



TE RAU ORA



Whaia te Aronga a Ngā Kaiwhakawhānau Māori

**The Māori Midwifery Workforce in Aotearoa
Ngā Kaiwhakawhānau Māori - JUNE 2020**



Ngā Maia Māori Midwives Aotearoa

Kō Ranginui e tu
iho nei
Kō Papatuaanuku e takato mai
E Kāranga ana mā runga ngā ahau o Hine-Hauora-moe-angiangi
Mea ngaa tai o uta o Hine-Waiora-Moana
Nau Mai, Haere Mai
Piki Mai, Kake Mai
No reira
Tēnā Koutou, Tēnā Koutou
Tēnā Koutou Katoa

Ngā Maia is a National body that represents Māori Birthing.

The kaupapa of Ngā Maia focuses on Māmā, Pēpi, Whānau and promoting Mātauranga Māori in pregnancy and childbirth.

Our whakatauaiki reflects our kaingaakau/commitment:

“Ki te whakaohoho i te Mauri o ngā Tikānga o ia whānau o tēnā o tēnā”

na Mere Clarke (Tairawhiti) rāua ko George Cherrington (Taitokerau) te kaupapa i whakatau

Our Tohu / Logo

The Kaupapa of Ngā Maia is the foundation of Ngā Maia. Birthing traditions were passed from generation to generation by word of mouth and Māori art forms.

The choice of the tapatoru in the design represents niho taniwha which in turn symbolizes our stories, histories, and events. They are also a sign of resilience, strength and Te Whāre Tangata. They embody the essential male and female essences, protection, openness, and the movement/pulsation of life between them. It also links the two knowledge foundations between ‘te kauwae runga’ (the sacred lower jawbone) or realm of esoteric and most sacred knowledge and ‘te kauwae raro’ (the sacred upper jawbone) or the knowledge of daily existence.

The smaller tapa toru within the larger signifies the nine phases of growth. The balance of life required to create new generations derived from the male and female essence. The koru kape rua represents creation, growth and also the unity of tupuna, mātau and mokopuna-whākapapa. The larger tapatoru represent the whānau and the midwife supporting the process of birth together. The colours symbolize wai - the sacred waters, whenua-our land and archetypal mother and growth. Therefore we acknowledge the strength and balance that we have access to through the wisdom from Te Ao Māori and the potential for hau-ora, aro-ha and mauri ora for whānau wellbeing that can flow from birth and into life.

We acknowledge those who contributed to this knowledge and the artistry that combines these symbols into our tohu. We also give thanks to Regan Balzer for the image of Hine Te Iwa Iwa on Te Toi Whenua/Our home page and Horomona Horo for his inspirational tangata puoro oriori as an example of the ways we spoke to our pepe within the whāre tangata as unborn to this world and following birth into Te Ao Mārama/The world of Light.

Tihei Mauri Ora!

(Nga Maia Maori Midwives; Web site page).

Whaia te Aronga a Ngā Kaiwhakawhānau Māori

Author: Jean Te Huia.

*MA Nursing, PG Dip Mid, P G Dip Public Health, PG Dip Primary Healthcare Tamariki Ora,
PG Dip Sexual and Reproductive Health, Lactation Consultant, Quality Health Auditor
Ph D Fellow, Te Whāre Wananga o Awanuiarangi.*

Date: June 2020

ngamaia@xtra.co.nz



Recommended Citation : Te Huia, J. (2020). *Whaia te Aronga a Ngā Kaiwhakawhānau Māori: The Māori Midwifery Workforce in Aotearoa*. Te Rau Ora.

ISBN 978-0-473-53819-4

Published September 2020

© Te Rau Ora

Table of Contents

Abstract.....	6
Introduction.....	7
Te Pai Mahutonga.....	8
The Current Maternity and Midwifery Sector Workforce Needs.....	8
Kaupapa Māori Research: Maternity and Midwifery Services Reality	9
Māori Practitioners Meeting the Needs of their Profession.....	11
Conclusion.	12
Methodology	13
Identifying and Contributing to discussion and Ideas for the future needs of Māori midwives and Māori midwifery students.....	14
Translating the Discussions into Actions.....	15
Māori Midwives acknowledge their rightful place in Aotearoa as the protectors of mātauranga Māori birth.....	16
Participants.....	17
Recruitment	17
Engagement	18
The Survey Questions	18
Focus Group Interviews.....	18
Data Analysis.....	20
Results for Question One: Describe your understanding of a Māori midwife?.....	20
Orientation: Locating Māori Women. Self-recognition and importance placed on being a Māori midwife.....	21
Mātauranga Māori Birthing Rites	22
Findings Question 1	22
Results for Question Two: What are the challenges for you to practice as a Māori Midwife? A) For yourself? B) For the needs of your client?	23
Midwifery Practice in Aotearoa; Influences for Māori midwives and Māori whānau	23
Results A) Māori Midwives Needs.....	24
Results B): Māori birthing māmā, pēpi and whānau needs	27
Findings Question 2	30
Results for Question Three: What Changes in Midwifery Practice/Workforce could better support you in your role as a Māori Midwife?.....	31
Route Decisions for Revolutionary Change- Identifying Inequities and Opportunities.....	31
Findings Question 3	36

Results for Question Four: What are your workforce development needs for the future? ...	37
Professional Development Plans and Aspirations	37
Findings Question 4	39
Summary Findings.....	40
The Health and Disabilities Systems Review.....	40
Hauora Māori.....	40
Recommendations	41
1. Governance Review & Organisational Development	42
Rationale	42
Key Focus Areas.....	42
Opportunities/Options for Ngā Maia Consideration.....	42
2. Workforce Development	43
Rationale	43
Key Focus Areas.....	43
Opportunities/Options for Ngā Maia Consideration.....	43
3. Recruitment and Retention	44
Rationale	44
Key Focus Areas.....	44
Opportunities/Options for Ngā Maia Consideration.....	44
4. Training and Development	45
Rationale	45
Key Focus Areas.....	45
Opportunities/Options for Ngā Maia Consideration.....	45
5. Information, Research and Evaluation.....	46
Rationale	46
Key Focus Areas.....	46
Opportunities/Options for Ngā Maia Consideration.....	46
Conclusion	47
Consent Form.....	48
Bibliography	49

Jean Te Huia

CEO- Ngā Maia Māori Midwives



Research Report Statement

This is the first and most comprehensive integrated look at Māori Midwifery Workforce needs in Aotearoa; described through the 'voices' of Māori Midwives.

Abstract

This report is a culmination of Ngā Maia Māori midwives' undertakings to bring the 'voices' of Māori midwives to the fore, to acknowledge their 'mana' and 'authority' to identify the rightful place of mātauranga Māori birthing and to shape the evidence to inform Māori workforce development priorities, with a focus on hapu Māori māmā, their pēpi and whānau. These testimonies presented are based on Māori midwives' discussion's, survey responses, personal interviews, and Māori midwives' focus group hui. The data represents the values and priorities identified by Māori Midwives themselves, who articulate their professional development needs, in order to raise the profile of indigenous health, so we may understand the need and direction required to build upon a culturally appropriate professional Māori midwifery health workforce, retain its quality and continually review its input. This project is an important platform for situating Māori midwives as te Tiriti partners, in the midwifery landscape of Aotearoa and facilitates amplification of the experiences of Māori midwives and hapu Māori māmā, their pēpi and whānau who are served by the profession.

There is a lack of research evidence, checks or balances that explains the work experiences of Māori midwives. In addition, there is little research or explanation to describe the disparities that exist within midwifery for Māori māmā, their pēpi and whānau, as they continue to experience persistent racism and inequities that impact on them, throughout their midwifery continuum. (Tupara & Tahere, 2020).

The terms of reference for this project, were wide and challenging and required the research team to confront many of the inequities, the maternity system continues to perpetuate on Māori whānau. The reality of this situation bought home in stark contrast, midwifery care imposed on Māori, that most of society believe is the best in the world. Through their 'voices and experiences' Māori midwives delivered their pūrakau - stories, shared their despairs and explained their frustrations whilst offering their advice. I am forever grateful and wholeheartedly thank them for their courage to share their world.

Introduction

This is a collaborative project between Te Rau Ora, Ngā Maia Māori Midwives Aotearoa and Counties Manakau District Health Board. Each organisation brings into the 'partnership' a wealth of knowledge, meā ngā tikanga and expertise from their perspective organizations, with notably *Wāhine Toā Leadership*.

This project focuses on the Māori Midwifery Workforce where midwives are the main providers of maternity care in Aotearoa (MOH, 2019). 60,000 babies are born each year, Māori represent 21% of this birthing cohort, and evidence indicates Māori birth rates are growing and that the birthing population of Aotearoa is 'Browning' (MOH, 2019). This project is the first research of its kind to 'GIVE VOICE' to Māori midwives, while simultaneously hearing the voices of our Māori birthing māmā. This project is an important first step, in providing research evidence to situate Māori midwives 'narratives', identify opportunities for future Māori Midwifery Workforce aspirations and to set goals to improve the recruitment, retention and elevate the roles Māori Midwives play within our Maternity and Midwifery sectors, so that Māori are genuine participants, not just observers.

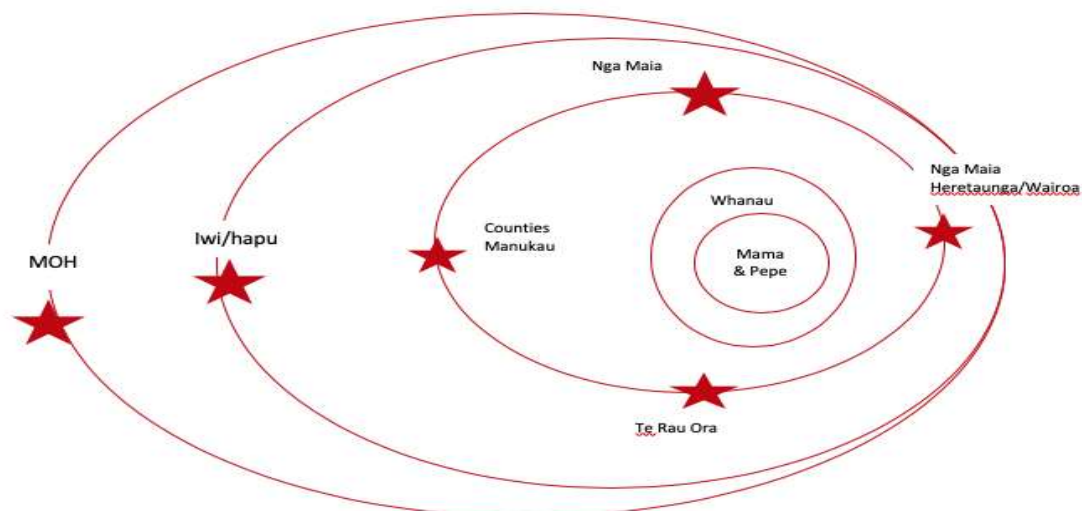
Decades of planning by DHB's, MOH and Workforce policymakers to define Maternal and Child-Health Workforce Strategies has not addressed the needs of Māori birthing whanau nor have they identified priorities adequately to address Māori workforce disparities (Windows, 2019). A National Maternal and Child-Health Workforce Strategy with a focus on mātauranga Māori is about te Ao Māori and can only be defined by Māori for Māori (Royal, 1992; Durie, 2003; Durie, 2011; Rees 2019).

Growing the Māori Maternal Child-health and disability workforce and creating environments in which Māori can thrive is a Tiriti obligation. Evidence shows Māori treating/helping Māori results in better health outcomes for Māori. Māori constitute 14.9% of the population, but account for less than 4% of the active medical workforce, and less than 7% for nursing and allied health workforces and where Māori midwives are outnumbered by all others, 300-1. (MOH, 2019).

This research project will identify opportunities for change, stimulate and prioritize discussion for a Māori Maternal Workforce of Māori Midwives that are currently under-utilized and present recommendations to assist the quality and practices of midwifery. International Law describes indigenous peoples rights to determine their own needs, Māori Midwives are acknowledged by Māori as meeting the birthing needs of Māori whanau, hapu and Iwi.

Te Pae Mahutonga

Te Pae Mahutonga, a Māori health promotion framework introduced by Professor Sir Mason Durie has been adapted to identify the relationships and accountabilities of this project, He Aronga a Hine, and Whaia te Aronga a Kaiwhakawhanau Māori.



- **Māmā & Pēpi** – at the center
- **Whānau** – focused on Māmā & pepe
- **Ngā Maia** – Māori Midwives Aotearoa and partners in project
- **Te Rau Ora** – Kaiako and project leaders
- **Counties Manukau** – Symposium
- **Iwi/hapū** – Kaitiaki/cultural/spiritual advisors
- **MOH** – Health Workforce development team

(Durie, 2011).

The Current Maternity and Midwifery Sector Workforce Needs

Disparities and inequities between Māori and non- Māori have been the basis of ongoing and various health, social and education reports since the 19th Century. (Windows, 2019). Understanding this phenomenon is the key to resolving these issues, it is unfair to suggest that wider determinants of health, poverty, lack of education, and social factors are the only drivers of good health in the midwifery sector. Equity is complex, however inequity between Māori and non- Māori including how structural factors such as colonisation and institutional racism is applied within the maternal and childhealth arena, can only be understood from a te Ao Māori view (Karena-Waretini, 2014).

Barriers exist in maternal and childhealth services for Māori, where access is not equitable, and prevent Māori from having the same access as non- Māori, even when services are accessed, the quality and outcomes for hapu Māori entering those services are not equitable as Māori do not benefit the same as for non- Māori (Windows, 2019). National Quality Improvement Programs, meant to improve Māori inequity, have in some cases- increased inequity for Māori and often solutions and programs designed without Māori contribution, leads to the ongoing manufacture of in-appropriate programs that continue to contribute to inequities for Māori and adds to ever-increasing health system failures.

It is crucial to understand and to acknowledge the intergenerational effects, from the settlement of European colonisation to the present day, Māori have been deprived of land, resources, and social and cultural capital. With each generation, the accumulative effect of dis-advantage influences the next generation of Māori (Windows, 2019). Life course frameworks, (Windows, 2019) offer a useful means to understand and explore the interrelationships between individual life experiences and social structures which describe, intergenerational trauma (Karena-Waretini, 2014) that affects Māori birthing whānau on a daily basis, when left unchecked and un-challenged, these matters remain unresolved.

Kaupapa Māori Research: Maternity and Midwifery Services Reality

- There are a lack of Māori midwives in Aotearoa.
 - There is no official Māori Midwifery Workforce Development Plan.
 - There are a lack of Kaupapa Māori midwifery leadership and professional development education programs available for Māori midwives working in the profession.
 - Māori midwives are under -represented in leadership and management roles.
 - Mātauranga Māori birthing narrative is missing in midwifery in Aotearoa.
 - Hapu māmā prefer a Māori midwife, but are generally unable to source one during their hapu-tanga.
 - Registration with an LMC <16wks are 17 % lower for Māori hapu māmā.
 - Encounters between Māori hapu māmā, pēpi and whānau during their midwifery journey are not well received by Māori on multiple levels.
 - The sexual and reproductive health screening and treatment of hapu māmā is inadequate, and needs system change and changes to scope of midwifery practice.
 - Needs and services for Māori hapu māmā seeking termination of pregnancy, are not well understood and the roles of midwives in this area are confusing and adhoc.
- (Tupara & Tahere, 2020)

Evidence suggested by various authors (Kenney, 2011; Goodwin, 1996; Graham, 2018; Stevenson et al., 2016) is that Māori Birthing needs are met, when hapu māmā feel safe and confident, supported by their Māori Midwife. The changing Māori demography and population trends; and historical, socio-political factors, is poorly understood, in order to determine whether the maternal and childhealth workforce is adequate to meet the maternal and child-health needs of Māori and needs to be better defined.

The organisational planning and quality of the midwifery workforce, in particular the 'cultural quality' of the midwifery workforce is critical for a changing and more diverse birthing population, where maternal health care that is both effective, and is designed to improve birthing health outcomes for a more diverse birthing Māori whānau becomes more available for Māori birthing whānau, but all indicators are that there are no ongoing cultural reviews, no sustainable workforce planning nor an acknowledgement that what we have now , is not working for Māori.

An ageing Māori population overall indicates improved overall health status; however, it is not necessarily an indication of improvement or reversal of health disparity for Māori. Examining demographics as an indicator of Māori health status, raises many political, social, and cultural issues that impact on Māori health. These issues then impact on workforce development when left unchecked, and unbalanced.

Over the past few years there have been gains in workforce resource issues, including Māori capacity such as Whānau Ora Policy and Funding, to support change. However, although significant, it is still insufficient to meet Māori health needs; this is evidenced by the outcome of the Wai 2575 (July 2019) Health Services and Outcomes Kaupapa Inquiry. The Waitangi Tribunal found that the Crown has Breached the Treaty of Waitangi and says \$220b on NZ health since 2000 has not improved Māori Health.

Culture plays a significant role in health as it influences how behaviours and symptoms are perceived, understood, and responded to by both those receiving and those providing health care. International and national research has found that health service outcomes are likely to be better where there is cultural alignment between patient and the practitioner. The Māori health workforce has a significant role to play in improving Māori health status and in particular, maternity services, where Midwives provide the bulk of care, midwifery must be responsive to the growing trend of Māori birthing women.

Workforce Development (WD) is a strategic approach by the 'Crown' in developing a workforce. The Health Workforce Advisory Board (MOH, 2019) works in partnership with the MOH, to provide oversight and sector leadership.

Several reports, (Rees, 2019) identifies that Workforce Development policy has become increasingly disconnected to Workforce Development environment in New Zealand for conceptualising and summarising the various activities needed to address Māori needs, and in particular I would suggest no review of the cultural content of midwifery to meet Te Tiriti obligations, or to meet the needs of Māori.

Māori standards of health are a function of social, economic, cultural, and environmental determinants and significantly impact on demands for and access available for Māori in order to access health services. While Māori health disparities cannot be attributed to health services alone, appropriate access to these services, greatly contribute to good health for Māori.

Understanding the workforce needs of Māori midwives, is an important first stage in understanding and planning for maternal child-health services for Māori that are better equipped, better resourced, and better placed to address current Māori birthing inequities.

To safeguard Māori birthing māmā, pēpi and whānau, change is necessary to enable Māori midwives to stand proud and thrive alongside their Tiriti partner, and evidence suggests this can only happen when Māori practitioners; Māori Doctors, Māori Nurses, Māori Allied Health Workers, Māori Psychotherapists, and Māori Midwives, themselves, determine what that is.

Māori Practitioners Meeting the Needs of their Profession

Te Ohu Rāta o Aotearoa (Te Ora) an organisation representing Māori medical students and medical practitioners working as specialists, clinicians, researchers, and teachers. Te ORA aims to advance Māori health by increasing the Medical workforce and providing a supportive network for its members (Te Ohu Rata o Aotearoa, 2020).

Te Kaunihera o Ngā Neehi Māori o Aotearoa National Council of Māori Nurses incorporated in 1993, the council was established in 1983 with support from the Mana Motuhake Māori party, in response to concerns Māori patients were not receiving appropriate hospital care and was exacerbated by a shortage of Māori nurses. The main focus over the

past 2 decades has been on appropriate health service delivery, education, and training of Māori for the nursing workforce, and raising the awareness of cultural sensitivity by health practitioners toward Māori patients in public hospitals (Te Kaunihera o Nga Neehi Māori, 2020).

Te Runanga o Aotearoa (Te Runanga) sits alongside the New Zealand Nurses Organisation (NZNO), and represents its Māori health professional members nurses, student nurses, midwives, kaimahi hauora, health care assistance and allied health professionals. Te Runanga was officially recognised in 1990 and was then established within the New Zealand Nurses Union, (NZNU) (NZNO website, 2020).

Waka Oranga National Collective of Māori Psychotherapy Practitioners, was initiated in 1994, a motion adopted at the 1995 AGM “*That the Constitution be amended to include in the objects the clause: “to ensure that psychotherapy in Aotearoa New Zealand is conducted in accordance with the articles contained in the Treaty of Waitangi”*” was resurrected in 1997. The National members of New Zealand Association of Psychotherapists then progressed on the long and lengthy journey of discussions exploring, debating and putting into action ways that psychotherapy could be guided by the articles and spirit of te Tiriti o Waitangi and Waka Oranga was eventually created in 2006 (NZAP, 2020).

Conclusion.

In order to determine the workforce needs of Māori medical Practitioners, it is imperative that Māori themselves be resourced adequately to initiate discussion with their own members first and then determine the outcome of those discussions to allow the workforce needs of the profession to be met, in partnership with the ‘Crown’.

Understanding the workforce needs of Māori Practitioners from a Māori perspective, is ultimately an opportunity to close the equity gap on Māori health.



Methodology

This research project 'Whāia te Aronga a Kaiwhākawhānau Māori' was conducted within a Kaupapa Māori paradigm that acknowledges Māori ways of knowing and doing as legitimate processes to improve the health and well-being of Māori birthing whānau.

The aim of this study was to focus on the Midwifery Workforce needs of Māori midwives through their lived experiences as Māori midwives working in Aotearoa today and to translate those experiences into actionable facilitators that would best inform systemic changes in maternal and child-health service workforces specifically targeted at Māori. It was important that Māori midwives themselves identified what that looked like, felt like and could be like.

Kaupapa Māori research methodology (Smith, 1999) and Māori women's theory (Pihama, 2001) is described as methodology developed to ensure the safety and integrity of Māori being researched and that research topics being conducted are beneficial and appropriate for Māori. Kaupapa Māori research gives 'voice' to the voiceless (Smith, 1999) and it was created to level the unequal power relationships within the research community and to stop 'outsiders' from making Māori, targets for their research subjects. Kaupapa Māori research methodology and Māori women's theory are both responses that seeks to advocate for the rights and needs of Māori women and to make a positive difference for Māori, whilst being active in building the research capacity of Māori. The overall aim of Kaupapa Māori research is to conduct research that upholds the mana of Māori during the research process, in the reporting of the findings, and in the advocacy for Māori that follows the research.

Our collaborative, community-based approach ensured that aspects relevant to the experiences of Māori midwives were appropriately considered. Whāia te Aronga a Kaiwhākawhānau Māori, was supported by Pou Ruahine, Erin Sandilands, RM, Ripeka Ormsby, RM and Stella Hokianga RM, by Pou Ora, Louise Morris and Connie Kaimoana and Pou Aronui, Tā Timoti Kāretu.



Photo: Ta Timoti Karetu and Beverly Te Huia, Nga Maia Regional Hui Heretaunga 2020

Identifying and Contributing to discussion and Ideas for the future needs of Māori midwives and Māori midwifery students

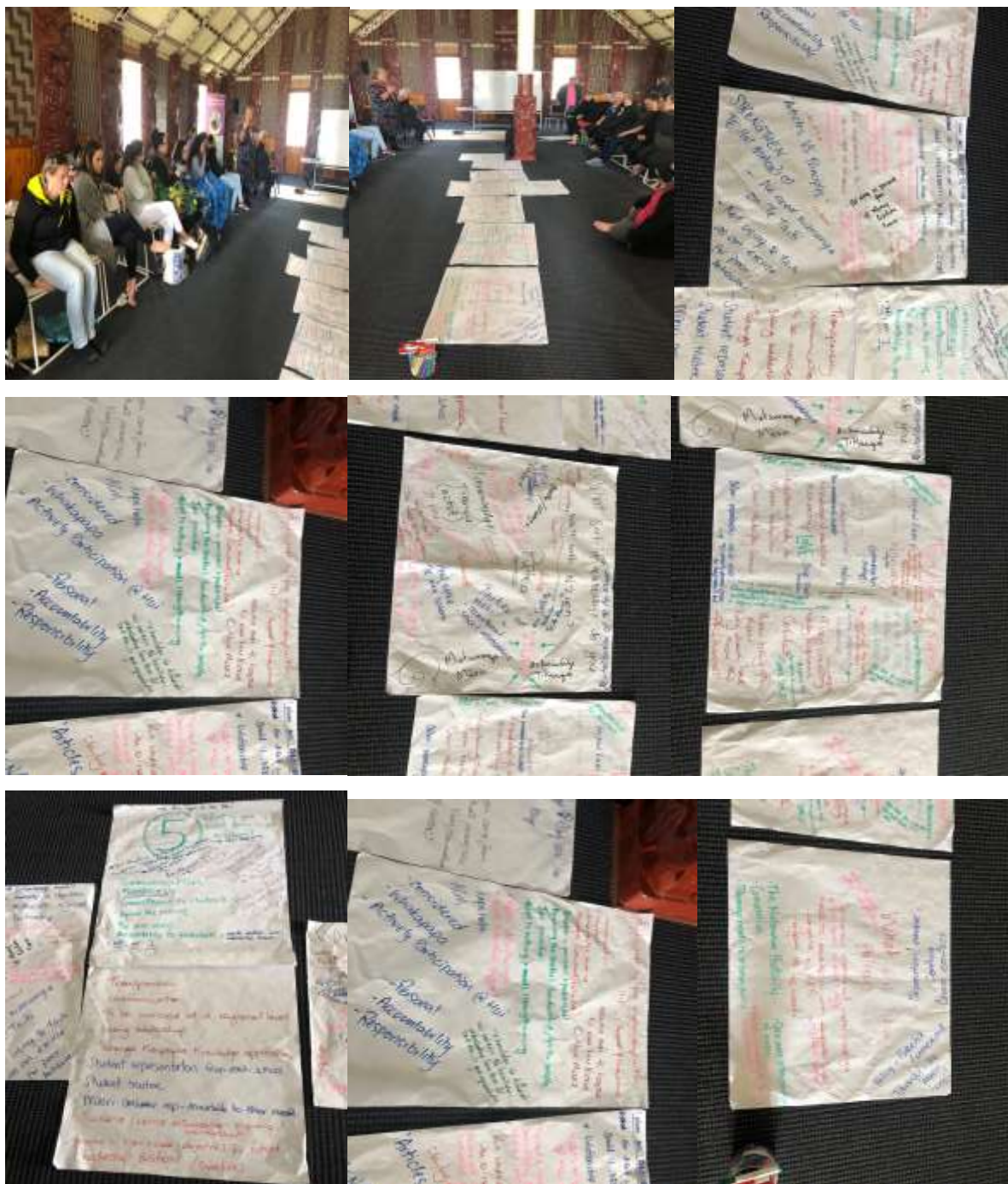
Māori midwives and Māori midwifery students met to wānanga in Northland over three days, from the 21st October until 23rd Oct 2019. Whaea Moe Milne (Ngati Hine) facilitated the Ngā Maia Māori midwives' workshop, where Māori midwives were separated into groups. The midwives were asked to identify te Tiriti partnerships and relationships, professional development and governance needs for the future, their dreams and aspirations, what would support them as the Māori midwifery workforce, Māori midwifery students, recruitment, retention and needs and to identify ways to bring about change for birthing māmā, whānau, hapu and iwi?



Photos: Ngā Maia Māori Midwives Annual Hui-A-Tau, Northland October 2019

Translating the Discussions into Actions

The outcomes were presented and discussed with the group continuing to feed-back, over the next 2 days. Four (4) themes emerged; 1) The importance of te Ao Māori, whākapapa, tikanga and being a Māori midwife. 2) Challenges; governance, leadership, relationships, working environment. 3) Roles and Responsibilities, resources, pūtea, 4) Need for more wānanga, more collegial support, reciprocal transparent roles, importance of kawa.



Photos: Ngā Maia Māori Midwives Annual Hui-A-Tau, Northland October 2019

Māori Midwives acknowledge their rightful place in Aotearoa as the protectors of mātauranga Māori birth



Photos: Ngā Maia Māori Midwives Annual Hui-A-Tau, Northland, October 2019

Participants

A total of 102 wāhine Māori who identified themselves as Māori midwives participated in this research project, they represent almost 30% of the Māori midwifery workforce in Aotearoa today. All participants identified as Māori and were living in Aotearoa at the time of the study. 63 Māori midwives, because of Covid 19 were unable to meet kānohi ki te kānohi or wānanga, and therefore completed a survey questionnaire. 35 Māori midwives attended focus group hui, in four separate regions following the lifting of Covid 19; Hastings, Napier, Palmerston North and Hamilton. 4 Māori Midwives elected to phone and speak with me personally. Of the 35 Māori midwives who shared their journey kānohi ki te kānohi - 31 held a current Practising Certificate, 5 Māori midwives were not practicing as midwives, but working with hapu māmā in areas of health promotion, smoke free and/or safe sleep as co-ordinators or antenatal educators. 1 had left midwifery altogether and was engaged in further tertiary qualifications in order to change her career.

Recruitment

Several invitations via email, social media, Facebook, and personal invitation were sent out over a period of five months from February 2020 until June 2020 inviting Māori midwives across the country to participate in the project. Ngā Maia Māori Midwives Aotearoa database was primarily targeted because of Māori midwives' affiliation to Māori midwifery, their geographical spread, as they are known to span Aotearoa urban, semi-rural and extremely rural across all DHB regions and because of their tribal relevance; whakawhānaungatanga. The invitation remains open, as the continuing need to engage within Kaupapa Māori Research Methodology Frameworks, acknowledges reciprocity, that includes continuous feed-back, information gathering which advocates for Māori participants, Māori Midwives, whanau hapu and iwi.



Engagement

- There were three (3) options that participants could choose to engage with the project.
- ⇒ Complete an anonymous survey questionnaire, where participants were asked to answer four questions. (Survey Monkey)
 - ⇒ Accept an invitation to participate kānohi ki te kānohi in a focus group hui.
 - ⇒ Contact the researcher directly (Confidentially) to kōrero. A phone number and email address were provided.

The Survey Questions

The four (4) themes identified from the Ngā Maia Māori midwives Hui-a-Tau held in Oct 2019 in Northland formed the basis of the four (4) questions in the survey in order that these 4 themes could be further defined.

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

Focus Group Interviews

As a qualitative method the Focus Group interviews were chosen because as Māori, we prefer to gather together and to enjoy each other's company whenever the opportunity arises. The focus group hui were conducted kānohi ki te kānohi and took place within the context of whakawhānaungatanga (relationships) which also gave honour to individuals, whilst also acknowledging the importance of being connected as a whānau (group).

A maximum number of 10 participants were invited for each hui to allow sufficient time for each participant to share their stories. About 4 hours was planned for each hui, in which time a meal was made available and provided. Most hui went past the 4 hours, six hours being the normal time, required for whakawhānaungatanga. The hui were conducted spontaneously, where the questions were introduced, but the discussion were generally broad and fluid. The hui were taped and then transcribed, as well the researcher took notes during the hui, and clarified responses periodically during the interviews.

A small 'koha' was given to each participant in acknowledgment of the participants time and costs for travel. All interviews were conducted in public facilities i.e. RSA restaurant, Hotel dining room, Motel Lounge or City Club where comfort, ambiance and warmth were considered important. An information sheet explaining the aims and objectives of the study and a participant consent form (Attached) were provided to each participant at the beginning of each hui. Participants were given the right to disengage at any time, and confidentiality was assured at all times.

Focus group hui (McLachlan, 2005) is considered as an appropriate qualitative data gathering process for identifying a group's beliefs about a particular issue in a non-directive manner, in a non-threatening environment. Focus groups have been recognised to be a powerful means to obtain and share such information from a group in a short period of time, and can be useful for groups who feel dis-empowered as it provides a safe place for participants to share their thoughts and feelings. The focus group approach can assist with the validation of experiences by other group members and are known to yield insights from the group's dynamics, that might not be so obtainable otherwise. The notion is that ideas are bounced off one another, allowing interpretations, reasoning, and an opportunity to de-brief. It is of particular importance where individuals within the group have endured or shared negative similar experiences.

The same four questions used in the survey, were introduced to the focus group participants for discussion. These questions formed the basis of the discussion, in order for the group to develop and share their collective ideas, the researcher reframed from participating in the discussions as an insider. It is acknowledged that there has been criticism for focus group hui, as participants can change their views during the group activities as they listen to other opinions. However, it is noted that shifts in opinions as a result of social interactions are considered normal, and considered appropriate for community needs assessments, educational planning, particularly in public health. As a starting point, focus group hui is acknowledged for obtaining social opinion and perspective to inform public policy and as a means to facilitate consultation within communities on social issues and to direct policy changes.

Focus group hui discussions can also be used alongside other qualitative and quantitative methods for the confirmation of the validity of data from different data sources-triangulation. In this project the use of a survey questionnaire and individual phone interviews was also used to assess participants views and to gather the data, and validation of responses were compared and analysed together-triangulation.

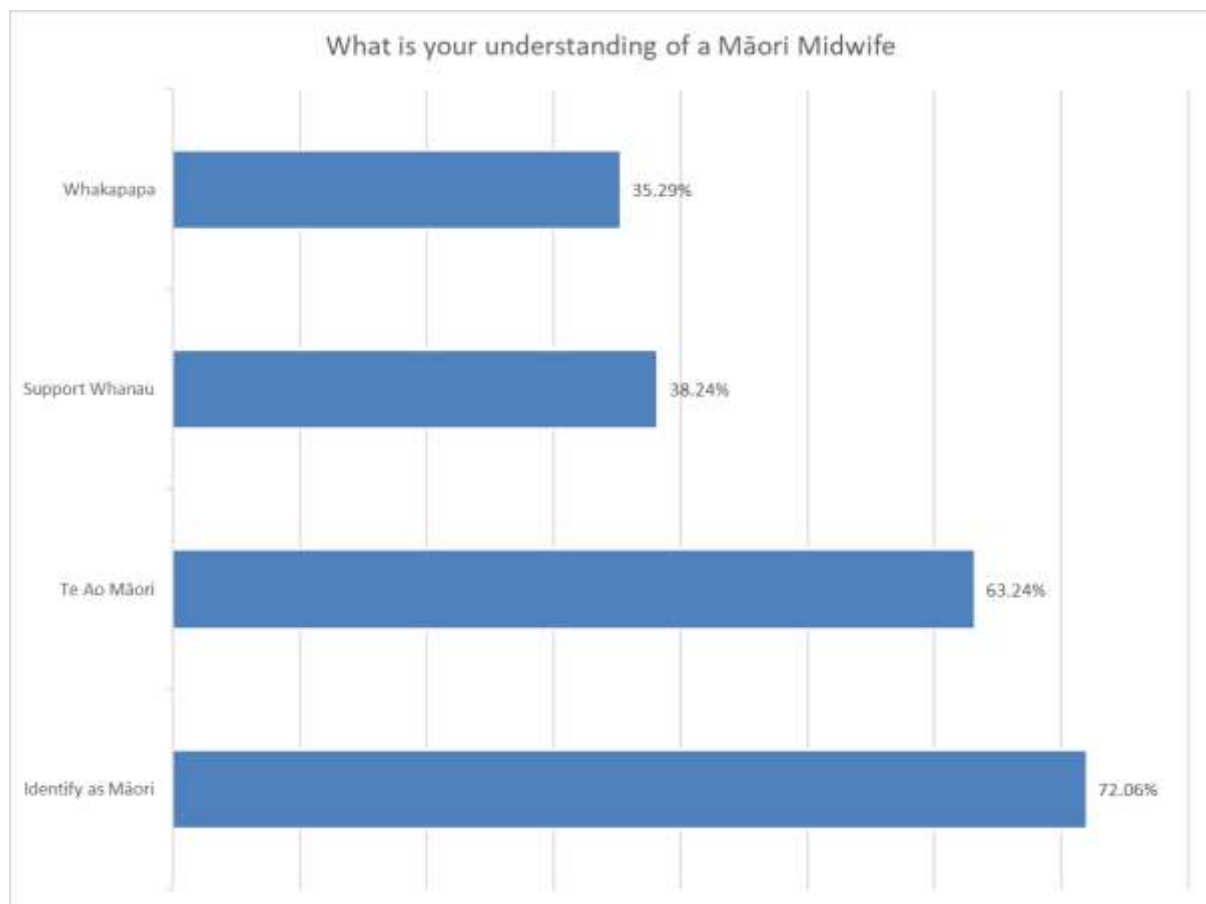
Data Analysis

Interpretive phenomenological analysis (IPA) guided the analysis of the interviews. IPA was elected as the analytical tool, because the focus of IPA on narrative and understanding participants experiences and determining the meanings they verbalise within their stories fits well within a Kaupapa Māori research project, that seeks to validate and privilege the voices of Māori midwives.

The aims and objectives within IPA is to identify commonalities and themes and differences in meaning, that the same participants give to an experience. In order to identify these themes, IPA involves reading and re-reading the interview transcripts and validating responses along with the survey questionnaires, to interpret the meanings of the participant's thoughts and experiences and to categorise them into themes. Once themes emerged, they were grouped together to form main concepts.

Results for Question One: Describe your understanding of a Māori midwife?

Fig 1.



Orientation: Locating Māori Women. Self-recognition and importance placed on being a Māori midwife

A key focus of this report is to understand and acknowledge self-recognition and the importance placed by midwives themselves to being a Māori midwife, and to recognise the qualities that they believe sets them apart from other midwives in order to support whānau birthing aspirations.

The literature review acknowledges that Māori women have a history of courageous, innovative, and ground-breaking contributions to the political, social, cultural, environmental, and economic landscape of Aotearoa (Tupara & Tahere, 2020). Māori women are described as Guardians of whākapapa, renowned and gifted in the cosmology of te Ao Māori and their influence in the creation and protection of man-kind is a common theme in Fig 1, 72.06% identify themselves as Māori, 63.24% identify their need to connect to te Ao Māori, with 38% acknowledging their importance in supporting whānau aspirations. 35.29% Māori midwives agreed it is a privilege to carry the mantel of their whākapapa and to connect with mātauranga of birthing.

The Māori language holds the key to significant mātauranga birthing and cultural knowledge, which describes the intricate time-honoured traditions and understandings of pregnancy and birthing in the context of te Ao Māori, a Māori perspective.

- ⇒ Tāpuhi, (midwife) a person who assists whānau in the birth of pēpi.
- ⇒ Hapu, means both to be pregnant, conceived in the womb, kinsman and subtribe.
- ⇒ Whāre-tangata -the birthplace of humanity-mankind, the womb.
- ⇒ Whenua, means both placenta, afterbirth, and land 'Papatuanuku'
- ⇒ Whaka-whānau, means both to birth, and Whānau, the extended family unit that a pēpi is born into.
- ⇒ Whākapapa, family heritage, blood ties, family lines that connect one generation to another, connecting ancestors to the pēpi. Whaka-papa, connections of blood ties to land, papa- tuanuku the earth mother.
- ⇒ Iwi means both strength, human bones and the extended kinship group, the tribe.
- ⇒ Whāngai- customary Māori practice, a pēpi raised not by the birth mother, but by another mother (Royal, 1992; Irwin, 2020).

Maori Midwives said:

'Maintaining Te Ao Māori values, and acknowledging one's whākapapa'

'I am Māori first and foremost, I am Māna Wāhine 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'

Mātauranga Māori Birthing Rites

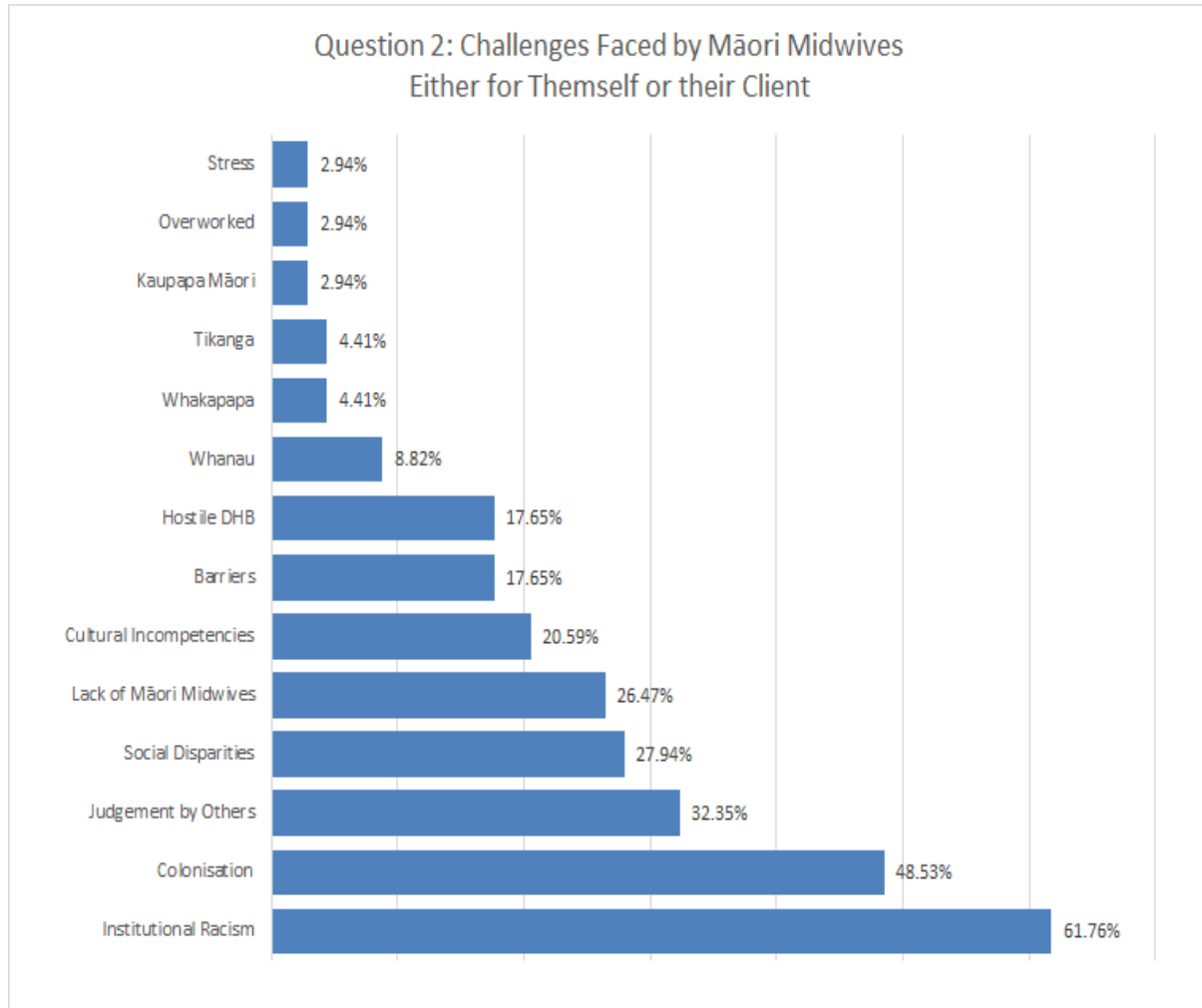
Māori midwives acknowledge that birthing within mātauranga Māori, serves to connect the intricate social relationships of Māori whānau in ways that locate and help embed pēpi within whānau, within the whākapapa of their ancestors. Māori midwives stated that to be called a Tāpuhi, instead of 'midwife' gave new meaning to the role of a midwife from a Māori perspective. Tāpuhi roles, are whānau centric, not delivered in isolation and included karakia-prayer, waiata-chants/songs, pūrakau-storytelling, rongoā-medicine/herbs, and mirimiri-massage. Kāranga-ceremonial call and kārakia were practices used in childbirth, ensured to clear the spiritual pathways of the pēpi as it transcended from the whāre tāngata – the house of humanity- the womb, to Te Ao Mārama, the world of light (Irwin, 2020).

Findings Question 1

Pregnancy and childbirth were honoured processes pre-European and its importance to Māori can only be understood in the context of te Ao Māori, a Māori world view (Waretini-Karena, 2014). Hapu Māori māmā were considered tāpu - sacred, during pregnancy and childbirth, their pregnancy and safety of their pēpi were matters for the whole whānau. Pregnancy and childbirth ensured privileged circumstances for hapu māmā, excused from daily chores, offerings of the best food, kaupapa Māori education and support. Pregnancy and childbirth were considered a normal process of life, young women were educated to understand and be well prepared. Rōngoā- medicines, were accessible for contraception and fertilisation. A tikanga related to birthing was the returning of the whenua -afterbirth-placenta to the whenua (Pāpatuanuku - The earth mother), thus retaining the physical links between the pēpi, their whānau whenua and ancestral whākapapa. Māori midwives expressed their desire and need to re-connect, re-establish, and support Māori whānau through tikanga.

Results for Question Two: What are the challenges for you to practice as a Māori Midwife? A) For yourself? B) For the needs of your client?

Fig 2.



Midwifery Practice in Aotearoa; Influences for Māori midwives and Māori whānau

Participants were asked to identify the leading challenges for them to provide midwifery care, for themselves and for birthing whānau. Fig 2 shows that without doubt, the leading three (3) challenges and workplace dis-satisfaction for the Māori midwifery workforce is Institutional Racism as the major factor, selected by 61.76%. Colonisation accounts for a 48.53% of respondent’s response. Judgement by others, 32.35% and Social Disparities for their clients, 27.94%. It was evident from the verbal accounts of Institutional Racism, by the participants, that Māori midwives and Māori whānau are affected equally.

The Māori midwives we interviewed offered powerful insights into their roles as Māori midwives, highlighting the ongoing tension and challenges in their experiences to provide care to hapu Māori whānau within a Eurocentric maternity system.

Results A) Māori Midwives Needs

Māori midwives, highlighted their feelings of isolation, being over worked, endeavouring to maintain midwifery care whilst feeling personally responsible for the social outcomes of their clients. Māori midwives also acknowledged that their midwifery care was often made more difficult, by Māori whānau whose struggles to maintain the bare basics of life, were their first priorities.

“It was my third visit to her, and she still hadn’t done her scan. Then she told me she didn’t have a ride, or the money to pay for it...”

Māori midwives spoke of being made to feel accountable and were sometimes phoned to follow-up Māori wāhine and judged negatively by others in the maternity sector, when hapu māmā did not complete scans or blood tests, required of them by obstetricians or secondary care teams.

“The obstetrician said angrily to me, ‘You need to hand over these women if you can’t look after them properly’ - because my lady hadn’t done her growth scan.”

“We’re just ringing you up to find out why your lady hasn’t done her bloods.”

“I know she’s under secondary care, but could you just go around and tell her she needs to do the GTT, and can you make sure she does it properly.”

Māori midwives spoke of being bullied, being over reviewed and audited, being constantly questioned, and challenged and being made to feel professionally and personally inferior.

“We heard this knock on the door, one of the hospital midwives was standing there ... she said ... the obstetrician told me to come down and see what you two idiots are doing down here?”

“I had been up all night ... I had finally put her in the postnatal ward and was doing my notes and having a cup of tea ... this care associate comes up to me and says, ‘You need to go and clean the shit out of the plug hole. You used the bath.’ ... I said, ‘That’s not my job!’ ... I then rang the midwifery advisor. She said I had to clean the bath myself, after using it for a water birth. I said registrars don’t clean up after themselves. She said nothing.”

“Racism, colour of my skin, my surname, not being taken seriously, my clients undermined, undervalued, working defensively, instead of being with my clients, working in fear spending most of my time documenting, clients being judged, rudely spoken to ...”

Examples were given by Māori midwives of being deliberately excluded from conversation, lied to and mis-informed especially when Māori whānau were under surveillance from child welfare services.

“So, I said, ‘What’s happening? Can she go home or not?’ I then went back into the room, and we started packing up her things and then this woman comes in and tells us they are taking the baby...”

“I saw this letter in her notes. They had already decided but they didn’t tell me?”

Māori midwives also revealed a profound loss of faith and trust in the mainstream maternity system and expressed ongoing concerns over the health and safety of their Māori whānau, stating that the majority of the midwifery workforce were not born here in New Zealand and many lacked the opportunity or desire to understand the cultural needs of Māori accessing maternity care.

“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 ...”

“When we went to check the CTG, she had taken the straps off and gone outside for a smoke. That’s when Blah Blah said, ‘It wouldn’t happen in our country, we just tie them to the bed.’ I looked at her and said. ‘You’re not in South Africa now you know?’ She just stared straight back at me. Her blue eyes didn’t even flinch.”

Many Māori midwives elected to accompany Māori whānau into mainstream maternity hospitals to provide secondary midwifery care themselves, when officially not required to do so within their roles as primary health Lead Maternity Carers (LMC), in order to better advocate the needs of Māori whānau. It is apparent within this report that paradoxically, Māori midwives, suffer equally the disparities Māori whānau experience when accessing mainstream maternity care in hospitals.

“I said, ‘OK then, I’ll come with you.’ - because I knew how scared they were, even though I was scared.”

“I rang the hospital to see what was happening, but there was so much bull-shit going on ... I decided the best thing to do was go up there myself ...”

“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.”

“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...”

“We have more problems with working as Māori, Pakeha midwives don’t get the same amount of questioning or looking into their practices as we do...”

“Racism, colour of my skin, my surname, not been taken seriously, my clients being ... undervalued in terms of our culture, used as a token, sometimes working defensively ... working in fear spending most of time documenting...”

“Racism, negative perspectives of Māori both for midwife and whānau”

“Poor cultural understanding by mainstream”

Results B): Māori birthing māmā, pēpi and whānau needs

“They got no support in there ... racism ... institutional racism is imbedded 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, wāhine and negatively impacts on whānau for generations!!”

Recognising also the limitations their care provided for hapu Māori māmā whose lives were severely impacted on by social barriers to health; Intergenerational trauma, unemployment, extreme poverty, lack of education and transport, no or overcrowded unhealthy living conditions, exemplified by a lack of ongoing infrastructural support. Combine this existence for the majority of hapu Māori whānau, along with the increased availability of meth, alongside a prevailing gang culture within their communities and the full recognition of this situation, is blatantly missing from the mainstream midwifery narrative. In contrast a simple reality that aging Māori LMC midwives know and understand and therefore negotiate safely, on a daily basis.

While it is fair to say, the gang world is not freely available to mainstream in order for them to understand the maternity needs of gang members. Māori midwives state proudly that they have been around for a long time, have access to gang homes, and have probably delivered most of the gang members themselves. The ‘whānau midwife’ is the role most mature experienced Māori midwives are known by within communities, delivering successive pēpi for the generations of the same whānau, irrespective of whether they are gang members or not.

Māori midwives acknowledge the hospital can be a terrifying place, but spoke in humour, of 6ft, fully ta- moko gang members transformed, who witnessed the birth of their pēpi and were reduced to tears. In essence, being a Dad is as biological a phenomenon as being a māmā. Research is available that proves, that fathers who attend the birth and immediate care of their new-born baby, are more likely to respond to positive paternal involvement throughout the child’s life. Sadly though, the presence of ‘Gang Members’ within mainstream maternity hospitals, is more likely to bring about a referral to child welfare agencies for Māori whānau. Māori midwives said, hapu māmā, often hid the presence of ‘gang father’s’, sometimes through-out the entire pregnancy and it seems for good reason; those gang fathers who did attend the birth of their pēpi, were often if not, mis-understood, reduced to ‘voiceless spectators’ in the birth of their pēpi.

“I was told at the front desk they could hear them fighting from the next room, so they called security. I walked in. He was sitting on the floor against the wall, beside the bed. She was holding the baby. ‘What’s happening?’ She told me he wanted to go outside for a smoke, but she wouldn’t let him, so they started arguing! ... I then found out she was scared to let him leave the room in case something happened...”

“The hospital midwife rang me at 9pm and told me to get up there. ... He was intimidating staff and frightening other patients. ... When I got there, he was standing outside the door holding fish and chips. ... He told me he had gone to get them something to eat but when he got back, they had locked the doors. ... He said he rang the bell but couldn’t see anyone. No one would let him back in so he said he started knocking on the windows, hoping someone would hear him and open the doors. ... That’s when the police arrived...”

The unfairness of the maternity system on rural Māori whānau when it imposed extra cost on them, was further recognised by Māori midwives, who describe how under resourced Māori whānau are expected to travel up to four hours to have a scan, or to attend specialist antenatal appointments and worse still to leave their tamariki and partners for weeks when made to await delivery in a tertiary hospital, when their condition was deemed as an unsuitable ‘risk’ that would otherwise, allow them to birth in their own primary unit.

“She yelled out to 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! It’s 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...”

The workforce of Māori midwives through-out Aotearoa is small, and many know each other personally, often Māori midwives will ring another Māori midwife in another region, to tell her of her ‘lady’ and to ‘hand-over care’ or to ask her to ‘watch out for my lady’.

“I got a call from blah blah ..., her lady was coming from Wairoa at 38 weeks for unstable lie ... I rang the specialist when she arrived. The head was well down. I said we should get on with it, but they wouldn’t, so they made her stay at the whāre. A week later I got a call from the hospital. They were calling the police because things were

missing from the whāre... When I got to the hospital the next day one of the midwives showed me photos taken on the phone of the woman's room at the whāre. It was a mess, ... but how come they are allowed to do that? How are they allowed to go into her room and take photos when she's not there? ... and then circulate them around the hospital to all the staff? ... If they had of listened to me in the first place, she would have been home a week ago. It's their fault this has happened."

The forced evacuation of hapu māmā can raise speculation when Māori māmā were deemed 'At RISK', for gravida over 5, or when their BMI (Body Mass Index) was over 35, both re-occurring themes for Māori birthing māmā and for which some Māori midwives' stated was 'normal for Māori'. These Māori midwives speculated that the ethnic difference of hapu Māori are not fully taken into consideration by mainstream maternity assessments. This perceived lack of confidence in the maternity system by Māori midwives adds further 'risk' to Māori midwifery practice, when by default they do not actively ensure Māori birthing wāhine evacuate for birth and identifies the need to further understand these phenomena.

"I went around to see her again ... because they said she had to go to blah blah to birth her baby ... because her BMI was over 35 ... but when I tried to explain it to him, he got mad. ... He said, 'But I'm working. There's no-one to look after the kids.' ... And then he looked at her and said, 'Oh, you fat bitch. I told you before to go on a diet.' ... I felt really sorry for them and started thinking where I could find someone to help look after the kids for them ... but there was nobody..."

Māori whānau across generations, understood the sacred role of the whāre-tangata, to bring new life to the whānau. Whāngai is the Māori customary birth practice where the pēpi, is born then raised by someone other than the birth mother. Whāngai pēpi are special, raised to know, love, and appreciate both their birth mother and Whāngai mother simultaneously. Many of us as Māori, including myself who was a whāngai pēpi, believe this is a normal function of mātauranga Māori birthing. Māori midwives acknowledge that the customary rite of 'whāngai' still happens regularly today, however this practice is frowned upon, and misunderstood by mainstream maternity hospital policies and environments not designed for diversity. Māori midwives stated that some DHB's protocols have even been written to forbid whāngai in 'their DHB'.

Māori midwives told of their negative experiences, where 'whāngai mother's' were forbidden or excluded from being allowed to stay overnight in postnatal rooms, even when hospital staff were told the baby was going to another member of the whānau, the birthing

mother was often forced to breast feed; or to sign forms to say she elected not to breastfeed. Often the birth parents were forced upon discharge to carry the baby themselves, only to hand the baby over in the car park, and some birth mothers were unexpectedly visited postnatally, at home by child welfare services, after receiving a referral of concern, from hospital maternity staff.

Findings Question 2

This qualitative research provides an in-depth narrative of the lived experiences of about 30% of Māori midwives working as midwives in Aotearoa today. Those we interviewed do not purport to speak on behalf of other Māori midwives, however, the legitimate question that arises from their experiences and their concerns expressed for Māori whānau they care for, has to be their collective understanding of ‘Institutional and Personal Racism’ that Māori face within the mainstream maternity system, which many 62% of Māori midwives, believe exists on a daily basis.

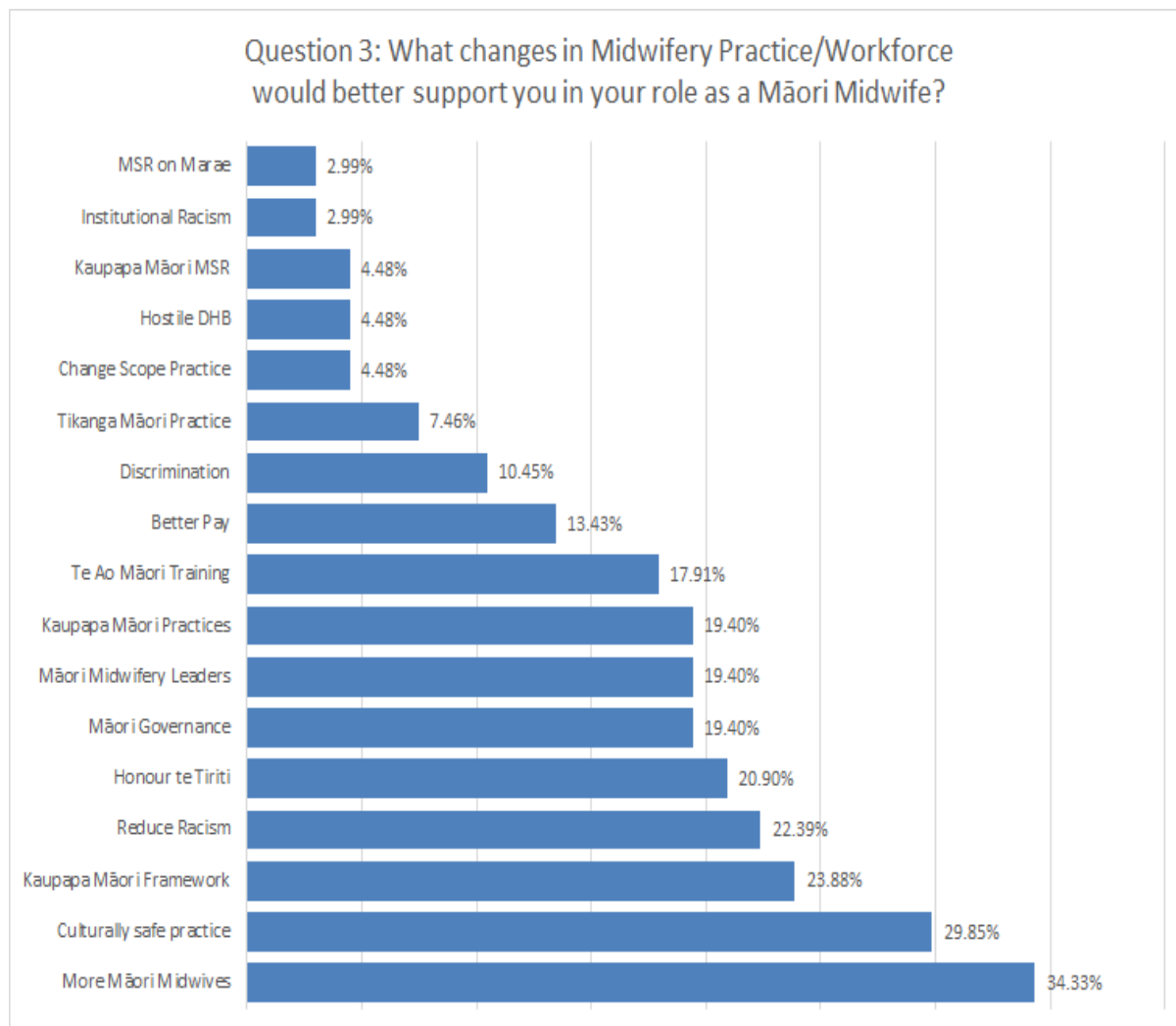
Institutional Racism exists in many forms throughout the maternity and midwifery sector as identified by the participants. Māori Midwives experienced a heightened sense of tension, which they determined led to an increase in their anxiety levels and stress levels, for both themselves and for their clients, when navigating the maternity sector.

Many Māori midwives expressed concerns that increasing ‘cultural knowledge’ and ‘better understanding of Māori maternity health needs’ would not necessarily lead to a reduction in institutional racism in maternity and midwifery care, in fact many believed the reverse would be true. As defined by Mereana Pittman (2020), ‘*The only thing worse than a racist, is an educated racist*’.

Cultural Competence and Cultural Safety Programs, such as Turanga Kaupapa, were never intended to address ‘racism’ or educate ‘racists.’ The competence literature available and models presented on this subject, which is vast and far reaching throughout the world, suggests ‘Cultural Safety Education’ does not take sufficient heed of the issues of racist ideology and actions, and as such fails to change or to deal with the negative impacts such behaviour expresses, and that it is perpetuated in places such as that experienced by Māori within the maternity sector. Change will only come through structural change, such as that imposed by ‘Legislation’ where Māori representation is based upon Māori needs, and Māori Population Based Services, including workforce numbers from a Māori perspective ‘or by honouring te Tiriti.’ (Waretini-Karena, 2019)

Results for Question Three: What Changes in Midwifery Practice/Workforce could better support you in your role as a Māori Midwife?

Fig 3.



Route Decisions for Revolutionary Change- Identifying Inequities and Opportunities

The literature review (Tupara & Tahere, 2020, p.91) identifies that the capacity and capability of Māori to lead and then respond appropriately to the needs of the Māori midwifery workforce, as well the needs of whānau Māori, is multi-faceted. Fig 3 shows 34.33% of respondents agree that the biggest inequity for them, is also their greatest aspiration, to have more Māori midwives beside them. Being able to provide culturally safe practises 29.85% within a Kaupapa Māori Framework, 23.88% as being the three opportunities they most consider as being important.

Many 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 hapu Māori māmā.

“I told her the blood test said she was at risk ... and they wanted her to do an amniocentesis. ... She said, ‘NO’, because it could hurt the baby ... but when she went for her visit to the obstetrician, they did it anyway ... and then later on she had a miscarriage ... Whether it was because she did the amnio I don’t know?”

“Isolation, mainstream medical world- lack of understanding for Māori needs.”

“The colonial oppressive medical system that has crept into midwifery undermines many aspects of wellness and partnership.”

“Secondary care midwives influence Māori women when they are admitted antenatally, sometimes they change care from me, because they are made to believe they are missing out on something more than I have offered...”

Māori midwives raised concerns over contraception, stating that in some cases, wāhine Māori māmā were given a LARC- Long Acting Reversible Contraception prior to being discharged from hospital and that some wāhine Māori did not fully understand how they worked. Some Māori midwives speculated that temporary medical sterilisation was being forced onto wāhine Māori without their knowledge or properly informed consent? Māori midwives also raised concerns over the limited scope of practice of midwifery in their ability to support the sexual and reproductive lives of Māori wāhine.

“I’m not sure, but they give them a Jadelle or a depo, or put a Mirena in at the section, and some of the women dig them out themselves ...”

“And she came to see me again and said, ‘I know I’m pregnant’ ... ‘I haven’t had my period since I had my last baby.’ ... ‘I’m usually pregnant by now?’ ...”

“And this pakeha midwife said, ‘I don’t even know why they keep having kids? They can’t even look after the one’s they’ve got now! They should be sterilised!’ ...”

“That’s where midwifery care could make a difference, we should be able to give them their contraception, and treat them for STI’s ...”

“As LMC midwives we work in communities that know and trust us, it makes sense if you’ve birthed all their babies to be able to give them contraceptives, there’s a total lack of understanding of what we do in Māori communities.”

“I treated her for chlamydia twice. The next time I tested her I gave her extra medication because unless he got treated as well, we weren’t going to win...”

An exploration of current maternal mental health screening practices amongst Māori (Holder, 2019) was equally described as adhoc and referred to multi-level barriers that hamper Māori outcomes. The publishers further acknowledged institutionalised and interpersonal racism affected Māori māmā and pēpi, with the potential for life long and for some, devastating consequences.

“We need to be acknowledged for the extra work we do for our whānau...”

Māori midwives also conveyed a greater anxiety, to the continued colonisation of Aotearoa, the loss of mātauranga Māori Birthing Knowledge and resistance by mainstream to re-introduce aspects of Tikanga Māori back into midwifery care by the continued lack of acknowledgement of Māori as Te Tiriti Partners in the development, contribution or delivery of midwifery care in Aotearoa today.

“They wouldn’t let us use the muka ties because they said it wasn’t sterile...”

“I went to the meeting but because I was the token Māori, they wouldn’t listen to me. I then tried to get the kaumatua to come with me ...”

“I’ve seen these midwives from overseas sitting at the computer, answering questions on the treaty: a tick box. Then when they’re finished, they’re supposed to be culturally safe to work with our whānau?”

“You can’t go in there and just do what you want, even if that’s what the woman wants. It’s a joke. They talk about partnership but in the end it’s about the system and making sure you stick to the rules, their rules ... otherwise ...”

“Yeah, and they want to know every detail, (DHB Midwifery Staff) but not to help. Just so they can talk about them and run them down.”

“They look down their noses at us. We are judged. Even though we are midwives, they just see us as Māori’s.”

“There’s no respect for our knowledge, or even for how long we have been midwives for ... they (Obstetrician) send their flunky in to recheck a VE, even though I’ve been a midwife longer than they have been a locum, ... they don’t trust us ... we have been black listed (turning to her colleague) .. when they see us coming you can see the distrust in their faces ... (they both nod) ... the way they look at us, it’s horrible. ... Just imagine how our women feel...”

“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, 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 try to 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.”

“You can’t get a Māori midwifery workforce; we haven’t been able to ever ... you ... It requires the government to make a dedicated plan to support the growing of Māori midwives, or to support and invest into Māori midwifery leadership roles. ... I don’t have any faith that will ever happen. ... Look at how many overseas midwives there are ... and another problem is there aren’t enough of us, on the same page ...”

“And that’s not anything any government has ever tried to do. So, what I see is a lack of commitment from the government to support a better maternity service that meets the needs of Māori. They deny Māori tamariki a positive and affirmative start in life. Because what I believe is, our Māori midwives provide ... that initial antenatal education and kaupapa Māori support for young pregnant women to understand their responsibility ... to go on to be good mothers. And when that whole area of the workforce is missing ... in terms of a young Māori family and a young Māori group of people not coping or becoming parents for the first time ... it’s not fair ...”

“Yeah, and when you look at the health workforce issues in New Zealand, the system, the status quo, works to maintain the status quo.”

“I think it is imperative that 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.”

*“Yeah. I just ... I mean when I think about Māori midwives and the work we do in addition, that we burnout. ... Because you are not supported within the current model of midwifery to do that extra work. ... So it kinda fulfills a bunch of things, whether intention or not. You have a Māori midwife that is burnt out and stops working which is [a position] then not filled. ... So, there is a system that benefits by only supporting what **they** want...”*

“So, they are very quick to blame and shame and I think midwifery has a lot to do with that because midwifery has ... is very ... what’s the word? Is very problematic in that it’s open to criticism both public, professional, personal... You know, we’ve got doctors against midwives, we’ve got establishments against independent midwives that say they shouldn’t be using the hospital and public health system. It’s such a political hot potato, midwifery. And in the midst of all of that, we’ve got the struggle for us as Māori to be autonomous and to be saying what we need as Māori, in the midst of all that midwifery political unrest.”

“You know, when you look at midwifery and where does it fit into our health system, I think Māori people struggle and you can see that from the Treaty of Waitangi claim, and what they have done or not done for health ... because while we are struggling to fit midwifery into a Māori content, ... and that’s about the workforce as well as the service ... we as Māori are still struggling to fit Māori into a health context. You know, where do we fit into the NZ health system as a whole? ... Because I think that that’s also a problem. ... I think that while we are struggling for independence and while Māori continue to struggle to find their place in NZ society, ... midwifery is just one of the realms or one of the areas that has yet to be defined by Māori, ... we need to be able to describe what that looks like, for ourselves, and then be resourced appropriately to do it!. By Māori for Māori ... no one will do it for us ... they have a vested interest in keeping us down!”

“Yes, why do we have to be called MIDWIVES and not TĀPUHI? we should be defining the role of the TĀPUHI, and then as Māori we have a right to determine what that is! What that looks like for ourselves as TĀPUHI, and how that would look like for our whānau...”

“Yes, Mereana Pitman said, ‘the Namer of the Game rules all things!’”.

“You can’t separate Māori mothers, babies and whānau and silo them. That’s what the current midwifery model does. There’s nowhere in there for whānau. It’s all about the mother and the baby... We can do better than that...”

Findings Question 3

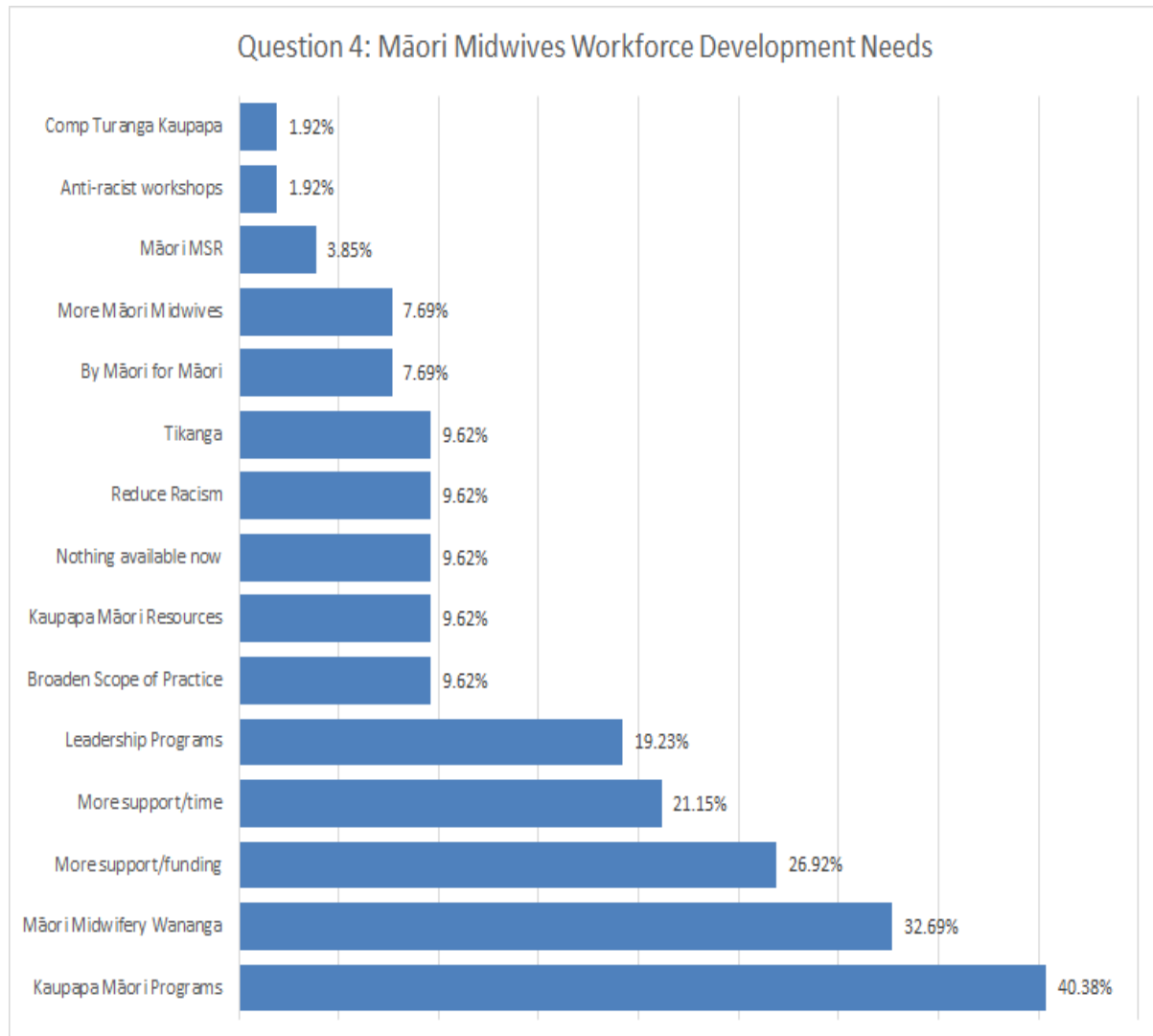
Māori midwives working in the maternity sector identify multiple spaces that require attention in order for the maternity and midwifery sector to be able to meet the social, cultural and, health needs of Māori clients and for themselves. There is a strong call for unity, among Māori midwives themselves, and for By Māori for Māori solutions and service development particularly in areas of mātauranga Māori birthing, Kaupapa Māori frameworks, that would allow Māori a greater say and leadership in what that should look like. Inconsistencies exist in Cultural Competence, including a lack of knowledge and commitment by non-Māori midwives, with little or no re-dress for birthing whānau to have their needs culturally accommodated.

Māori midwives also recognised the need for Kaupapa Māori professional review mechanisms, such as a Kaupapa Māori Midwifery Standard Review Process where Māori as the recipients of care, would be enabled to participate. Māori midwives expressed 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 healthcare for whānau Māori.

Findings around the emotional well-being of midwives in Aotearoa (Dixon et al., 2017), revealed that although midwives who work in DHB work fewer hours, LMC midwives providing case loading continuity-of-care, had better emotional health and higher levels of empowerment than those who were DHB employed. Further evidence within the study provides evidence that working together with the support of midwifery partners, and having flexibility and autonomy has the potential to be protective for those working in it. More Māori midwives within the profession, was the greatest need identified by Māori midwives.

Results for Question Four: What are your workforce development needs for the future?

Fig 4.



Professional Development Plans and Aspirations

The value attributed to Kaupapa Māori Programs is highest on the list of respondents needs, 40.38% and is an integral component of Māori midwives’ workforce development aspirations. Being able to wananga together ‘whakawhānaungatanga’ 32.69% and more funding to be able to achieve these goals, pūtea - 26.92% are the leading workforce development needs identified by Māori midwives.

Māori midwives spoke of their dreams for the future, aspirations for self-determination, where the ability to encompass te Ao Māori into their practise would ensure Māori whānau cultural connections for better outcomes, as prerequisites to continued good health.

“Māori midwives can make positive differences for Māori whānau, who have been intergenerationally marginalised ...”

“We can enable whānau to attend kaupapa antenatal class to broaden their knowledge about ipu whenua, pito and Muka, wahakura, whāre tāngata...”

“More Māori midwives in the motu, supporting each other.”

“Let us decide what we need, more wananga, more hui, more safe places to connect...”

“Brown lives matter ... We matter ...”

“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...”

“Worried that if we refer our clients they will fall thru the cracks. Worried because our voices are not listened to. Basic human rights that are broken every day in a society consumed by consumerism instead of ecological environmental holistic approaches, alongside the knowledge passed down from our tupuna.”

“Compulsory cultural safety education for every non-Maori working with our whanau”

“I had to pay and do my MSR again I felt angry that I have to justify my midwifery practice to tau-iwi who can’t even say my name properly...”

“The MSR process is a pakeha construct, why should we have to explain to pakeha how we work...”

“We need to be able to have our MSR on marae, we are accountable to our whānau first and foremost, not to pākehā midwives...”

“Having to be reviewed through pākehā professional bodies, justifies their pakeha worldview, we are voiceless, I have to work twice as hard...”

Findings Question 4

Mātauranga Māori birthing rites in a contemporary undertaking are described by Māori midwives as flourishing today, including the ongoing and endearing practice of Whāngai. Māori midwives expressed with some trepidation, the growing birth rates of Māori pēpi, predicted to be 30% of Aotearoa population, and suggest more Māori babies being born to more Māori whānau, will put more cultural demands on an already resistant Eurocentric maternity system.

Equally and more Ironically, in response to the re-conscientisation and growing influences of te Ao Māori activities, such as te Kohanga Reo over the past 40yrs, a growing urge by birthing Māori to reconnect to being Māori equates to a shortage of Māori midwives to provide this service. Māori research provides evidence and advocates like Dr David Tipene Leech, whose ongoing relentless pursuit to address un-acceptable Māori SUDI (Sudden Unexplained Death of an Infant) rates, witnessed a Māori solution in the use of wahakura.

The legitimisation and importance of cultural connectedness in birthing, puts further pressures on Māori midwives, who themselves expressed their desire and need to wānanga and to learn more Māori birthing knowledge (Tikanga) but struggled to find the time, the extra funding for appropriate resources and the appropriate tutoring upon which to learn these skills. Māori midwives felt further aggrieved that some pakeha midwives are introducing mātauranga Māori Tikanga into their own midwifery practices.

The role of Tāpuhi in keeping alive mātauranga has been undermined by the state, through Colonisation and Assimilation policies, The Midwives Registration Act 1904 and the 1907 Tohunga Suppression Act. The attempted state apprehension of a new born Māori baby in 2019 has driven a new call for accountability and to question the role of the DHB's (District Health Boards) as official 'Crown Entities' in determining Māori motherhood, Māori birthing practices and Māori maternal and child-health realities. Māori have human rights and rights as citizens of Aotearoa to be treated and respected in ways that honour them, their ancestry and whākapapa as 'Māori' and to be acknowledged for their rightful place as the indigenous peoples of Aotearoa, lawfully protected within the obligations signed in te Tiriti o Waitangi.

Summary Findings

Māori as Tiriti partners have not been served well by the Health and Disability System, Māori midwives are severely under-represented in every area of the maternity and midwifery sector. Māori midwives are proportionately outnumbered 300-1 within the midwifery work force. Māori as the indigenous peoples of Aotearoa, experience significantly different negative maternity health outcomes, from a maternity system that is suffering from systemic collapses and where the preventable mortality and morbidity of Māori women and Māori babies persists unabated. (Tupara & Tahere, 2020).

The Health and Disabilities Systems Review (Simpson, 2019) identified that the following changes were needed:

- ⇒ Ensuring consumers, whānau and communities are at the heart of the system.
- ⇒ Cultural change and more focused leadership.
- ⇒ Developing more effective te Tiriti based partnerships within health and disability and creating a system that works more effectively for Māori.
- ⇒ Ensuring the system is integrated and delivering plans ahead with a longer-term focus.

Hauora Māori

The review also acknowledged that Te Tiriti relationships need to be reflected throughout the health and disability system and improving the equity of health outcomes for Māori requires the system embed mātauranga Māori into service delivery. To ensure Māori as Tiriti partners, structural, governance and legislative changes have been proposed. Resources are to be directed to where they are needed most, and the services must be designed to suit the needs of whānau.

The recommendations:

- ⇒ A Māori Health Authority to be established with independence to advise the Minister and monitor performance with respect to Māori outcomes.
- ⇒ Provisions related to te Tiriti be updated.
- ⇒ DHB/Iwi partnerships strengthened, locality plans to provide kaupapa Māori services.
- ⇒ Population based funding formulas to include ethnicity and deprivation factors. (Simpson, 2019).

Recommendations

An overall focus of a Kaupapa Māori National Maternal Child-Health Workforce Strategy is about Māori midwives re-defining their own workforce priorities and then re-developing a pathway to achieve their own collective aspirations. At the forefront is for Ngā Maia to become the preferred Midwifery (Māori Birthing) choice in Aotearoa for Māori birthing māmā, that focuses on mātauranga, Kaupapa Māori birthing practices delivering primary health care, principally maternity, midwifery and well child services to whānau Māori in partnership with Whānau Ora. This objective would require structural and operative change.

The outcome would ensure equitable outcomes for Māori in Maternity and Maternal Childhealth care as determined by 'He Korowai Oranga' (2019) the Ministry of Health Māori Health Plan, raise the awareness of Māori birthing needs, and ensure a more equitable service.

The measurable outcomes will:

- Support whānau, hapu, iwi and community development
- Support Māori participation in all levels of the maternity, midwifery, and childhealth sectors
- Ensure consistent culturally effective maternity, midwifery, and childhealth service delivery
- Support and maintain working relationships across sectors.

A National Maternal Child-Health Workforce Strategy which would support Ngā Maia Māori Midwives aspirations focuses on five primary areas which are central to the success of an effective and efficient functional Maternal Child-Health Māori Midwifery Work Force Strategy that includes the following areas:

1. Governance Structure Review & Organisational Development
2. Workforce Development
3. Recruitment and Retention
4. Training and Development (Cultural Competence)
5. Information, Research and Evaluation.

1. Governance Review & Organisational Development

The Governance structure for a strong Ngā Maia Workforce Development (WD) plan includes a collection of approved and valued mechanisms, structures, processes, and system's oversight that would lead to effective and efficient policies, planning and accountability to whānau, hapu and iwi Māori. The objective of the plan would support the attempt to standardise information and knowledge for both the National and Regional Committees in developing a strategic WD plan across Aotearoa, New Zealand.

Current Governance structure includes a (5) five member elected BOT and various regional ropu of Māori Midwives through-out NZ. A lack of resources, financial and spirited team effort, and restrictive NZCOM domination continues to dis-empower Ngā Maia's efforts to develop and to support a strong and efficient Māori birthing and childhealth culture, across Aotearoa that could better meet the needs of a diverse birthing Māori population.

Rationale

Ngā Maia will develop an organisational culture of high performance serving whānau Māori in Birthing and maternal childhealth care.

Key Focus Areas

- To embrace Te Tiriti o Waitangi—across all sectors of the maternity, maternal and childhealth arena.
- To codesign and protect the interests of Māori birthing knowledge and Māori childrearing practices both traditional and contemporary
- To uphold organisation values and demonstrate financial and organisational effectiveness to support the WD strategic objectives
- To be innovative and responsive to Māori birthing and childcare needs
- To review and update the Turanga Kaupapa cultural framework
- To build a more culturally responsive Māori workforce that affirms Māori birthing and childhealth needs.

Opportunities/Options for Ngā Maia Consideration

- Establish and re-affirm Tiriti Relationship with NZ Midwifery Council and New Zealand College of Midwives
- Establish relationship/partnership with NGOs such as Whānau Ora Commissioning Agency.
- Establish relationship with NZNO Māori Midwifery members.

2. Workforce Development

Ngā Maia aims to be the “preferred” Midwifery voice of choice in Aotearoa that focuses on delivering traditional Māori Birthing practises; to deliver primary healthcare, principally maternity, midwifery and well child services to whānau Māori.

Ngā Maia considers the wider changing environment and the realities of “economies of scale”. Ngā Maia has the potential to align with NGO’s or Whānau Ora – both a metaphor for mainstream, but a reality for Māori, Whānau Ora is an alliance of Māori providers that now operate as a single service provider (retaining their own legal entity and autonomy)

Rationale

The disparities for Māori utilising maternity, midwifery and childhealth care is evidenced in the negative outcomes experienced by Māori whānau, and is proportionate to a 300-1 Māori midwifery workforce shortage across Aotearoa.

Key Focus Areas

- To co-design strong clinical and cultural policy and activity frameworks using a bicultural partnership model
- To build the professional, clinical, and cultural knowledge of Māori birthing and childrearing practices across Aotearoa
- To establish a strong public image of Māori birthing and childrearing practices
- To be a lead voice for Māori birthing, childhealth and social services involved in Māori birthing
- To lead the recruitment, retention and resurgence of a Māori birthing and child-health workforce and promote the growth of Māori leaders in the sectors
- To establish and provide Kaupapa Māori Birthing and Maternal and Child-health Education programmes to increase Māori workforce.

Opportunities/Options for Ngā Maia Consideration

- Further develop and support current relationships with Māori NGO’s
- Joint venture opportunities with existing education providers
- Seek Government assistance through new Innovation Funding
- Incorporate, Kaupapa Māori meā ngā Reo, meā ngā Tikānga.
- To capture ‘Tikanga Birthing Data’, currently NOT Considered important.

3. Recruitment and Retention

Ngā Maia aspirations of Recruitment and Retention are very broad. This is not just about establishing a Kaupapa Māori Midwifery School, but also employing and maintaining a sustainable workforce, developing and co-designing ideas about traditional Māori birthing within a 'contemporary' model and rethinking what a Māori maternal and child-health workforce looks and feels like.

Rationale

A sustainable workforce encourages confidence for stakeholders and reduces costs associated with recruitment and turnover. Critical to retention is professional development and succession planning. It is beneficial to identify and support the growth of Māori leaders - who desire to develop and grow and who are capable of new and/or evolving roles including post graduate studies.

Key Focus Areas

- Professional development and development of leadership programmes postgraduate, masters, and Doctorate study; redefining Māori Birthing and Child-health curriculum
- Tuakana /Teina models; mentoring and midwifery of first year of practise programmes supporting recruitment and retention of Māori students
- Succession planning; supporting existing Māori practitioners, recognition of knowledge, engagement and mentoring Tuakana/Teina
- Stakeholder engagement; align with wānanga, introduce study to incubator programmes, careers, and target youth still in school.

Opportunities/Options for Ngā Maia Consideration

- Meaningful engagement with whānau, hapu and iwi
- Identify relationship opportunities with existing Māori NGO's
- Communications Strategy, Marketing and Public Relations Campaigns
- Develop and deliver Kaupapa Māori Midwifery of First Year Practice Programme.
- Develop and deliver Kaupapa Māori Midwifery Standard Review.

4. Training and Development

To ensure that all trustees, staff, and Māori Midwifery practitioners are competent in understanding and exemplifying the values, kaupapa, and tikānga that underpins the role and aims of Ngā Maia. Ngā Maia is founded on kaupapa Māori principles of Te Tiriti o Waitangi. Ngā Maia has a dual responsibility to both Māori and non-Māori. To ensure that Māori birthing whānau will effectively access clinically and culturally appropriate maternity, midwifery, and child-health services.

Co-design and co-ordinate Kaupapa Māori birthing and maternal child-health education programmes with whānau, hapu and iwi and with wider midwifery sector- MOH-DHB.

Rationale

There is opportunity to develop standards and curriculum that fit the NZQA education qualification framework in furthering a workforce of Māori practitioners in the areas of Māori birthing, and Māori maternal childhealth that better meets the needs of Māori.

Key Focus Areas

- Ngā Maia will consider the National and Regional needs of its members in order to identify their own education and training pathways.
- Integrate kaupapa and tikanga Māori into all practice settings
- Provide access to cultural supervision and mentoring
- Co-design culturally appropriate resources
- Integrate Induction/Orientation processes and procedures

Opportunities/Options for Ngā Maia Consideration

- Meaningful engagement with whānau, hapu and iwi
- Identify relationship opportunities with existing Māori NGO's
- Identify and foster partnerships with Kura kaupapa Māori and Wānanga Schools of Learning.
- Communications Strategy, Marketing and Public Relations Campaigns
- Develop and deliver Tuakana/ Teina Kaupapa Māori Mentoring and supervision Program, to support recruitment and retention of Māori midwifery students.

5. Information, Research and Evaluation

Kaupapa Māori Practice is deniably challenging, not only from the perspective of limited knowledge and its application within contemporary Kaupapa Māori themes and models of care, but also acknowledging the diversity of Māori whānau realities. A one size fits all mentality, that has burdened Māori intergenerationally requires ongoing evaluation and research. To readily inform best practice, Kaupapa Māori research methodology should be conducted, and its results should be peer reviewed and analysed. Creating networks within the larger health sector as well as providing appropriate space for research facilities may attract Māori researchers. This will fulfil our desire to a greater understanding of the needs of Māori birthing cohorts and maternal and child-health populations. As we strive to increase appropriately trained Māori practitioners working in these areas.

Rationale

Kaupapa Māori services provide a treatment environment based on Māori cultural values, processes, and beliefs: tending to accommodate Māori views and philosophies of holistic health and wellbeing that is not predicated by Western concepts of health, disease, or illness (Durie, 2003).

Key Focus Areas

- Collaboration with other professional Māori healthcare and research providers- knowledge and resource sharing (i.e. Te Rau Ora, NZNO, Nga Manukura o Apopo, Te Ora)
- Assess the current and future needs of Māori midwives.
- Assess the current and future needs of stakeholders, whānau, hapu and iwi

Opportunities/Options for Ngā Maia Consideration

- Identify prospective other stakeholders, Ministry of Social Development, Ministry of Education, Philanthropic bodies, etc
- Add to the growing evidence of Kaupapa Māori Research, to inform practice and ministerial knowledge.
- To collect and analysis Kaupapa Māori Birthing and Midwifery data.

Conclusion

Te Tiriti o Waitangi is Aotearoa's most important equity tool and framework for establishing and monitoring the 'Crown's Responsibility' to ensure Māori rights to good health within the maternity and midwifery services sector.

The challenge is to realise the promises of te Tiriti by addressing inequities through legislation, policies, cultural practices, and services, and incorporating checks and balances that contribute to ensure Māori rights to good maternity, midwifery, and child-health outcomes are defined By Māori for Māori.

The key messages from Māori Midwives is consistent with views held by Māori birthing whanau. That the current maternity and midwifery health systems do not prioritise mātauranga Māori cultural well-being, does not promote Māori midwifery capability and advancement and in doing so, does not support Māori whānau's cultural birthing aspirations in any meaningful way.

It is of paramount importance that the 'Crown' understands and prioritises the need for Māori leadership and partnership to improve Māori access to timely, culturally appropriate, and high-quality maternity and midwifery services, to counter balance the ongoing effect of institutional racism from our organisations and services.

This must include resourcing and equipping our services, organisations and staff with the cultural knowledge, the tools and official sanction to complete this work successfully, and then in-rotate the checks and balances required to ensure that the ongoing cultural quality of midwifery is delivered to meet the obligations of te Tiriti, not just in words and statements, but in practice.

This document and others within this project, reflects the start of a conversation involving Māori, the Crown and the maternity and midwifery sectors. We (Māori) would expect a range of work to emerge from these discussions and recommendations presented in these documents, both from the Ministry of Health, Health Workforce New Zealand, District Health Boards, Professional Midwifery bodies and others.

Jean Te Huia

CEO
Nga Maia Māori Midwives
Aotearoa



Photo: Jean Te Huia Midwife and baby Te Iwa; mokopuna: By James Rob, 2019

Consent Form

Project Title: He Aronga a Hine

Project Supervisor: Dr Kahu Mc Clintock (PhD)

Researcher: Jean Te Huia RM, RN MA

- I have read and understood the information provided about this research project in the information sheet package
- I have had an opportunity to ask questions and to have them answered
- I understand that notes will be taken during the focus group hui and that they will be audio-taped and transcribed
- I understand that I may withdraw myself or any information that I provide for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I agree for my whānau to be involved in the focus group hui, if they agree to accompany me.
- I wish to receive a copy of the transcripts from the focus group hui (Please circle one) Yes No
- I wish to receive a copy of the final research report (Please circle one). Yes No

Participant’s signature.....Date.....

Participant’s name.....

Participant’s Contact Details.....

.....

Bibliography

- Durie, M. (2003). *Nga Kai Pou. Launching Māori Futures*. Aotearoa, New Zealand. Huia Publishers.
- Durie, M. (2011). *Māori health models – Te Pae Mahutonga* | Ministry of Health NZ <https://www.health.govt.nz/.../maori-health-models-te-pae-mahutonga>
- Goodwin, D.W.T. (1996). “*He Tāpu te Whāre Tangata*” *Support for young Māori mothers during pregnancy, birth and motherhood*. Thesis report. Massey University.
- Graham, A.W. (2018). *Tika Tonu: Young Māori mothers’ experiences of wellbeing surrounding the birth of their first tamaiti*. Thesis report. Victoria University of Wellington.
- Health Workforce Advisory Board.(2019). *Health and Disability Review*. Wellington. Health Workforce Advisory Board.
- Holder, G., et al. (2019). Brief report. A qualitative study of maternal mental health services in New Zealand. Perspectives of Māori and Pacific Mothers and Midwives. *Māori Health Review*. Issue 82-2019. www.Māorihealthreview.co.nz Reference: Asia Pac Psychiatry 2019; Sep 2.
- Irwin, K. (2020). *Te Kuku O Te Manawa*. Report One of Two. Office of the Childhealth Commissioner. June Report; Wellington. ISBN 978-0-473-51774-8.
- Kenny, C. (2011). *Midwives, Women and Families: A Māori Gaze: Towards partnerships For maternity care in Aotearoa New Zealand*. Postdoctoral Fellow in Ethnicity and Indigenous Health at the School of Public Health, University of Alberta, Canada.
- McLachlan, C. (2005). *Focus Group Methodology and its Usefulness in Early Childhood Research*. NZ Research in Early Childhood Education, Vol. 8. Auckland University of Technology.
- Ministry of Health. (2019). *Report on Maternity 2017. Maternity Tables- Women giving birth in New Zealand*. Accessed online February 2020. MOH Website.
- NZAP. (2020). *Waka Oranga National Collective of Māori Psychotherapy Practitioners Website*
- Pihama, L. (2001). *Tihei Mauri Ora. Honouring our voices. Mana wāhine theory as a Kaupapa Māori theoretical framework. Doctor of Philosophy in Education, University of Auckland New Zealand*. Retrieved Nov 23rd, 2019, from www.kaupapaMāori.com/assts//pihamal/tehei_mauri_ora_chap10_pdf
- Pittman, M. (2020). Personal Interview, Hastings.
- Rees, G.(2019). *The Evolution of New Zealand’s health workforce policy and planning system ; a study of workforce governance and health reform*. <https://doi.org/10.1186/s12960-019-0390-4>.

- Royal, C. (1992). *TE HAURAPA. An Introduction to Researching Tribal Histories and Traditions*. Wellington. Bridget Williams Books Ltd.
- Simpson, H. (2019) Health and Disabilities System Review. - Interim Report. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā .Wellington: HDSR. This report is available from www.systemreview.health.govt.nz/interim-report.
- Smith, L. (1999). *Decolonising Methodologies*. Dunedin: University of Otago Press.
- Stevenson, K., Filoche, S., Cram, F., Lawton, B. (2016). *Lived Realities. Birthing experiences of Māori women under 20 years of age*. *ALTERNATIVE*, Vol 12, Issue 2.
- Te Kaunihera o Nga Neehi Māori. (2020). Council of Māori Nurses. Website.
- Te Ora.(2020). Te Ohu Rata o Aotearoa, Māori Medical Practitioners. Web site.
- Te Runanga o Aotearoa. (2020). Te Runanga Māori Nurses, New Zealand Nurses Organisation. Website.
- Tupara, H., & Tahere, M. (2020). *Te Aronga a Hine: The Māori Midwifery Workforce in Aotearoa, A Literature Review – February 2020*. Wellington, NZ: Te Rau Ora.
- Wai 2575 (2019). Te Tiriti O Waitangi Health Services and Outcomes Kaupapa Inquiry ... <https://www.health.govt.nz/our-work/populations/maori-health/wai-2575>
- Waretini- Karena, R. (2014). *Transforming Māori Experiences of Historical Intergenerational Trauma*. A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD) in Indigenous Studies. Te Whāre Wananga o Awanuiarangi.
- Waretini-Karena, R (2019). Personal Interview. Te Whāre Wānanga o Awanuiarangi.
- Windows- (2019). *A Window on the Quality of Aotearoa New Zealand's Health Care 2019*. Health Quality and Safety Commission New Zealand. Wellington. ISBN 978-0-908345-94-6. www.hqsc.govt.nz