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“I’d probably just say that they probably just don’t care”: a qualitative study of the experiences of wāhine Māori of mental health screening during the perinatal period

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Abstract

Background For many women, having a baby is one of the most exciting and rewarding experiences; however, not everyone experiences the same positivity and pleasure when pregnant or having a new baby. For some, the ongoing hormonal and physical changes, mood swings, and personal and familial situations can create a lonely experience that can lead to distress and mental health issues. Wāhine Māori (Māori women) experience greater rates of postnatal distress (PND) and are less likely to seek help than women of European descent. Screening for PND could help identify those at risk of developing mental health issues or distress before it escalates. However, it is unclear how often Māori mothers are screened, or what their experiences of screening are.

Method Using a Māori-centred approach, we explored the experience of wāhine Māori of mental health screening during the perinatal period.

Results Eleven wāhine Māori were interviewed about their experiences, with transcripts analysed using thematic analysis. Four themes and 12 subthemes were found in the data. Participants reported feeling a lack of relationship with their midwives, experiencing inconsistent care, lacking trust, that their views were unimportant, fearing judgment, concerns about losing their children to authorities if they disclosed mood issues and a lack of culturally appropriate care.

Conclusions There was an overall sense of inadequate screening support for mental health concerns among Māori mothers in Aotearoa New Zealand. These results indicate the need for more culturally appropriate screening tools and a genuinely holistic approach to perinatal services encompassing a more whānau-centred approach to maternal care.

Summary

This qualitative study of the experiences of Māori women of screening for perinatal depression showed issues with screening practices, a lack of screening, and issues related to interactions with the healthcare system. Even when screening did occur, the mistrust and fear of the system made it difficult for Māori women to disclose distress.

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Highlights

- Wāhine Māori (Māori women; the Indigenous people of New Zealand) experience higher rates of postnatal depression (PND) and are less likely to seek help compared to non-Indigenous women living in New Zealand.
- Māori women in this study reported inconsistent care and screening practices, felt their views were unimportant and unheard, reported a lack of culturally appropriate care, and had a fear of judgment and concern about losing their children to authorities if they disclosed mood issues.
- A lack of relationship and trust meant that screening was inadequate, and issues were not disclosed, thus increasing risk.
- This study indicates the need for more culturally appropriate training for midwives to allow improved care and screening practices.

Keywords Perinatal distress, Postnatal depression, Mental health, Māori, Indigenous, Screening, Early detection

Introduction

Wāhine Māori (Māori women) are more likely than women of European descent to experience poorer perinatal outcomes [1] and depressive symptoms postnatally [2]. Of wāhine Māori that experience low mood, less than 50% will engage in help-seeking [3]. Māori are also disproportionately likely to die by suicide in the postnatal period [4], with 57% of suicide deaths in the six weeks post-birth being wāhine Māori [5], despite Māori only forming 19.6% of the population of Aotearoa New Zealand (NZ) [6].

The majority of maternal health care in NZ is provided by midwives, who act as Lead Maternal Caregivers (LMCs), independently or through hospitals. LMCs can also include obstetricians and General Practitioners (GPs). Although women have a choice of LMC within the free public system, obstetricians are typically only assigned in the public healthcare system where the pregnancy is deemed high-risk. Only 8% of mothers seek care with a private obstetrician (insurance/private paid) [7].

Many wāhine Māori, especially young wāhine, struggle to access adequate midwifery care despite seeking to organise an LMC relationship early in their pregnancy [8]. Workforce shortages likely exacerbate this, but adequate information and resources to support building this relationship is also lacking [8]. Other barriers to help-seeking for Māori are well documented and include negative attitudes of health professionals [9], the impact of colonisation, such as institutional and systemic racism [10], and Māori disproportionately carrying the burden of social inequities [10–12], and stigma [13].

Despite the higher prevalence of risk, difficulties accessing care and lower rates of help-seeking, little is known about the experiences of wāhine Māori being screened for PND. Understanding the experience of screening is important to help improve screening practices in a way that meets the needs and complex realities experienced by Māori. Given these factors, we aimed to explore the perceptions of mental health screening in wāhine Māori.

Method

Research design overview

This is a qualitative descriptive study. A Māori-centred approach [14] with semi-structured interviews was used to explore the experiences of perinatal mental health screening of wāhine Māori. Interviews were conducted by a member of the research team who is Māori and completed *kanohi-ki-te-kanohi* (face-to-face) at a location of the participant's choice (including online). All interviews were offered to be opened and closed with a *karakia* (blessing), and time was allowed for *whakawhānaungatanga* (building connections). This process allowed participants to learn about the interviewer and their reasons for doing the research. *Whānau* (family and support) could be present in the interview. The semi-structured nature of the interview allowed the interview to be participant-led and to continue *whakawhānaungatanga*.

Recruitment process

Recruitment occurred between September 2022 and March 2023. Participants were recruited by email invitation, through researchers' networks and subsequent snowballing recruitment. Participants were offered an NZD\$50 *koha* (gift) in the form of a gift voucher of their choice in recognition of their time, and that knowledge is a *taonga* (treasure) given to the research team. Recruitment stopped when theoretical saturation was reached, and no new information was shared in the interviews.

Inclusion criteria

To be included in the study, participants needed to *whakapapa* Māori (have Māori ancestry) and have been *hapū* (pregnant) within the last two years. As interviews were conducted in English, participants needed to understand and communicate English sufficiently to complete the informed consent process (either written or oral) and participate. Interviewing in English did not preclude participants and the interviewer from using common *te reo* Māori *kupu* (words in the Māori language) such as *hapū*

(pregnant), pēpē (baby), kai (food), and whānau (family). There were no exclusion criteria.

Recording and data transformation

Oral consent recordings were recorded and stored separately from interview recordings. Interviews were recorded and transcribed verbatim. The interviewer also made handwritten field notes from the interviews. All information that could be identified was removed during transcribing. Participants were assigned code names (e.g., P1) to maintain confidentiality. Each interview was transcribed by a research team member and checked by another to ensure the accuracy of the transcription. Where te reo Māori kupu (Māori words) were used in the interviews, these were maintained in the transcripts with the translation indicated by square brackets.

Data-analysis

A reflexive thematic analysis (TA) approach was used. This approach focuses on the researcher's subjectivity and demands a recursive and reflexive involvement with the dataset to obtain a robust analysis of themes across the data [15]. TA was the chosen method of data analysis due to its widely accepted use in health research and that it seeks to understand people's subjective experiences [16].

All research team members coded transcripts independently, and the codes generated were combined into a list. The research team members then met to discuss the codes generated, group these into similar sub-themes, and review field notes. Where duplicates of codes were included in the same subtheme, these were removed. Where the same codes were included in different sub-themes, the research team discussed where the codes fit best regarding the screening experience for wāhine Māori. Subthemes were grouped, resulting in the development of themes. Where there was disagreement, the 'Indigenous Giveaway Rule' was enacted, with priority

being given to the views of members of the research team who were Māori.

Findings

Participants

Eleven wāhine Māori mothers (henceforth referred to as wāhine) were interviewed about their screening experiences during pregnancy and 12 months postnatally (see Table 1 for demographics). Interviews ranged from 28 to 64 min. All participants referred to their lead maternity carer (LMC) as a 'midwife', thus the term 'midwives' is used throughout unless specified. Several wāhine described childhood sexual abuse or sexual assaults as adults leading to the development of mental health difficulties such as post-traumatic stress disorder, mood and anxiety disorders, or having previous miscarriages and stillbirths that they were still grieving. Overall, field notes indicated that wāhine felt angry about not being important members in their own healthcare and not being seen and respected by healthcare professionals.

The research generated 12 subthemes and four themes, as outlined in table 2. Despite being themes, it was noted that the themes impact each other. Specifically, relationships were seen as paramount by wāhine but were often perceived to be undervalued by midwives. However, relationships had the potential to buffer the historical impacts of negative experiences. Similarly, without the relationship (and likely due to the historical effects), wāhine did not feel comfortable disclosing feelings of distress, even when they were screened. Without having a relationship, it was perceived as challenging for midwives to know when the wāhine may need screening and to arrange appropriate follow-up care. As such, care was seen as unresponsive to the needs of wāhine, often culturally insensitive, and not holistic

Historical impact

The category of historical impact captured the experiences of past institutional trauma that led to mistrust of institutions and people representing those institutions. These previous experiences meant that wāhine Māori felt that their views were not heard and not prioritised based on their interactions with healthcare professionals. This impact permeated through the lack of relationships and screening, making wāhine feel that their well-being was not important, and negatively impacted the experience of the care they received.

Past negative experiences with institutions make trust difficult

Several participants had negative experiences with the systems established to protect and support vulnerable populations. These experiences led to participants being fearful that disclosing mental ill-health would result in

Table 1 The participant information summary includes age, number of children, and location

Interview	Age band	Contextual information	Location
1	30–35	First child	Opotiki
2	30–35	Second child	Christchurch
3	25–30	Fourth child	Christchurch
4	15–20	First child	Christchurch
5	15–20	Second child	Christchurch
6	20–25	Second child	Christchurch
7	35–40	Fifth child	Gisborne
8	20–25	First child	Christchurch
9	15–20	First child	Christchurch
10	30–35	First child	Christchurch
11	25–30	First child	Christchurch

Table 2 Themes and subthemes generated

Theme	Subtheme	Example quote
Historical impact	Past negative experiences with institutions make trust difficult	"I think more, the thing is too, woman being scared of having a baby taken off of them for these problems... then they're gonna take that the wrong way. And then next thing you know, you've got Oranga Tamariki [child protective services] involved because they think you're not fit enough or because you're just, you know? It takes little things being said in a different tone or, like, being said in a different way [to lose your baby]." – P5
	The views of Māori are not important or are unheard	"They asked if she [female student nurse] could come in while I was giving birth. But they didn't, like... this man walked in with her and the nurse. I was "I don't want no males here apart from my brother and [partner]" but... But I didn't know that he was the one that was gonna cut me and stitch me." – P1
Relationships are paramount	Continuity in relationships	"And how are you supposed to build or make a relationship? If you've seen someone different every single time?" – P2
	Manaakitanga/feeling cared for	"Appointments were very clinical, if that makes sense? Like it was just the measuring, the weighing, the recording, and then it was over" – P3
Screening process	Collaborative and skilled midwives make a difference	"Because my midwife I could talk to her about anything... She could tell if things are going on. Yeah, no, she just knew me..." – P7
	Covert screening practices create confusion	"She mentioned post-natal depression but never followed up. I didn't even know if that was a screening or just a conversation" – P4
Issues with care	Screening is not prioritised	"They didn't ask much about mental health but if you tell them you are depressed they actually don't ask you much" – P6
	Healthcare professionals respond to physical symptoms but not psychological	"I was sent to the hospital for my infection, but nothing was said about my mental health" – P1
Wāhine want more culturally appropriate care.	Whānau need to advocate when health professionals do not	"She wasn't going to change. So, she was like, 'I'll give you five to think about it. And I'll come back. And I said to my partner. Can you please tell her I can't do it. And so, I skeddaddled out around the corner somewhere. And he messaged me and said, she just kept on.'" – P2
	Wāhine seek holistic care including mental health support	"I wonder about their training. Do they have any training about working with Māori?" – P7 "What would help, would like, like the midwife for example, actually asking if you're alright? That could start something off, and then maybe, like, you'd realise, maybe you're not. And then from there on, help could be organised?... You're sitting there having a conversation about your baby, like, you don't want to sit there and be like, 'Oh, I'm depressed, you know?'" – P5
Negative stereotypes about Māori impact the care received		"Because like, if my midwife asked me like, you're like, 'Isn't the make-up of your problem, your financial situation? I wouldn't feel comfortable to tell her that because I'd be scared she's gonna go run off to an organisation [like child protection services].'" – P5

their baby being removed from their care. Specifically, they believed the systems were not there to help; they were there to “catch people out”.

*“If you’ve been in trouble with Oranga Tamariki [child protective services] before, and you start f*cking talking about that you’re depressed or, you know? That’s like, a scary thing. You wouldn’t want to talk about your demons just in case they take your baby away... it’s a risk to talk about” – P3.*

“I think more, the thing is too, woman being scared of having a baby taken off of them for these problems....then they’re [the system] gonna take that the wrong way. And then next thing you know, you’ve got Oranga Tamariki [child protective services] involved because they think you’re not fit enough or because you’re just, you know? It takes little things being said in a different tone or, like, being said in a different way [to lose your baby]” – P5.

For participants who had previously engaged with a midwife, those experiences influenced their level of trust, comfort, and experience with their current midwives. Participants with older children reported decreased support from midwives in subsequent pregnancies. Specifically, the assumption was that prior experience meant wāhine did not need information, support or screening like first-time mothers. For many of these wāhine, this was not the case, particularly when previous pregnancies had been associated with complications, negative experiences, or a lack of information and support, or the current pregnancy was complicated. This highlighted the importance of not making assumptions about the needs of wāhine.

“I think she’d dropped the ball just because of like what number child he was” – P3.

“Yeah. Like that was not, not even just for that, for a lot of just the general sort of checkup, [the midwife would say] ‘oh like, you’re alright! This is your fifth baby’ sort of situation” – P4.

Having a baby that needed medical attention after birth, such as being in neonatal intensive care (NICU), reminded one wāhine (woman) of having children removed from her care (by child protection services), leading to fear about building attachments with the baby in case the baby was removed later.

“I was too scared to build a bond; I’m scared that someone’s going to come and break it” – P6.

Another wāhine had her first baby at the age of thirteen, and during that pregnancy, she was suicidal, self-harming

and was placed in an inpatient mental health unit due to concerns about her safety. Oranga Tamariki (child protection service) had been involved and her experience of that pregnancy and postnatal period was “traumatic”. She was nineteen and pregnant with her second child when interviewed. She reported that she had the same midwife, and despite knowing her history, the midwife did not screen her for any mental health issues, nor did she enquire about her moods at any stage of the pregnancy. She indicated that she believed the lack of screening was due to system being focused on the babies and not caring about mothers.

“I don’t know. I’d probably just say that they probably just don’t care, to be honest. Like, not worried or bothered. If I was just put to it honestly. I put it down to, not caring enough, not being... I guess just being there for the babies, not helping the mums” – P5.

The views of Māori are not important or felt unheard

Several wāhine described experiences that were dehumanising and did not help to build trust with medical teams. This included male clinicians being invited into the birthing room with no explanation or seeking of consent. Due to the perceived power imbalances, wāhine were often unable to refuse procedures or had to become very obviously distressed before their views were considered.

“They asked if she [female student nurse] could come in while I was giving birth. But they didn’t, like... this man walked in with her and the nurse. I was “I don’t want no males here apart from my brother and [partner]!” but.... But I didn’t know that he was the one that was gonna cut me and stitch me [the obstetrician]” – P1.

Several wāhine described situations where they were concerned about their pregnancy and progression of birth, and when they raised the concerns with their midwife, their views were dismissed. Wāhine associated post-pregnancy complications such as untreated infections with not being heard by their midwives and not having intervention soon enough. Some wāhine felt that the responses they received to their questions were not supportive, and so stopped asking questions, thus failing to have their questions and need met.

“She [midwife] was making me feel real stupid, so I stopped asking questions” – P2.

The sister of one of the wāhine tried unsuccessfully to advocate for her younger sister, who was having severe

mental health issues following family harm by her partner, as the sister was concerned about the wellbeing of the wāhine and baby. Instead, the concerns were misinterpreted and rather than facilitating the protection of the mother and child, the baby was removed from the mother's care.

"Baby's like, a few hours old type of thing, and they twisted her words completely. Made it like she was a crazy mental person just because she, like, had depression. And she was leaving a domestic abuse relationship. How can you take a kid off someone leaving violent relationship?" – P5.

Several wāhine described being unsupported in their preferred birthing practices. It was noted that many of these birthing practices were not unusual or were consistent with a developing evidence-base such as home births, water births, and delayed umbilical cord clamping. When these were raised, wāhine felt that their desires were dismissed, and they could not engage in these practices. This highlighted a lack of collaborative birth planning between midwives and wāhine, resulting in wāhine not feeling safe in this relationship or not feeling a sense of autonomy over birthing their babies.

"There's no options. There was no kind of talking about, like, if I want to? If I brought up home birth it was like [from the midwife], "Oh, no! I don't want to do that..." I feel like it was just, it was more convenient for her for me to have baby there [hospital]... Just no promotion of natural. Or, like, what I wanted to do – I feel like it was just... it was more convenient for her" – P3.

Relationships are paramount

The theme of 'Relationships are paramount' highlights the central te ao Māori values of whanaungatanga (relationships), manaakitanga (the process of showing respect, generosity and care for others), and the importance of the ongoing nature of these relationships for wāhine to feel safe. Relationships had the potential to buffer against negative experiences in the health system but were often not established in the wāhine-healthcare professional relationship. Thus, it was hard for wāhine to feel comfortable in these transactions as there was no relationship.

Continuity in relationships

All participants reported sporadic engagement with their midwives. Many struggled to find a midwife and tended to rely on whānau recommendations. However, the shortage of midwives made it challenging to find a midwife, particularly over the holiday period. Some wāhine engaged midwives who job shared, resulting in wāhine

feeling that they saw "a different [midwife] each week". The change in midwives impacted the ability to form a relationship and reduced the continuity of care and the wāhine's willingness to share information due to a lack of relationship.

"And so, they do one a week on a week off. And I'll take either landing on a locum which I've never heard of before, either. So, I had this lady [NAME3] as well. So, it was between [NAME1] or [NAME2] and [NAME3]. So, you were seeing a different one each time. And how are you supposed to build or make a relationship? If you've seen someone different every single time?" – P2.

Collaborative and skilled midwives make a difference

Three participants described supportive relationships with midwives who were considerate of their needs. These midwives were collaborative in their approach, flexible so that they met the needs of the wāhine and would meet the wāhine where and when it suited them. There was a sense of a safe and trusting relationship where the wāhine felt cared for and that the midwife had strived to connect with them as a person.

"Because my midwife, I could talk to her about anything... She could tell if things are going on. Yeah, no, she just knew me... You know, our appointment wasn't just the baby. You know, she would take the time out to say 'Hey, look, are you okay?'" – P7.

However, it was noted that sometimes, good relationships were not enough – particularly when the wāhine was struggling with depression or there was a high level of fear about the outcome of disclosure. Specifically, in one situation where the midwife was described positively, the wāhine still disengaged and did not want the midwife to do a home visit as she was embarrassed about the state of the house. Thus, withdrawal from the relationship could indicate a number of factors.

"But you do. You've got a good relationship, but you're still wary of what you share, aren't you? Yeah, I think I'll always, always be like that" – P5.

"That's why she couldn't help me, cause I didn't want her too. I didn't want her to help me" – P6.

Manaakitanga/feeling cared for

Whakawhānaungatanga (the process of making relationships and connections) is key to building trust in te ao Māori (the Māori worldview), and the relationship or lack of relationship with midwives were mentioned in every interview. Many participants reported a lack

of relationship with their midwives and healthcare professionals, meaning interactions felt transactional and impersonal. Several participants described feeling that their midwife did not care about their wellbeing, and that they were “*just a number*” that the midwife would be “*paid for*”, that there was no conversation, just weighing and measuring and “*that was it!*”. Thus, the appointment failed to meet the expectations or needs of wāhine, making it hard to form a relationship and decreasing motivation to attend.

“Because we kind of we’re just put in that box. Yeah. Ya know? That box of ‘They don’t matter as much.’”
– P7.

“My midwife never turned up for some appointments. I just felt like they didn’t care” – P3.

Feeling cared for and supported was even more important when wāhine were struggling with mental health and needed additional support. In these situations, manaakitanga (the process of showing respect, generosity and care for others) would have helped build the relationship, provided an opportunity for support, and ensured the continuity of care. Instead, a lack of support meant the care relationship was often disrupted.

“I would have loved it if my midwife would just turn up here at home, yeah, because she was aware that I was having mental health issues and I got real bad anxiety and I struggled to leave the house to go to these appointments” – P6.

Interactions with midwives were frequently described as brief and clinical, where the wāhine felt unseen. The focus was often on the wellbeing metrics of the baby, such as size and position (during pregnancy), or weight gain (postnatally), with the wāhine being observers of this process rather than active participants. Even after the birth, wāhine concerns about feeding or feeling unable to form a bond with the baby were not discussed. The focus on metrics shifted the relationship from personally oriented to medically oriented.

“She [midwife] really didn’t interact with me at all. Like, I barely seen them”– P2.

“All she done after I had baby was come over home, once, I think? Maybe once or twice? Twice, I think. And she just weighed, baby. Measured him. Measured his head. It’s just baby.... didn’t ask anything about me.” – P1.

The relationship was particularly important when wāhine had a history of receiving non-protective responses to disclosures of needing help. A poor relationship, and the

perception that the midwife was rushing to complete tasks, left no space for disclosure of difficulties with coping or distress - partly because wāhine did not feel safe in this disclosure, and partly because there was no time to raise concerns. There was an acknowledgement that many people struggle to ask for help, but this was even harder when there was no relationship or time, or there had never been a signal that it was okay to be distressed.

“A lot of us are too shy to speak up or don’t feel comfortable in the environment we’ve been in or who is asking us” – P5.

At least one participant stopped going to their appointments because they felt their midwife did not care about their wellbeing and did not listen to their concerns. This resulted in no relationship, feeling unsafe, and subsequently, a lack of disclosure about their deteriorating mental health. It also meant that wāhine did not receive the necessary information about PND, which further increased their risk. Others described their midwife as critical, and responding angrily when the wāhine did not follow instructions.

“I was brushing my teeth getting ready for my scan, which was at 8:50 in the morning, and my waters just went, there were no contractions. So, I was really confused. Like, this is a bit different?! And I rang my midwife, but she was away, so I had the backup midwife answer. And she was telling us we need to stay at home... we were really concerned because it was just so much. It was like my waters just kept breaking. So, we were following our gut. And our gut was telling us we needed to be in hospital, but she was going against that... And we went in. They got us a room and everything. And they rang her [the midwife]. And then she just come in, like, yelling: ‘You should have rang me first! Why don’t you ring me?’ And I was like, ‘I don’t want her like she’s already made me start crying!’” - P2.

“She didn’t even check in on me, just told me the pain was normal and it would pass” – P5.

Screening process

The screening process theme captured subthemes related to the need for screening and the screening practices experienced by wāhine Māori. In particular, all wāhine who participated reported a high level of complexity that would likely increase their risk and need for screening. However, because screening wasn’t prioritised or happened covertly, many wāhine did not believe there was an opportunity to raise their concerns.

Covert screening practices create confusion

There was a perception that some midwives may have created an opportunity to discuss distress but that wāhine did not believe the question asked to be about their mental health. Participants reported being asked how they felt but tended to answer about their physical health rather than their psychological health, as they believed that this was what the midwife was asking about. Others did not respond because they thought they might “*get into trouble*” if they disclosed to healthcare professionals that they were not coping, particularly if unsure whether mental health screening or not was occurring. Thus, asking generic questions may be perceived by the LMC as creating an opportunity to talk about mental health without asking directly. However, the lack of explicit screening meant that wāhine were unsure how to answer and were less likely to disclose distress due to fear or stigma.

“She mentioned post-natal depression but never followed up. I didn’t even know if that was a screening or just a conversation” – P4.

“She did ask me: ‘How are you feeling today?’ Especially as it was getting closer to give birth. Yeah. She was she was asking more often and visiting my son... But if you tell them you are depressed, they actually don’t ask you much.” – P6.

“I’m just gonna say that, like, how do you ask a mum? Because I wouldn’t just walk up to someone knowing they’re damn well depressed then asking them, like, ‘Are you depressed?’” – P6.

Screening is not prioritised

Despite the researchers not purposefully attempting to recruit participants with specific experiences of screening (such as negative experiences of those who were not screened), all participants reported that screening for perinatal depression or distress did not occur. The lack of screening was noted in the context that all wāhine had additional risk factors for developing PND, such as a history of depression, past hospitalisation due to poor mental health, being exposed to family harm, the recent death of a parent, and for one participant, suicide attempts during a previous pregnancy. Midwives were perceived by wāhine as unaware of the increased risk due to not having asked about the wāhine’s history, not screening for family harm, or not seeking to understand the current situation of the wāhine.

“Yeah, it was really rough. There was a lot of tears. Like, I haven’t Everyone’s been messaging me now... it was really rough. “Have you got the three-day blues?” and I might know that I got PND before I had the baby because I was crying and my partner

had to hold me all the time. And I’m just so tired of it all” – P2.

Several wāhine indicated that they believed the lack of screening could be due to the perception that wāhine Māori are “*staunch*” and did not experience distress and, therefore, were unlikely to experience PND. Other wāhine believed that the lack of screening was because healthcare professionals “*did not care*” about the well-being of wāhine Māori. The perception of lack of caring was reinforced by the inaction of medical teams when distress was raised, or the subsequent minimisation of distress. The lack of discussion about distress meant that midwives did not understand how much the wāhine were struggling, and wāhine felt that they were not cared about, so they did not raise it again. Thus, this was a missed opportunity to support wāhine and challenge these beliefs.

“I’ve been stressing out a lot and she’s like, ‘Oh, just comes with pregnancy’, but I knew it in myself [it was a concern]” – P8.

“[would have liked to] probably spoken more about depression and baby blues” – P2.

Two of the wāhine lost parents during their pregnancies, and neither were asked how they were coping nor screened in any way for distress. One wāhine, whose father had been terminally ill throughout the pregnancy and died two weeks before the baby was born, reported that she did not go to her appointments because everything was too difficult and that she was struggling to cope. However, due to the lack of identification of her distress, and despite her recent loss, this was not acknowledged, and support wasn’t offered.

Issues with care

Although not directly related to screening, issues with care also related to screening practices through the experiences of wāhine during the perinatal, delivery, and post-natal periods.

Healthcare professionals respond to physical distress but not psychological

Several wāhine reported struggling with their mood or anxiety after giving birth, and several had medical complications. Wāhine reported that they were more likely to be referred to a doctor for medical complications than to have follow-up or a referral made for their mental ill-health. In fact, no wāhine reported referral to specialist services for psychological distress despite several struggling with mood and having significant risk factors and signs of PND. Most of the time, distress was not acknowledged except when the wāhine’s mood negatively

impacted the midwife. Wāhine also felt health care practitioners did not want to ask about distress or may not be trained to respond to the distress of wāhine.

“Probably so it’s [distress] not a bother to them ... I don’t know if they’re even trained to care about that.” – P3.

“I had a doctor’s appointment booked right after the birth, but they only asked me about the physical recovery, not my mental state.” – P7.

“I was sent to the hospital for my infection, but nothing was said about my mental health” – P1.

Whānau have to advocate when health professionals do not

When wāhine felt shamed or judged by the appointment, they tended to withdraw and stop actively engaging in or even attending appointments. In these cases, there was little follow-up or querying the change in behaviour (which could indicate distress). Despite the range of healthcare professionals involved in care, there was no follow-up or advocacy. At times, whānau members had to advocate for the wāhine, but many whānau had negative experiences of the health system, which meant they were not confident in their ability to advocate or to access the help needed. In some examples, whānau needed to step in due to the words of wāhine being misinterpreted resulting in babies being removed from care as the wāhine was not able to advocate for themselves.

“She just admitted that it wasn’t all in my head that she was being horrible. She wasn’t going to change [her view]. And so, I skedaddled out around the corner somewhere. And he [partner] messaged me and said, ‘She just kept on and [he] just told her. She doesn’t look very happy!’ And then, I went back to the room and then, she came in again. And then she was trying to explain herself again.” – P2.

There were also several experiences where wāhine were not consulted about having other people in the room. Often, wāhine did not feel comfortable asking who the person was or why they were there due to fear of upsetting their medical team. Having other people present without consent came at the cost of the comfort and dignity of the wāhine, impacted the time the whānau could be together during delivery and after birth, and prevented other whānau members the wāhine wanted to present.

*“I just don’t like to inconvenience other people ... you know, just, I don’t want to make people feel sh*t. Even when he was born, you know, they [healthcare professionals] should step out...but that doesn’t happen. She was just sitting there on her little desk...”*

And I didn’t want to say anything out loud because the lady was in the room.” – P3.

Wāhine want more culturally appropriate care

Many wāhine had specifically selected midwives who reported engaging in holistic perinatal care. They felt this approach was better aligned with their values and those of te ao Māori, which considers the person and their experiences in the context of their whānau (family), whakapapa (ancestry and history), wairua (spirituality and connection), taiao (the environment), tinana (physical health) and hinengaro (mental health and wellbeing). Despite many midwives describing themselves as holistic, few participants, if any, experienced what they perceived to be a holistic level of care. Instead, wāhine felt that the description of being “holistic” was used to describe a practice that was not as aligned with standard care and was more often sub-standard care. Overall, participants experienced their cultural practices disregarded, where they could have supported the wellbeing of themselves, their baby and their whānau.

“Maybe they don’t know how to deal with Māori woman or whānau as much as Pākehā.” – P4.

“I wonder about their training. Do they have any training about working with Māori?” – P7.

“We’ve joined up with Early Start where we specifically asked for a Māori or Pacific worker. But we were we were given a European worker. She’s lovely... But we were hoping to, you know, get someone with cultural [knowledge]... You know? Really saying to them: ‘We really want a Pacific or a Māori person.’ And they obviously don’t have any because we didn’t get one” – P2.

Often when Māori midwives were selected, there was a lack of hapūtanga practices (traditional birthing) that left wāhine feeling disappointed and disconnected. Wāhine perceived this lack of te ao Māori practice was due to the pressure of Māori midwives to fit into the existing hospital systems and structures. Thus, a lack of support for tikanga Māori negatively impacted the birthing experience and wellbeing afterwards. However, when Māori midwives were able to embrace tikanga Māori and te ao Māori, wāhine Māori had better birthing experiences, felt more held in the relationship, and felt better overall.

“I’ll never ever in a million years forget. We’re thinking I would not pick another Pākehā midwife. I had a Māori midwife last time and she treated me like an angel” – P8.

One-third of participants advocated for the needs of screening and support of their partners as part of holistic

whānau-centred care. Within the narratives of struggling during the perinatal period were descriptions of partners having to take over as the wahine was not coping, or stories of the partner struggling themselves. When the whānau struggled, there was increased pressure on the wahine because of the lack of support, highlighting the need to consider and include the whānau who cares for the wahine and baby in discussions. However, whānau were not involved in screening and were not screened themselves.

“He felt completely lost. He said he didn’t know what to do” – P6.

*“My partner, it’s his first baby... he was nervous as sh*t. But there are no services for men either... They should include fathers more... it’s not just the mothers who are going through this” – P8.*

Wāhine want holistic care including mental health support

All wāhine sought midwives to be their LMCs because they believed that midwife care was more holistic, personal and less clinical than other healthcare professionals. Wāhine sought to be cared for in the context of forming a relationship with the person who looked after them and their baby. Midwives were seen as the ideal health professionals to screen for distress, given the frequency of the appointments and that the appointments were part of a partnership throughout pregnancy. Because of this, all wāhine reported that while they were not screened themselves, they would like midwives to engage in regular screening practices and build time into consultations to focus on the wellbeing of the mother and the baby. Routine screening was seen as particularly important to try to invite conversations about mental health, particularly when mothers may be struggling to disclose themselves.

“What would help, would like, like the midwife, for example, actually asking if you’re alright? That could start something off, and then maybe, like, you’d realise, maybe you’re not. And then from there on, help could be organised?... You’re sitting there having a conversation about your baby, like, you don’t want to sit there and be like, ‘Oh, I’m depressed, you know?’” – P5.

Despite wanting their midwives to be interested in them and to engage in screening, wāhine were compassionate towards midwives and recognised midwives needed to monitor many factors throughout pregnancy and during and after birth. There was also concern raised that midwives were not trained to have conversations about mental health or how to screen for distress.

“I don’t think it’s their... in the things they have to do. And that’s what sad. [When raising it with a midwife] ‘Oh, I’ve never heard of it before that!’ Like, it must be in the textbook or something? Today it’s all about family violence. Now they’re always looking for that.” – P2.

Negative stereotypes and the experience of racism impact care received

The experiences of stereotyping and racism were described in several interviews. Several wāhine felt like they were treated differently because they were Māori. This resulted in disengagement from care, feeling unsupported and non-collaborative approaches.

“One of the first questions you answer pretty much anywhere you go is what ethnicity you belong to. And I hate answering that question just because I think it’s going to categorize you into, like, you know, bumped off the waiting list” – P3.

“I was like, I was like giving a real good real attitude. ‘You want to give it to me? I’ll give it to you.’ Just because we are Māori, you don’t need to treat us any differently. You know? We’re all humans.” – P8.

Stereotypes were also commonly expressed. Stereotyping included making assumptions that participants had gestational diabetes or that family harm was being experienced because wāhine were Māori. Similarly, mood issues were often assumed to be due to stressors associated with contextual factors driven by social inequities, and rather than working to address the mood issues or responding to the realities and needs of wāhine, difficulties were dismissed.

“They think [domestic violence] that’s the only thing that’s Māori. The only thing that could go wrong.” – P2.

“Because like, if my midwife asked me like, you’re like, ‘Isn’t the make-up of your problem, your financial situation?’ I wouldn’t feel comfortable to tell her that because I’d be scared she’s gonna go run off to an organisation.” – P5.

Several participants believed that they were not screened and received less care than others was because midwives believed that support would be obtained from whānau (family). Māori are whānau-centric people, and sources of support often come from whānau. Whilst being whānau centred is a strength and a value for Māori, assuming that all wāhine had this support was risky. Some wāhine did not have whānau support or had whānau who did not have the information needed to navigate the postnatal period. Others were in relationships

where family harm had occurred, and there was no safe support. Wāhine believed that placing the responsibility for care on whānau meant healthcare professionals involved in care would have less responsibility.

“They [midwives] probably assumed I had support from whānau, but no one actually asked...I think they just expect that whānau will handle it, so they don’t bother to ask how you’re coping” – P7.

“They assume we’re Māori, so we must have all this whānau support, but it’s not always like that” – P8. She said, ‘Your whānau will support you,’ and I knew I had my family around, but I still needed more help” – P1.

One participant reported her mother had experienced PND and had her children removed for a period. Her midwife told her that she would likely experience PND herself but did not screen her at all. She reported spending her pregnancy in fear of miscarriage or having her baby taken away. However, her mother, who was her only support, was on her own journey of healing and could not provide her with the support that she needed. The participant subsequently developed PND and, for ten months, struggled with no support from whānau or her midwife. Despite the belief that whānau were assumed to be the primary source of support, participants reported that whānau were not included in the screening process, nor was there any support for whānau.

“When I didn’t want to be with the baby because of the trauma, my partner took over completely. He made sure everything was sorted while I was struggling” – P2.

“The fathers need to be screened as well. They observe more, they will notice things before we do.” – P8.

Discussion

Based on these results, it appears that wāhine Māori are not being effectively screened for PND, despite a high level of complexity and often experiencing elevated distress. When screening does occur, it is not occurring in a manner that facilitates disclosure or is not overt enough for wāhine to know the purpose of the questioning, thus failing to create an open opportunity for discussion about distress. When disclosure was made, wāhine felt it was not taken seriously unless it directly impacted the healthcare professionals. Critical barriers to screening and disclosure included experiences of systemic and provider racism that influenced wāhine feeling safe, historical traumatisation with institutions like child protection services that made wāhine fearful about the impacts

of disclosure, a lack of relationship with the midwife (or other LMC), a lack of collaboration allowing wāhine to be partners in their healthcare, and a lack of whānau inclusion. Overall, there was a sense of anger about the lack of care received, and a belief that reduced quality of care was part of the experience of being Māori and interacting in the health system.

Reports of racial bias by midwives and other healthcare professionals were present throughout the interviews. Racial bias is problematic on many levels and may increase the risk for PND, as experiences of racism have been shown to reduce maternal mental health [17, 18] and the wellbeing of the baby [19, 20]. Wāhine Māori who experienced healthcare provider racism are also 66% more likely to suffer PND [17]. Thus, healthcare professionals who behave in a way that is perceived to discriminate against wāhine due to being Māori may increase the risk of PND, which is perpetuated by the lack of screening and lack of protective responses to distress. Risk is further increased based on cumulative experiences of racism [9]. Thus, those wāhine that have experienced unfair treatment by institutions like child protection services may be more vulnerable, thus needing more frequent screening and support.

Understanding Māori culture was crucial for the wāhine and has been highlighted as important in maternity care [21] and in this study. Only 10% of midwives in NZ are Māori. However, 20% of women giving birth identify as Māori [7]. Therefore, this indicates a shortage of midwives who are Māori to meet the needs of wāhine Māori. Midwives have described the need for education on Kaupapa Māori (Māori value-driven) approaches, cultural competence, and mental health services [22] and this study further highlights the need for this. Better understanding of te ao Māori and the impact of colonisation, social inequities and the complex realities for wāhine Māori navigating perinatal care may also help to improve care delivery and reduce stereotypes and racism [23, 24].

There were several times when wāhine believed that midwives may have asked about distress, but this screening was felt to be rhetoric or focused solely on physical wellbeing, or alternatively, the wāhine did not feel safe to raise concerns. All wāhine indicated a desire for LMCs to screen for psychological distress. Good screening should occur regularly, in a meaningful way and whenever there are concerns so that screening does not seem tokenistic. Failure to discuss mental health issues maintains, and in some cases exacerbates, stigma and shame, thus decreasing the likelihood of concerns being raised in the future [25, 26]. Regular and well-delivered screening also signals that the LMC is comfortable asking about mental health and provides opportunities to raise concerns. Alternatively, all wāhine with a history of mental distress could

be automatically referred to support services [4] that provide additional wraparound support and screening. However, this would require considerable financial investment in maternal mental health funding to ensure there were adequate services to meet demands and would not necessarily reduce the wariness associated with historical trauma and systemic racism.

One way to enhance screening practices is the inclusion of whānau, not only in regular midwife appointments but also in screening. Including whānau is recommended as best practice for screening but also ongoing during perinatal care and has several advantages. One, it provides an opportunity for whānau to raise concerns about wāhine who may not be coping, may be experiencing distress, or who feel unable to raise the issues themselves; two, it provides additional information to augment concerns, identify strengths and provides a more comprehensive screen; three, screening partners may help to identify partners who are not coping as is seen in up to 10% of partners postnatally [27] and may provide an opportunity for intervention and improved well-being for the whānau. Four, it provides more holistic whānau care so that whānau can better support the wāhine and baby. However, including whānau is challenging, and many LMCs are unsure how best to do this [28].

A lack of access to support when distress was raised highlights an issue frequently experienced by wāhine Māori. Access issues to mental health services in NZ are widely documented, with greater barriers being faced by wāhine Māori [4, 29, 30]. A lack of access to services may contribute to a lack of screening, with midwives and other healthcare professionals believing that if PND is present, there is nowhere for the wāhine to get support [31, 32]. Thus, screening may be perceived as pointless if there is nowhere to refer and the perinatal workforce is not skilled to deal with psychological distress.

Limitations

This study was with a small sample of wāhine Māori who shared their views about their perinatal care experiences. It is noted that despite not recruiting specifically for people with negative experiences of screening, all participants reported not being screened and having negative experiences of perinatal care. We recognise that this may not be the views of all wāhine, as we also recognise that there are midwives who are engaged in holistic, Māori-centred birthing practices and those who follow screening recommendations. Thus, we should not assume that these experiences are the experiences of all wāhine Māori receiving perinatal care.

Recommendations

Improving screening for perinatal distress for wāhine Māori involves many cultural safety recommendations

that would likely benefit all women. Screening effectiveness and frequency can be improved with training [33] that provides psychoeducation and strategies to improve the understanding of its value by LMCs. In particular, it is essential to ensure that training highlights why screening is important, how best to screen (including with whom), and how to interpret and respond to results. Training should also include barriers to screening and understanding the contextual factors that may impact wāhine answering questions honestly and utilise strategies to help overcome these barriers that is responsive to the needs and realities of wāhine. This also requires options to refer wāhine for psychological care when required, which is noted as a barrier for LMCs at present [28].

Secondly, screening should include the whānau to help better understand the wāhine's context and mood. We advocate for the screening of distress of partners, who are often a primary source of support (and sometimes stress) and, at times, struggle to cope themselves. Failing to identify distress in partners adds to the stressors experienced by wāhine through their concern about their partners and decreased support available for themselves. Thus, whānau should be centre of care for midwives and healthcare professionals.

Thirdly, based on these findings, midwives would benefit from further training about the needs and realities of Māori, and how to work with whānau Māori in a safe and culturally informed manner. This includes a greater understanding of hapūtanga practices, the impact of colonisation on pregnancy and birthing, and the values associated with te ao Māori that may need to be considered. Prioritising the training of Māori midwives will also facilitate this, particularly if there is support to practise within the realms of te ao Māori and not just within the existing frameworks of the health system.

Finally, the implementation of a culturally responsive framework for screening similar to Te Ha o Whānau [21] would help to improve the responsiveness and subsequent outcomes of wāhine Māori and their babies in NZ. Such a framework, which has been designed using Kaupapa Māori (Māori-value based) methodologies, could help to overcome some of the issues raised by wāhine Māori in the current study by using a Māori-centred framework. Te Ha o Whānau that centralises care around Tikanga manaakitanga (acting with care and respect), Tikanga rangatiratanga (creating systems where wāhine and whānau can make decisions about their healthcare and that of their baby), and Tikanga whakawhanaungatanga (the establishment and maintenance of meaningful relationships) all areas that were perceived as missing in their care by wāhine in this present study. Not only would this produce more equitable outcomes for Māori and reduce the experience of

hostility often experienced by Māori in the health system [34], but may also produce benefits for non-Māori.

Future research

Future research could explore the experiences of good screening practices to understand better how screening could be improved from a strengths-based focus. Similarly, it would be useful to explore the use of covert screening practices, including the use of screening tools and their impact on the relationship and disclosure. This may be particularly important for those working with wāhine Māori given that the recommended tool for screening in NZ may inadequately screen wāhine Māori due to a lack of focus beyond standard depression symptoms, thus failing to capture a te ao Māori view of wellbeing and may further perpetuate a sense of disconnection.

Conclusion

Although small, this study highlighted significant gaps in perinatal mental health screening that is failing to meet the needs and complexities experienced by wāhine Māori. Few of the participants indicated feeling a sense of manaakitanga (feeling safe and cared for) during their pregnancy, and none were aware of being screened for their mental health. In addition to this, systemic trauma as a result of colonisation and implicit racism of government systems (including healthcare) resulted in the majority of wāhine expressing their inherent fear of 'systems', and that asking for help would lead to losing their child. These fears, and for some, realities, exacerbated feelings of mistrust, disappointment, sadness and anger. The experiences shared by wāhine highlighted the necessity for midwives to consider further training in cultural safety and tikanga (customary values and approaches) when working with Māori, such as a whānau-centred approach to pregnancy and childbirth. Furthermore, developing a culturally appropriate screening tool combined with screening training and clear responsibility for training could significantly improve perinatal mental health care for wāhine Māori.

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Author contributions

PH co-designed the project, completed the interviews, coded transcripts, brought her mātauranga (knowledge) to the project, and contributed to the writing and revision of the manuscript; MCBP and NF transcribed and checked a portion of the manuscripts, coded transcripts and contributed to the writing of the manuscripts; AK and CMcC coded transcripts and contributed to the writing and revision of the manuscript and LD co-designed the project, completed the funding and ethics applications, transcribed and checked

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Data availability

The datasets generated and/or analysed during the current study are not publicly available due to the sensitivity of data and the potential for identification but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the Auckland University of Technology Ethics Committee (AUTC) on 18/08/2022, approval number 22/184. After reading the participant information sheet, all participants provided informed consent either by oral consent protocol (for online interviews) or written informed consent form (for face-to-face interviews).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Reflexive self-description

PH is a Māori (Ngāti Porou, Te-Whānau-a-Apanui, Ngapuhi) registered psychologist and PhD student. She has five children and eight grandchildren born in NZ. MCBP is a researcher with lived experience of PND and who is Māori (Ngāti Awa, Te Arawa). She has four children born in NZ AK is a Pākehā clinical psychologist and has three children who were born overseas. CM is a Pākehā postgraduate student completing her counselling psychology internship with an interest in working with wāhine (women) and tamariki (children). NF is a Pākehā Occupational Therapist who has three children who were born overseas. LD is a Pākehā Health and Clinical Psychologist I who has two children born in NZ.

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References

- Dawson P, Auvray B, Jaye C, Gauld R, Hay-Smith J. Social determinants and inequitable maternal and perinatal outcomes in Aotearoa New Zealand. *Women's Health*. 2022;18:174550652211075913.
- Deverick Z, Guiney H. Postnatal Depression in New Zealand: Findings from the 2015 New Mothers' Mental Health Survey. 2016.
- Signal TL, Paine S-J, Sweeney B, et al. The prevalence of symptoms of depression and anxiety, and the level of life stress and worry in New Zealand Māori and non-Māori women in late pregnancy. *Australian New Z J Psychiatry*. 2017;51(2):168–76.
- Meredith C, McKechar C, Haitana T, Pitama S. Whāia Te Iti kahurangi: seeking perinatal mental health equity. Māori offer solutions for the health system. *Mental Health Prev*. 2024;36:200362.
- Perinatal and Maternal Mortality Review Committee. Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2016. 2018.

6. Statistics New Zealand. 2023 Census population counts (by ethnic group, age, and Māori descent) and dwelling counts. Accessed 11/09/2024, 2024. <https://stats.govt.nz/information-releases/2023-census-population-counts-by-ethnic-group-age-and-maori-descent-and-dwelling-counts/>
7. Bartholomew K, Morton SM, Atatoa Carr PE, Bandara DK, Grant CC. Provider engagement and choice in the lead maternity Carer System: evidence from growing up in New Zealand. *Aust N Z J Obstet Gynaecol*. 2015;55(4):323–30.
8. Makowharemahihī C, Lawton B, Cram F, Brown S, Robson B. Initiation of maternity care for young Māori women under 20 years of age. *N Z Med J*. 2014;127(1393).
9. Bécares L, Atatoa-Carr P. The association between maternal and partner experienced racial discrimination and prenatal perceived stress, prenatal and postnatal depression: findings from the growing up in New Zealand cohort study. *Int J Equity Health*. 2016;15(1):1–12.
10. Espiner E, Paine S-J, Weston M, Curtis E. Barriers and facilitators for Maori in accessing hospital services in Aotearoa New Zealand. *NZ Med J*. 2021;134(1546):47–58.
11. Palmer SC, Gray H, Huria T, Lacey C, Beckert L, Pitama SG. Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis. *Int J Equity Health*. 2019;18:1–12.
12. Dawson P, Jaye C, Gauld R, Hay-Smith J. Barriers to equitable maternal health in Aotearoa New Zealand: an integrative review. *Int J Equity Health*. 2019;18:1–14.
13. Ataera-Minster J, Trowland H. Te Kaveinga: mental health and wellbeing of Pacific peoples. Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey. Wellington: Health Promotion Agency; 2018.
14. Cunningham C. A framework for addressing Māori knowledge in research, science and technology. *Pacific Health Dialog*. 2000;7(1):62–9.
15. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Res Psychol*. 2006;3(2):77–101.
16. Thompson Burdine J, Thorne S, Sandhu G. Interpretive description: a flexible qualitative methodology for medical education research. *Med Educ Mar*. 2021;55(3):336–43. <https://doi.org/10.1111/medu.14380>
17. Bécares L, Atatoa-Carr P. The association between maternal and partner experienced racial discrimination and prenatal perceived stress, prenatal and postnatal depression: findings from the growing up in New Zealand cohort study. *Int J Equity Health*. 2016/09/22 2016;15(1):155. <https://doi.org/10.1186/s12939-016-0443-4>
18. Harris RB, Cormack DM, Stanley J. Experience of racism and associations with unmet need and healthcare satisfaction: the 2011/12 adult New Zealand health survey. *Aust N Z J Public Health*. 2019;43(1):75–80.
19. Thayer Z, Bécares L, Atatoa Carr P. Maternal experiences of ethnic discrimination and subsequent birth outcomes in Aotearoa New Zealand. *BMC Public Health*. 2019;19:1–8.
20. Thayer Z, Bécares L, Marks E, Ly K, Walker C. Maternal racism experience and cultural identity in relation to offspring telomere length. *Sci Rep*. 2023;13(1):10458.
21. Stevenson K, Filoche S, Cram F, Lawton B. Te Hā o Whānau: a culturally responsive framework of maternity care. *N Z Med J*. 2020;133(1517):66–72.
22. Roia TMM. What works for midwives supporting māmā through emotional distress? The University of Waikato; 2023.
23. Levesque A, Li HZ. The relationship between culture, health conceptions, and health practices: a qualitative–quantitative approach. *J Cross-Cult Psychol*. 2014;45(4):628–45.
24. Durie, M. Whaiora: māori health development. Auckland, New Zealand: Oxford University Press; 1994.
25. Jauch M, Occhipinti S, O'Donovan A. The stigmatization of mental illness by mental health professionals: scoping review and bibliometric analysis. *PLoS ONE*. 2023;18(1):e0280739.
26. Highet N, Gamble J, Creedy D. Perinatal mental health and psychosocial risk screening in a community maternal and child health setting: evaluation of a digital platform. *Prim Health Care Res Dev*. 2019;20:e58. <https://doi.org/10.1017/S1463423618000336>. e58.
27. Ansari NS, Shah J, Dennis C-L, Shah PS. Risk factors for postpartum depressive symptoms among fathers: a systematic review and meta-analysis. *Acta Obstet Gynecol Scand*. 2021;07(7):1186–99. <https://doi.org/10.1111/aogs.14109>.
28. Mellor C, Payne D, McAra-Couper J. Midwives' perspectives of maternal mental health assessment and screening for risk during pregnancy. *New Z Coll Midwives J*. 2019;55(55):27–34.
29. Maessen SE, Wright T, Wouldes T. Parental mental health problems during pregnancy and the postnatal period. In: Cutfield WS, Derraik JGB, Waetford C, Gillon GT, Taylor BJ, editors. Brief Evidence reviews for the well child tamariki ora programme. A better start national science challenge. Auckland, New Zealand; 2019. pp. 96–119.
30. Ministry of Health. Maternal Mental Health Service Provision in New Zealand: Stocktake of district health board services. 2021.
31. *Journal of Clinical Nursing*. 2013;22(15–16):2286–2297.
32. Salamanca-Buentello F, Seeman MV, Daar AS, Upshur RE. The ethical, social, and cultural dimensions of screening for mental health in children and adolescents of the developing world. *PLoS ONE*. 2020;15(8):e0237853.
33. Jardri R, Maron M, Pelta J et al. Impact of midwives' training on postnatal depression screening in the first week post delivery: a quality improvement report. *Midwifery*. 2010;26(6):622–629. <https://doi.org/10.1016/j.midw.2008.12.006>.
34. Graham R, Masters-Awatere B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. *Aust N Z J Public Health*. 2020;44(3):193–200.

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