Midwife, Figure 9 shows that only **76%** experienced a Māori Midwife as their LMC, while **24%** could not find a Māori midwife at all.

**Figure 9:**

"Cause we know up here aye, the caseloads are high." Māma 7

"I really wanted a Māori midwife. I'm really disappointed about that." Māma 9

"I watched 'My Māori midwife,' the doco series. After I had already got my midwife." Māma 9

"I just couldn't find one." Māma 2

"Yeah, it was quite hard to find one." referring to a Māori midwife. Māma 16
Figure 10 shows that the majority (63.2%) of participants in Whaia te Aronga a Hine Ngā Māma study found their midwives through whānau connections, while the next most popular option was through the 'find your midwife' website which is associated with New Zealand College of Midwives.

Figure 10:

'My mum found my midwife." Māma 2

"Aunty Con. She got me a midwife". Māma 4

"I was given her card at the Drs." Māma 5

"My mum had her." Māma 6

"I went to her cause she cared for my sister in law." Māma 10
It is no surprise that whānau play a significant role when choosing a midwife. Whānau are an essential societal structure where fundamental teachings and socialisation of things take place and where wellbeing is not isolated to individuals (Durie, 1994). The wellbeing of individuals is sourced in the wellbeing of whānau, which in turn affects the wellbeing of hapū and iwi (Ministry of Health, 1998).

**WHAT’S A ‘WHĀNAU MIDWIFE’**

A sample of Māori women from Whāia te Aronga a Hine Ngā Māma study (37%) devised the term ‘whānau midwife’ to describe a particular midwife who cares for generations and extended members of the same whānau or hāpu. This whānau midwife was described as holding a special place within the whānau as the person in possession of whakapapa (genealogical) knowledge and is commonly known by all members similar to that of traditional Māori birth attendance (Tikoa, 2014). The renewed emergence of this figure within contemporary Māori whānau and hapū is of particular significance as it signals that Māori have the capability to identify not just the needs of Māori pregnant women and their whānau in this new environment, but also the professional scope in which to address and fulfill their needs.

The participants described the ‘whānau midwife’ as something special which is added to that of a Māori midwife which is only obtained through years of experience of caring for whānau and its members and who shares with them the customary practices and mātauranga of that whānau. The ‘whānau midwife’ is entrusted with the protection and safety of the whānau members, especially that of the māma and pepi, and whose scope of practice is expected to extend the standard midwifery scope to ensure this protection.

"Go with someone different, cause everyone's with her. I was, nah, she's normal, and everyone already knows her." Māma 3

"Literally, the whole whānau had her." Māma 3

"Because of my mother and my sister, I understood how she worked." Māma 2
"Feel safe with her" Māma 3

"I didn’t have a choice really. She cared for all the whānau". Māma 19

"Hope that she would have my back if I needed." Māma 3

"She was there for all my whānau." Māma 4

"She met all my family. A whānau midwife is special, yeah. Someone who really knows what’s going on". Māma 8

"Yeah, I got offered another Māori midwife, but I want to stay with her cause of my whānau." Māma 4

"I had the choice of another Māori midwife, but I had to have her." Māma 6

"So when me and my sister were living in the same house, so we would always have the same visit. She would do us at the same time." Māma 4

"My Nan got her, and she knows me best." Māma 11

"It was like coming home." Māma 11

"So when all my kids and whānau see her, they are all like, oh look there she is. The kids are like, Oh, she did us aye? Yeah, she did yous." Māma 4

"My Māori Midwife went with my baby to SCBU to keep an eye on her. That’s that more caring thing." Māma 6

"Yeah, shes met all my family. My family came anyway." Māma 4
One participant identified the care of the 'whānau midwife' as something common to that shared with other whānau members, especially her cousins. She went further to want something more unique, unlike what the others had all experienced.

"I want something special, that’s mine, not like the rest of the cuzys." Māma 3

Interestingly, another participant thought that the choice of LMC had no relevance to her birth outcome and, therefore, choose any midwife for her second birth after having an 'uncomplicated birth with her 'whānau midwife' during her first pregnancy.

Unfortunately, her experience with her second midwife was dramatically different and disappointing. She is currently back with her 'whānau midwife.'

"I had a really good birth with my first baby. So I didn’t realise that it was because of the care that I had. So what I did, I wasn’t bothered with a midwife the second time. I went community base; it was a disaster."
Māma 8

The majority (85.7%) of the participants identified with having a 'whānau midwife' resided in rural and remote rural 'home towns.'

THE THREE 'PS': PARTNERSHIP, PARTICIPATION, AND PROTECTION

In summary, Māori Midwives are a vital component of Maternity care for Māori women and their whānau.

The three 'Ps' which are commonly associated with Te Tiriti o Waitangi are identified in this report as common themed reasons for preferring a Māori midwife.

The partnership model is promoted as the provision of midwifery care in New Zealand by the New Zealand College of Midwives, where “the midwife works in partnership with the woman/wahine throughout the maternity experience. (New Zealand College of Midwives, 2015). Participants of Whaia te Aronga a Hine Ngā Māma explained how 'comfortable’ they felt with a Māori midwife and that the forming of such a therapeutic relationship involves a more interpersonal, emotional, and spiritual nature that is required to be recognised in clinical practice.

That the partnership also extends to include members of whānau, hapū, and iwi. The welfare of the whānau is a priority, rather than the interests of an individual and without judgment.
“I felt that going with a Māori would be, you know. Cause I don’t want to be treated differently to how Pakeha would treat you. I don’t want to be rude, but they can be ummmm, you know, racist”. Māma 4

“We feel connected to Te Ao Māori. The land and the people. Its good to learn for baby”. Māma 7

“It felt like the stars aligned when we got our Māori midwife.” Māma & Pāpa

Participation: The inclusion of whānau is a key concept to wellbeing for Māori as signposted in Tikanga (Māori traditions) and whakapapa (genealogy). Participants of Whaia te Aronga a Hine Ngā Māma, explained how Māori midwives contributed significantly to their cultural needs and understandings. Māori wāhine were comfortable to follow, when appropriate, the lead of cultural practices from their Māori midwife. They felt included when traditional practices were furthered shared with their whānau.

“Yeah, I expected my Maori midwife to help guide me with that.” Māma 4

“We wanted to know about Rongoa and Mirimiri and where to get those things. You get referred so much during your experience that all you want is just an answer from your midwife, you know”. Māma and Pāpa 7

“I guess just our family being able to be in the room too. Yes, that’s cultural. Our family being in the same room as us.” Māma 7

“Yeah. There was stuff I wanted, but I didn't really know.” Māma 3

“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.” Māma 2

Protection is, by far, the most significant discovery of reasons for wanting a Māori midwife. The protection of cultural traditions and protection against a ‘system’ which is determined to judge Māori through the eye of a eurocentric lens.
Figure 11:

Tāpuhi
Māori Midwives

Cultural
Whānau
Midwife
The whānau claim the midwife as their ‘whānau midwife’ who then delivers multiple babies of the extended family.

Whānau
Māmā trust Māori midwives to care for entire whānau

3 Ps
Partnership
Trust and equal partnership

Protection
Protection & guardian against other mainstream health professionals

Participation
Contribute towards their understanding

Mana
Respect
Matauranga Māori is shared and tikanga is respected

Māori Midwives are role models for Māori women

Access
Connect
Māmā often calls on her Māori midwife to help her with her social situation

Expectations
There is an expectation from Māmā that Midwives will provide all care needed.

Competent
Māmā trust their Māori Midwives to be clinically competent

Whānau
Often criticised for sharing too much information with other whānau members

Mahi Aroha
Provide care outside her Midwifery scope

Mahi
Overworked and high case loads.

Contact
Difficult to get hold of

Availability
All Māmā found it difficult to find a Māori midwife

Remote rural
Nearly impossible to find a Māori midwife if you live rural. You have to travel

I have to travel if I want a Māori midwife

Source: Aronga a Hine
Māori women feel ‘protected’ against ‘the system’ when their LMC is a Māori midwife. Maori Midwives are identified and used by Māori women as a ‘buffer’ between themselves and the negative experiences expected by ‘the system’ or mainstream maternity carers. For this reason, the expectations of maternity care by and for Māori women places pressure on Māori midwives to provide extra responsibility beyond the scope of standard midwifery care.

**Figure 11:** Summarises the expectations and experiences of Māori Midwives by Māori women and whānau, while also meeting the professional expectations and codes of practice.

**BIAS AND RACISM**

There is extensive literature available to confirm the significant impact of effective communication from a carer to a patient in the primary care setting is fundamental to a satisfactory outcome. Where the maternity carer and the client do not share a common cultural background, there are increased difficulties in establishing effective communication and relationships. For Māori women, the majority of maternity care interactions do not come from carers of the same background and or culture. Thus, there is greater potential for misunderstandings and therefore reduced effectiveness of care (Jansen & Smith, 2006). These ‘misunderstanding’ often passed off as well-intentioned or unconscious actions have been more accurately articulated by the vulnerable recipients as ‘racism’ in which the actions have major consequences.

Māori women have identified long-standing barriers to accessing appropriate maternity care in New Zealand, and it is an unwelcome truth that the maternity care system is failing Māori (Stevenson et al., 2020).

The insufficient numbers of independent practicing Māori midwives, inadequate access to culturally responsive care, including whānau centered services and cost barriers (Ratima & Crengle, 2013), contribute to the negative experience, which is often shared with their whānau, influencing the entire communities perceptions and future behaviour. (Medical Council of New Zealand, 2008).

More disturbingly, the findings from Whāia te Aronga a Hine Ngā Māma have identified frank bias and racist attitude against Māori women and their whānau. This has been more commonly experienced within the mainstream maternity care environment and or when Māori and their whānau have engaged with secondary care and hospital services. Many
māma and whānau that were interviewed spoke of the harm they had experienced when they encountered mainstream or hospital care. While many of them understood and were grateful to receive clinical and often urgent medical care procedures, they were clear that it was the contact with specific health care professionals, which was the cause of anxiety, distress, powerlessness and sometimes, embarrassment.

While some participants identified one or two individuals who contributed to their feelings of racism towards them, many of participants of Whaia te Aronga a Hine Ngā māma described a culture of prejudice behaviour from all members of the staff, from the receptionist, nurses, midwives, and doctors, and that this behaviour followed them throughout the different divisions of the hospital.

**Figure 12** shows that over 2/3rds (68%) of Whaia te Aronga a Hine Ngā Māma participants, experienced racism during their maternity journey.

**Figure 12:**

![68% Experienced racism towards them.](image)

**Figure 13** identifies where their experience of racism took place.

With 57% experienced within the hospital or secondary care environment and 57% experienced within the 'all of maternity system' environment, i.e., radiology, laboratory, antenatal clinics. 37% experienced racism from their LMC, most of whom then changed midwife.
Figure 13:

- Where bias happens

Figure 14:

"You can tell on their faces that they are gone be rude."

"They look at you and give you that vibe and look of disgust. That type of thing because your Maori?"

"dumb Maori."

"I don’t mean to be rude but they can be... you know, racist."

"I’m not trying to say they are racist, but Yeah."

"Our culture just gets pushed aside as Maori"

"The hospital is filled with white people and I didn’t feel comfortable. I hated it!" māma 3

"Because I am Maori she thought I couldn’t afford the medicine."
"With Pakeha, I’m just on edge and like tippy toey. And you can’t be yourself or open. You just feel they are judging you." Māma 2

"We never got offered to take home the placenta—things like that. I had to ask for it, and they looked at me like- WTF. I was like second-guessing myself. Like oh, wait. Do we not do that. No, we do that. My sister did that." Māma 2

"Everything was fine up until the hospital. The hospital was like faaark!." Māma 7

"You know, with some Pākeha, you get treated totally different to them than you would from a Māori." Māma 4

“I feel the way people speak to someone like me or my cousins; we react to the way they speak to us. So if they come off aggressive, then so do we, and so it is like that. We don’t like you; we aren’t ganna see you again. We ain’t gonna like you next time. We gana remember you”. "Māma 2

"The hospital ain’t even my place” Māma 3

"Yeah, I’ve never been in the hospital ever, and since having baby...and the first person I got, rude”. Māma 3

"It’s like when you go to the hospital, and that’s filled with white people, to be honest. I didn’t feel comfortable at the hospital at all, and I was there for a whole week, and I hated it”. Māma 3

"The experience was so disempowering Mann. Everything was forced and then maltreated and them just not caring.” Māma 7

"The births were the same, but the hospital was the traumatising bit for me.” Māma 8

"The things that we wanted, like the Moka and all of those things that were taken away from us, we gave up at one point because we had to keep reiterating things because they weren’t reading our notes. They didn’t even know that we wanted that. Everything was forced.” Māma 7
“You also get really stressed out when they are not treating your family like, as not as important as you think they should. I was stressing out cause they were like sitting on the ground, and there were no more chairs left, you know, and they couldn’t get chairs. Moreover, that affects you as a mum, and your going through that.” Māma 7

“The balloon kept falling out, and I could hear them whispering and making fun of me and my body cause it kept falling out. And it actually got around to everybody, you know. I could hear them talking about me... It’s not fair. I was thinking, why do you even talk about my body and tell everyone that works in your area and now they are looking at me. I could hear them talking, and I couldn’t really talk to them because I was soo embarrassed. The whole world didn’t need to know. I haven’t even told my partner because I don’t want him to think of my body like that. That was so traumatising, and I was just crying. Like I could hear them. It was just like taking everything away from me when I was vulnerable too.” Māma 8

In some instances, Māori māma described heightened levels of anxiety about the possible future interaction with hospital staff, in which they expected to experience bias behaviour toward them and their whānau.

“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..” Māma 7

“They had really good intentions, but it wasn’t real.” Māma 8

“You just always feel uncomfortable.” Māma 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.” Māma 7

“Yeah, it feels like I’m in the category of – you don’t deserve it; your not good enough, like at the doctors.” Māma 6.

“You just sort of give up in the end.” Pāpa

“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.” Māma 8
By far, the most disturbing discovery of Whaia te Aronga a Hine ngā Māma, is the plight many Māori women experience during their maternity journey. Figure 15 shows that 26% of the Whaia te Aronga a Hine ngā Māma participants were fearful that their encounters with hospital and mainstream maternity services could lead to a notification to Oranga Tamariki and consequently, their babies being uplifted and that this could happen at any time.

A statistical snapshot of Pēpi Māori 0-3 months and the care and protection system show substantial, persistent, and increasing inequity in the removal of pēpi Māori into state custody (Office of Children’s Commissioner, 2020).

Key findings from the analysis of data (released in January 2020) show:

- The number of concerns reported about the safety of babies and children has increased.
- The number of social work assessments that find substantiated abuse for babies has decreased from a peak in 2013.
- Inequities for Māori compared with non-Māori are substantial and persistent.
- Assessments and removals of pēpi are happening earlier.
- The urgency of decisions to take babies into state custody has increased for pēpi Māori.
- State custody is intergenerational. (OCC, 2020).

The very real fear of baby uplifts is a disproportionate reality for many Māori women and their whānau. For 26% of participants, their interactions with maternity care was an anxious and worrying occasion. These Māori māma usually delay their interaction with the health care professionals, choosing instead to maneuver in and out of maternity care services and follow their own path, which they felt was less risk-averse.

Participants expressed having felt reassured by an LMC that was Māori. They felt Māori midwives were more empathetic and understanding of their social and domestic circumstances and that often the lifestyle lived by Māori, i.e., collective living arrangements and extended whānau involvement in parenting activities, was misunderstood by pakeha health professionals, including midwives. This put them at risk of being inappropriately judged, and it was well worth avoiding them altogether.
"...and then with all my other pregnancy, my second and third, how uncomfortable and how rude they were. not only being Māori, but I felt anybody would have acted this way, but he would get really mad to the point where he would swear, you know…. You shouldn’t be fucken treating us like that. You know? Yeah…”

So I had to tell him that he needs to stop coming and being like that because they are going to be like that. So he had to stop coming to our appointments because of the way he was because of the way they spoke to him when he spoke in the same tone back, it wasn’ OK. Or we jeopardise our children getting taken from us for nothing that was our fault. We were trying to attend our appointment, and you were very rude. Not only once, but thru the whole appointment. He just had enough.” Māma 2

"Yeah, and I said to her. I get an income for him, and it goes on only him.” Māma 2
"Oh, I did look at her and thought, oh, I hope you’re not one of those Māoris. Ummm, you know, to come and uplift my baby off me." Māma 5

"Only cause I was uplifted." Māma 5

I was uplifted from my mum and dad back in the past. Not only that too, but domestic violence too. And yeah, me and my siblings were uplifted from my mum and dad back in the 1980s.

"I just can’t trust anyone. I mean, especially if they’re working alongside OT." Māma 5

"I was lying there, and they were taking my baby. It was really scary. I had never had that experience before. I felt they were going to steal my baby." Māma 6

"Yeah, cause we are Māori. But only the easy to picked on. And that's how I feel. Especially if you have not very good whānau. Like heaps. Cause if you got nobody, then your easy target. Your all by yourself. They could switch my baby too. That shit doesn't always happen in the movies." Māma 6

"Cause I do not trust nobody to take my newborn baby through a ward, where there is actually sick people as well. So, what are they gonna do? Take baby through the office, and oh look. Like you could take off with my baby. Like who do you think you are just taking my baby." Māma 8

**HAPŪ WANANGA**

When asked about Tikanga or Māori cultural traditions and practices, some participants did not immediately account for traditional practices like; taking home of the placenta and cutting of the cord as something culturally significant to Māori; instead, many considered this practice as 'normal.'

100% of Whaia te Aronga a Hine Ngā Māma participants, supported the inclusion of Tikanga Māori throughout their maternal journey.

Some of the participants relied on their Māori midwife to advance this practice, while others were clear with what elements they wanted to be incorporated and when.

Most of the māma felt it was the responsibility of the whānau to carry out many the traditions with the Māori Midwife guiding them.
One Māma had her Pākeha Midwife incorporating what she thought should be Māori customary practices using 'pounamu (greenstone) and Moka (flax) ties to cut and tie the umbilical cord.

Figure 16: 

Wanted to experience Māori Tikanga

More noticeably Kaupapa Māori antenatal education sessions, more specifically, Hāpu Wānanga was a positive source of Tikanga Māori knowledge and guidance. 26% experienced Hapū wānanga, with 100% providing positive feedback.

"We went to hapū Wānanga, and we were so like – anti westernised ways of thinking." Māma 7

"Yeah, so I guess the pakeha antenatal classes. Well, the cost was the main thing. Cause they were so expensive. We knew that going to wānanga would help us out. And I thought we did the wahakura weaving in the Wānanga, but we didn’t, which I was fine with because we got a wahakura through a competition." Māma 7

"Oh yeah, they showed us heaps of stuff." Māma 16

"I told a few of them the things I had learned at hapu wānanga, like how to tie off the cord with Moka." Māma 14

"I learned a lot there like after that I was like – I’m gonna have this baby with ease. I was super excited." Māma 13
"Yeah, I learned that at Hapu wānanga. They teach you to stand up for yourself." Māma 7

SOCIAL SUPPORT

63% of the Whaia te Aroanga a Hine ngā Māma participants, experienced an increased need for social support and services during their maternal journey. While some of the participants recognised it was not the role of their midwife to provide the social services they required, 100% of the participants believed it was midwives’ responsibility to have an understanding of where such services could be accessed and at the very least activating a successful referral pathway.

"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." Māma 2

"I just feel and ‘im 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." Māma 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. Your 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. .." Māma 2

"Yeah, I need heaps of support. I haven’t got a carer and have all these problems with agencies" Māma 5.

"The midwife only does so much, but I need more than that." Māma 9
"We should be trying to show them that all Māori need more care. And Pakeha do not provide it, and they don’t provide options, so you just get this. When really, there are all these other options cause your Māori." Māma 6

"You should be able to get this and that cause your Māori and you need it." Māma 6.

"My idea is that they should do everything. All of the services." Māma 7

"We sort of didn’t realise that there are different levels to midwifery care. And you put your all into you relationship with your midwives and stuff, so knowing that and knowing that I had to be induced. So, I guess knowing that we weren’t control of our journey from then on was a bit sucky”. Māma 7

"You need to be really hands-on. Be available when I need help." Māma 8

"I just turned up at the hospital and had them. I didn't even know there were two of them. No one did until she started coming out." Māma
Traditionally, childbirth was viewed as a tapu process which celebrated the mystical forces of ancestors. Karakia and chants were recited to Hine-te-iwaiwa, the ancestor and goddess of childbirth, to encourage the baby forth from the womb. Whakapapa was also recited. The combined use of incantations and physical pressure on the uterus aided, according to Clarke, many deliveries. (Clarke, 2012).

For Māori, childbirth remains a sacred and significant event that is shared by whānau and hapū. Furthermore, Māori traditions around childbirth continue to be viewed as a tapu process in which whānau members have different roles that they expect to enact.

The medicalised and clinical concepts of childbirth and parenting, which have been promoted and adopted in New Zealand’s health system has disregarded the importance of these traditions for Māori. However, wāhine Māori continue to regard cultural practice as the most significant element of care, seeking this, amongst other factors, through a Māori Midwife.

The scope of midwifery care is designed to work in partnership with women and their families to meet their health and wellness goals. It is also well accepted that midwifery is the primary source of maternity care. Nevertheless, the dissatisfaction expressed in this study by Māori women concerns the limited, narrow, and clinical scope of the profession, which reflects a scope that was not defined or designed by Māori.

The complicated and often complex social circumstances that are disproportionately represented by Māori women are often overwhelming for the midwives that care for them. Also, the significant cultural relevance of maternity and birth for Māori is hidden.

For Māori Midwives, who overwhelmingly provide care to Māori women, the responsibility is far more significant, and the nature of the care is often beyond the scope of common midwifery practice.

Whanau Ora, Mother and pepi, Pepi Ora, and other wrap-around care initiatives for vulnerable populations with complex maternal needs have been evaluated as successful (Paterson et al., 2012). Hapu wānanga and other kaupapa Māori initiatives that provide cultural factors have also been supported in some areas of New Zealand. The problem with these ‘programs’ is they are viewed as ‘add ons’ and work outside the fabric of standard maternity care, stigmatising those that require or desire such initiatives as
‘vulnerable or complex.’ Often these negative labels put a spotlight on whānau by other intervention programs that reach past maternity care and into the parenting realm. Whānau are often branded with this negative stigma, which is difficult to remove.

The additional issues with such 'add on programs' is the complicated commissioning of them. While some regions of New Zealand support and promote kaupapa Māori services, others do not, causing inconsistency and disparities with access to appropriate services. Furthermore, this adds another layer to maternity services, confusing Māori women and their whānau who are left to navigate the problematic primary maternity care system.

The funding of kaupapa Māori programs is, in itself, a matter of concern. When kaupapa Māori is considered important, it is supported. However, when the funding is no longer available, these 'programs' are terminated, extinguishing any matauranga Māori gathered and with it, the potential to build on.

In Aotearoa, there are distinct obligations to Tangata Whenua under Tiriti o Waitangi that need to be honored. The basic principles of partnership, participation, and protection should pervade all aspects of health and maternity care. Broadening the maternity scope to embed and normalise values important to Māori within the existing fabric of maternity care would better meet the needs of Māori and bring an end to the concept that Māori needs sit outside of the norm.


Rumball-Smith J. Inequality in quality? The selection and use of quality indicators to investigate ethnic disparities in the quality of hospital care, Aotearoa, New Zealand. Dunedin: University of Otago; 2012


