

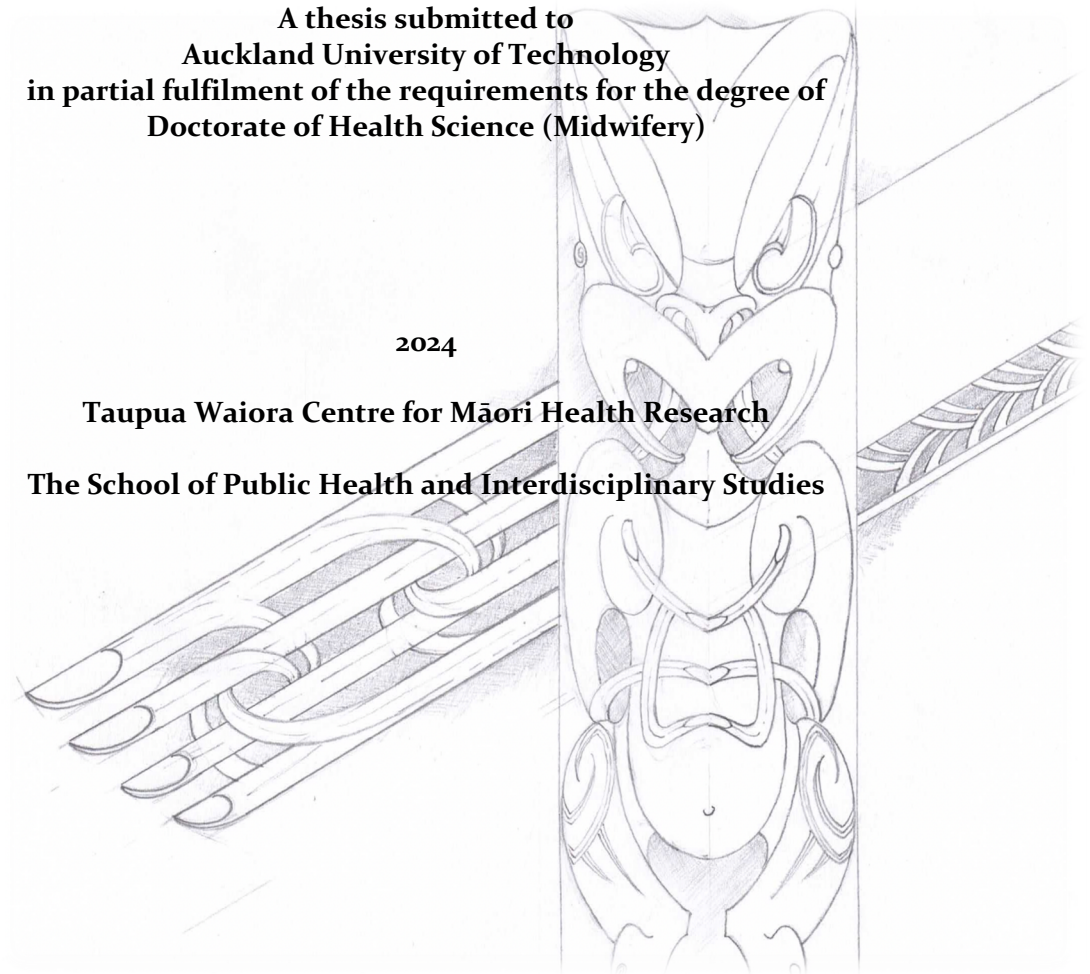
HE MATATAUIHI I NGĀ URUREI WHĒAKO HEI KAHU PŌKAI
The experiences of being a Māori midwife

Beatrice-Ann Materoa Leatham

**A thesis submitted to
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Abstract

This thesis explores the intricate nature of Indigenous midwifery within Aotearoa. The context has largely been constructed through the ethnocentric worldview of non-Māori and there is very little written that explores the understandings of being a Māori midwife or Kahu Pōkai. This realisation presented a sense of urgency to document distinctively Māori maternity knowledge. Repetitive evidence shows many Indigenous whānau are unable to access care that positively enhances their childbirth experience, and endure inequitable maternity outcomes and culturally unsafe experiences. By giving Māori midwives the opportunity to tell their stories this research aimed to reveal the uniqueness of Māori midwifery practice. In doing this, Indigenous midwifery knowledge that may provide alternative understandings to better support birthing whānau is exposed.

‘He Matatauihi i ngā Ururei Whēako hei Kahu Pōkai’ embodies the focus of this study. ‘Matatauihi’ refers to the sacred role of calling spiritual and physical energies to kaupapa (topic, focus) by the female voice. ‘Ngā Ururei’ conveys the ancient practices that are guided by the knowledge of deities. ‘Wheako’ are the experiences gained by the being that is human; and ‘Kahu Pōkai’ refers to the absolute commitment, unique passion and purpose that is activated for mothers and their babies. This title locates the study to the nature of Māori midwifery and childbirth. It exerts knowledge systems of both the tangible and intangible, acknowledges the responsibility of nurturing whakapapa, and offers insight to the privileged potential of this position.

Nine Māori midwives told their stories. Their insights are documented, building upon a limited source of literature on Māori midwifery in Aotearoa. Kaupapa Māori and Mana Wahine were crucial theoretical frameworks that allowed distinct Indigenous systems of knowledge to be integrated into the research. Hence, a traditional Māori pedagogy of learning was implemented. Te Whare-kōrero ā Kahu Pōkai provided the philosophical underpinning to ground the research in mātauranga Māori, specific to Kahu Pōkai. Preferencing knowledge in this way revealed Māori midwives practice in a transformative manner. They innately resist the patriarchal systems in which Māori maternities currently dwell to assert tino rangatiratanga (self-determination) of themselves and birthing whānau. Kahu Pōkai displayed an astute ability to navigate two often opposing worldviews, achieving maternity care that is responsive to the needs of birthing whānau.

This research makes several proposals; first and foremost, the need for Kahu Pōkai education that is firmly positioned in Māori pedagogy has become evident. Enduring negative Māori maternity outcomes demonstrate the Aotearoa midwifery sector is not cognisant to the significance of historical, cultural, and political prejudice. Robust understanding of this environment is crucial to the current context of midwifery. Significantly, there is a growing appetite for health services that are underpinned by mātauranga Māori. In response, a review of current midwifery practice models, especially the primary elements of the Partnership model, is critical. Further, supporting Kahu Pōkai to advance their cultural aspirations will strengthen the cultural capacity, retention, and, therefore, sustainability of the workforce. This will be crucial as Māori birthing rates increase.

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Attestation

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed:

Date: 30 November 2024

He Mihi

E Ngā mana o ia whānau, o ia hapū, o ia iwi, tāwharautia mai tātou i tēnei wā tonu ki tō tatou ao Māori e tau nei. He kākano tātou i ruia mai i Rangiātea, e kore e ngaro. E Ngāi Kahupōkai o tēnā whānau, o tēnā hapū, o tēnā iwi ko te iho me te aho o te wānanga nā Ruapōkai-i-te-rauroha ki a koe me tō mana ariki. Whakapiki ake, kake ake i Te Aratitia hei whakaniko i ngā hōkairanga tapuwae atua, ariki, tīpuna nō roto mai i te reo me ōna taonga tuku iho, hei oranga tāngata.

To my beautiful mum and dad, your passing shocked my world like nothing I had ever experienced. You always encouraged me and were excited (and somewhat intrigued) by my goals in life, especially this academic journey. Every day I wish you were still here with us; here to bless the completion of this thesis. Thank you for all the life lessons that have made me who I am today. You are so dearly missed.

To all the wāhine, whānau, and pēpē whom I have cared for; thank you for allowing me to share in your special journeys. I honour every little soul that I am privileged to witness enter Te Ao Tūroa. It is my deepest privilege to fulfil my role in supporting whānau during their childbirth journey. This research is for all our mokopuna. That they may be born into a world that acknowledges their uniqueness so they may thrive, mō āke tonu atu.

Papa Hōhepa, you will be forever missed. Your divine wisdom and mātauranga has filled the pages of this thesis. Without your contributions to our Māori world, this thesis and what I have learned would not be what it is. I am blessed to have had the privilege of being in your presence.

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you, the next generation of Kahu Pōkai, inspiration to be confident in your Māori-selves and flourish in your mātauranga.

Heather, Joanne, Nerissa, Nicole, Aroha, Shar, Kiley, Hine and Kendra; you are all incredible. I know your words by heart. They embody the mātauranga of our Atua. Thank you for sharing the passion and aroha you have for our mahi. Thank you for trusting me with your stories.

Uncle Roi, thank you again for gifting the three whakairo images, they have created a special presence in these pages. These whakairo images (pictured below) are subject to copyright and are therefore not to be reproduced without permission from myself, Beatrice Leatham or Roi Toia. I also pay tribute to all the academic, mātauranga mahi that has gone before me. I do not take for granted the privilege of having a wealth of knowledge to guide, support, and provide wisdom to this thesis.

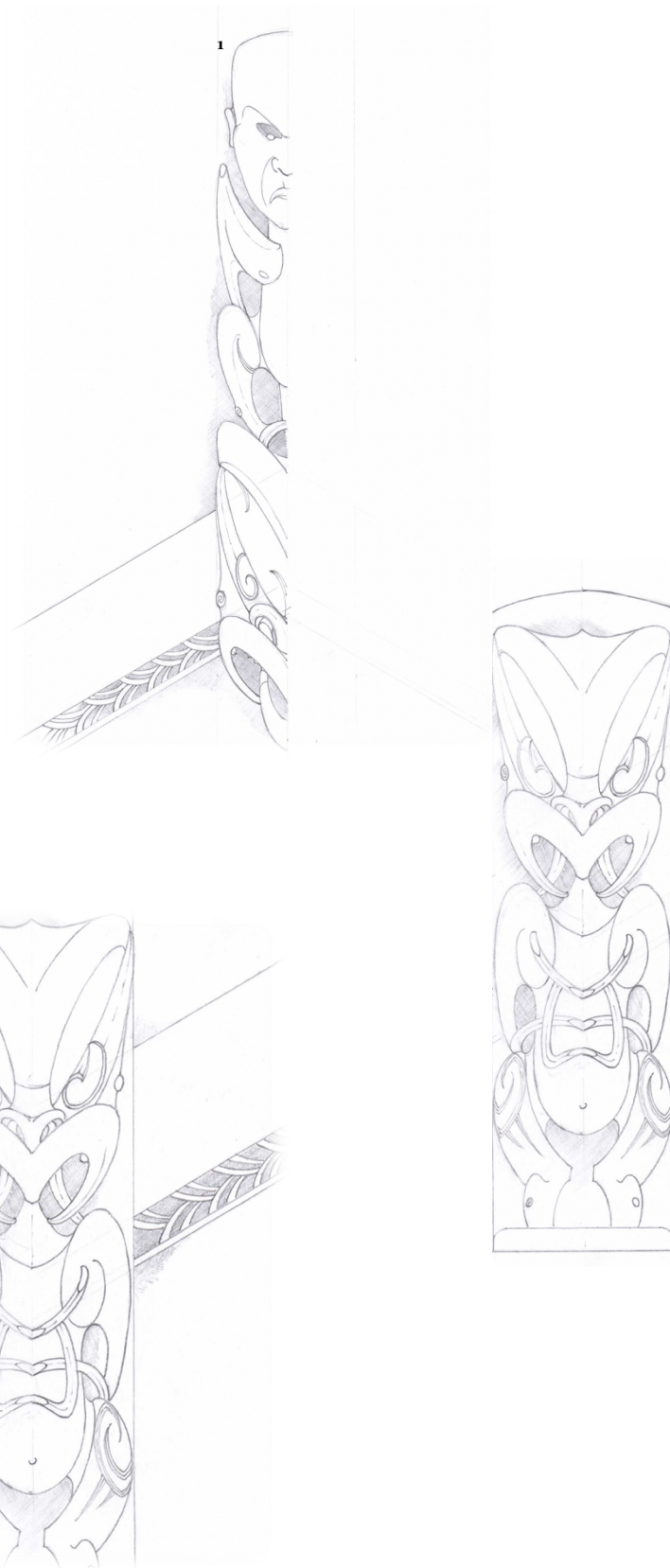
To my supervisors, Denise and Liz. All I can say is that your enduring expertise, support, and absolute patience has been tremendous! Liz, you have been part of my entire academic journey from Year One midwifery to now. I acknowledge your esteemed expertise in both midwifery and research, and particularly in the role you have had in my journey. Thank you does not express enough how grateful I am for that continuity. Denise, your leadership and mātauranga is nothing less than inspiring. You have been a constant Pou in this space of research. Your commitment to students is endless. I cannot thank you enough for the time, space, and confidence you gave me to keep going. Thank you.

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Lastly, thank you, for reading. I hope in some way my words resonate. In my Master's thesis, I quoted my mum. Her words still ring true, probably more so now she is no longer with us. As I said then, these words epitomise our worldview, that is Māori. The success of one is the success of us all. So, I dedicate this to all those mokopuna yet to come.

Ngā mokopuna ataahua, tēna koutou katoa, thank you, to everyone for your love encouragement & respect for each other, your success is so sweet (Ethel Rata Leatham, 2013).

No reira, e ngā mana o te whare-kōrero nei, he mihi nāku he mokopuna nā Te Whānau o Te Aopare, Te Whānau o Hinerupe, Te Whānau o Tamakoro, Ngāti Porou e.



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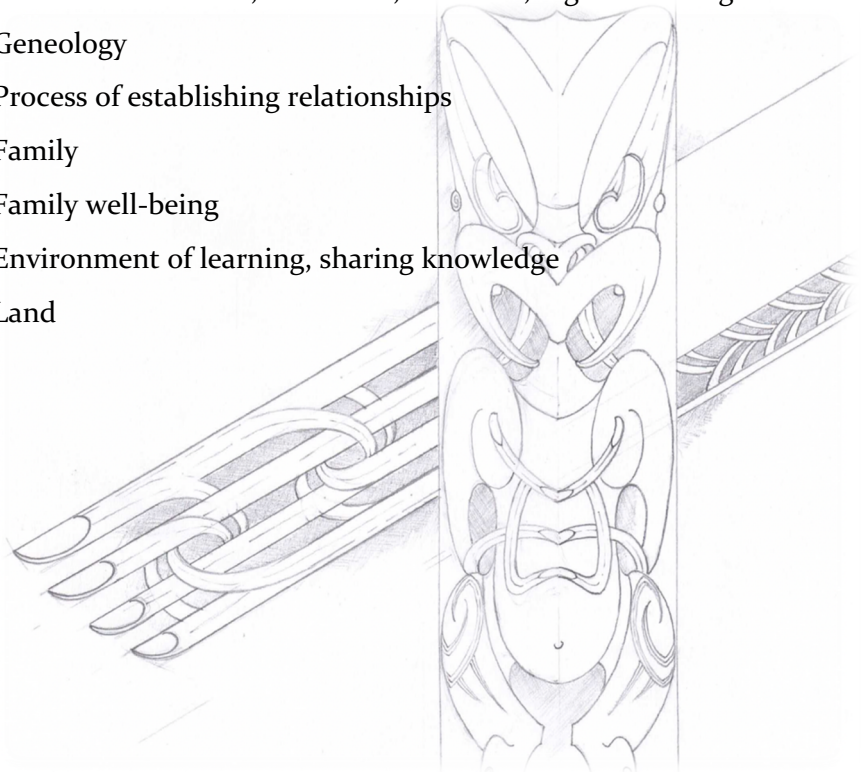
Glossary

Aotearoa	New Zealand
Aroha	Absolute appreciation, love
Atua	Deity
Ariki	Sacred high born
Hapū	Sub-tribe. Pregnancy
Hauora	Well-being, health
Hineahuone	First human being
Hinengaro	Physical mind
Hoa rangatira	Wife, husband, spouse
Iwi	Tribe
Kahu	Cloak of protection
Kahu Pōkai	Māori midwife
Kaikōrero	Speaker. In this research also refers to participants
Kaitiaki	Guardian
Kaiwhakawhānau	Person who assists birth or midwife
Kanohi ki te kanohi	Face to face
Karakia	Prayer
Karanga	Call
Kaupapa	Topic/purpose/plan
Kaumātua	Elder
Kawa	Protocols determined by Atua lore
Kawakawa-mai-Tawhiti	Te Araroa ocean
Ko wai au	Who am I
Kōrero ²	“Encapsulates all the senses involved in communication, not only the verbal or audio aspects. Traditionally kōrero meant to communicate from a neutral point of being” (Leatham, 2014, p. viii).
Kuia	Female elder
Kupu	Word
Kurawaka	The sacred region where the first female human was created
Mai rānō	From long ago, for a long time, ever since

² Definitions quoted from my Master’s thesis (Leatham, 2014) were given by Paraone Tai Tin in 2014. I have continued to use these definitions for consistency.

Mana	Authority/prestige
Manawa	“The manawa serves our physical and spiritual existence by keeping our bodies oxygenated. Equally it keeps us spiritually and emotionally connected to our environment. This is one of the physical and spiritual organs of Māori” (Leatham, 2014, p. viii).
Mana motuhake	Autonomy, self-government, independence, sovereignty
Manaaki	To support, take care of, hospitality
Manaakitanga	Hospitality, kindness, generosity, support. Caring for a person encouraging them, takes responsibility for any specific role that they may provide their whānau, hapū, or iwi
Mātanga hauora	Expert in well-being, health
Mātanga tikanga	Expert in tikanga
Mātauranga	Knowledge
Moko kauae	Traditional female tattoo on chin
Mokopuna	Grandchild or great grandchild or descendant
Mōteatea	Lament, traditional song
Ngā ringa hapai	Support person/people
Ngākau	Heart. The ngākau is the spiritual house for the life essence that is called māuri. The life essence reinforces our state of identity
Nukutere	Ancient waka of Hawaiiki belonging Ngāti Porou.
Oriori	Lullaby
Pēpē	Baby
Pōhatu	Stones
Pōkai	Pregnancy
Pōkaitanga	Pregnancy cycle
Pono	Truth or honest
Pūrākau	Factual story
Rangi	Sky
Rangatiratanga	Sovereignty, chieftainship
Takutaku	Incantation
Taiao	Environment
Taonga	Treasures, possession
Taonga tuku iho	Something handed down, heirloom, cultural property
Tangata whenua	Indigenous people
Tapuhi	Midwife

Te ao Māori	Māori world and its cultures. Māori worldview
Te Ao Mārama	“Traditional understanding is that this is the spiritual world, the world that we all came from and when we die we return there. This place is the spiritual infusion between the deities and their descendant to the universe. Today, Te Ao Mārama is referred to as the ‘world of light’; this understanding has come from when Papatūānuku and Ranginui were separated and the first beams of light were seen” (Leatham, 2014, p. x).
Te Ao Tūroa	“Traditional understanding is that this is the physical world. Literally translated as ‘the long standing world’, this is the world we are living in today” (Leatham, 2014, p. x).
Te reo	Māori language
Tika	Appropriate or correct
Tikanga	Practice, common sense
Tipuna/Tīpuna	Ancestor/ancestors (East Coast dialect)
Tino rangatiratanga	Autonomy
Tohu	Sign, symbol
Tohunga	Expert
Tohutō	Macron
Tupuna/Tūpuna	Ancestor/Ancestors (Northern dialect)
Tūranga nui a Kiwa	Gisborne
Urupā	Burial ground, cemetery
Wahine/wāhine	Woman/women
Waiata	Song, singing
Wānanga	To meet and discuss, deliberate, consider, higher learning
Whakapapa	Geneology
Whakawhānaungatanga	Process of establishing relationships
Whānau	Family
Whānau ora	Family well-being
Whare-kōrero	Environment of learning, sharing knowledge
Whenua	Land



PART ONE

Ngā Uranga ā Te Kahu Pōkai



3

Ngā Uranga ā Te Kahu Pōkai provides the whakapapa to the research. Uranga is when pēpē is crowning at birth, emerging from Te Ao Marama. Part One presents the whakapapa or background to the research. Like the developing pēpē, it is the gathering of mātauranga to support the genesis of new mātauranga. It includes the literature review, theoretical foundations, and the way in which the research was conducted.

Pictured above is my taonga hei tiki, named Rangatoro. Also depicted in this taonga is Materoa. Rangatoro is the mother of Kahutiaterangi. Materoa is an ancestress whom I am named after, along with my daughters and mokopuna. Rangatoro introduces Part One of this thesis as a representative of my whakapapa.

³ © Photo of my taonga hei tiki, Rangatoro.

CHAPTER ONE

Te Ihorei o Taku Koronga (Introduction)

Preface

Wāhine Māori are the guardians of Māori whakapapa (genealogy). Female leadership is exhibited throughout Māori pūrākau as formidable, and crucially influential upon the health of tangata whenua (Indigenous people of Aotearoa). Hence, poor maternal health of wāhine Māori is testimony to the demise of cultural confidence in te ao Māori (Māori world). As safekeepers to our whakapapa, any form of interruption to the well-being of wāhine undermines the preservation of whānau (family), hapū (sub-tribe), and iwi (tribe). In the current maternity system of Aotearoa, many Indigenous whānau are unable to access care that recognises their status as tangata whenua (Hickey et al., 2021); thereby dismantling their power to enhance their whakapapa. By giving Māori midwives the opportunity to tell their stories, this research aims to reveal the uniqueness of Māori midwifery practice; exposing knowledge that has not yet been recorded. In doing so, it paves the way forward for protecting the sacred space of birth for Māori whānau.

The research examines the experiences of Māori midwives. It is envisaged that unique Māori midwifery knowledge will be revealed. This chapter outlines the background to the research and rationale as to why it was imperative to explore the experiences of being a Māori midwife. To lay the foundation of language, the chapter begins by clarifying orthographies and important terminology used. Next, the aims, approach, and significance of the research are described. An outline of the midwifery professional bodies, practice models, and applicable frameworks provide for the context of midwifery in Aotearoa. A review of the Māori midwifery workforce offers a perspective to the unique nature of the stories to be told and, hence, the importance of the research question. The chapter will summarise the background to Māori health status, particularly Māori maternity health, including the context of the maternity sector in Aotearoa. Finally, an overview of the layout to this thesis is provided.

Te Reo Māori Me Te Reo Pākehā o Tēnei Rangahau (Orthographies and Terminology)

The main language of this thesis will be in English as, unfortunately as an Indigenous person, this is my first language. The use of te reo Māori will be intertwined fluidly to keep the reader in the flow of reading without interruption. Throughout the thesis I use the taken for granted reo (like the kupu, 'reo') or kupu Māori that are commonly used and understood in the Aotearoa

context. For other, more uncommon, reo a definition or insight to the use of particular terms is offered in brackets as above or footnoted if longer clarification is required. This will occur at its first use. Unless specifically referenced, I have used Te Aka Māori Dictionary (Moorfield, 2023) for footnote definitions. It is important to say, interpretation and understanding of te reo Māori differs from iwi to iwi, hapū to hapū, whānau to whānau, and I do not assume to give a universal interpretation or definition. It is merely my learned understanding that I offer for clarification and to help the reader move with my thinking. I have also presented a Glossary of te reo Māori.

It is my preference to use tohutō or macrons. In my previous thesis I was critiqued for the use of tohutō as it was suggested that they are not practised in Ngāti Porou. I have since had conversations with various fluent Ngāti Porou speakers and writers who advise the use of tohutō are discretionary. However, if I am referencing an author such as Taiaarahia Melbourne (2009, 2020) who does not use tohutō I will follow suit within the reference source.

To be consistent with the word Western, I will capitalise the word 'Indigenous' (except when it is within a quotation) (Ka'ai-Mahuta, 2010). I will use Aotearoa when referring to New Zealand, unless New Zealand is used in a quotation. Aotearoa is commonly used to describe the entire country. Pre-colonisation tangata whenua were identified by their whānau, hapū, and iwi. The kupu 'Māori' was created to identify the Indigenous peoples of Aotearoa (Leatham, 2014). The use of the term 'Māori' in this research is not to undermine the significance of tribal identity. I will also use 'wahine' specifically for wāhine Māori (Māori women).

The term 'Kahu Pōkai' is used for Māori midwife and, as such, will be capitalised. This is a new term that comes from old reo. Not all Māori midwives refer to themselves as Kahu Pōkai. It is a term offered to define what a Māori midwife encapsulates and, for some, is more fitting than using tapuhi or kaiwhakawhānau. Many of the definitions for kupu offered in this thesis, like Pōkai, came from Paraone Tai Tin. These definitions were learnt while in Pōkaitanga⁴ wānanga with Papa Hōhepa. Defining kupu in this way reveals their true meaning pre-colonial contact (wānanga, Paraone Tai Tin, July 2024).

Kahu refers to the cloak of protection, encompassing the skill and knowledge that guide birthing whānau through their pregnancy. Pōkai encapsulates pregnancy, however long that may be, and childbirth. Pōkaitanga is the pregnancy cycle, and includes the period of conception through to

⁴ Pōkaitanga – ancient term that describes the cycle of pregnancy from conception through to birth and the post-birth period.

birth and the post-birth period. The term Kahu Pōkai was developed during the Aotearoa Project which revised of the Scope of Midwifery Practice to align to a Te Tiriti framework (Te Tatau o te Whare Kahu Midwifery Council, n.d). The Māori name of the Midwifery Council, Te Tatau o te Whare Kahu Midwifery Council, was gifted to them by a Māori midwife, who was a board member at that time. Kahu refers back to the meaning held within Te Tatau o te Whare Kahu. Kahu Pōkai encapsulates the essence of protection or care during the cycle of pregnancy. This term describes the uniqueness of being a Māori midwife.

Kaikōrero and ngā ringa hāpai will be used rather than participants. These terms will be interwoven with Kahu Pōkai. Kaikōrero refers to being the speaker or narrator (Moorfield, 2023). Ngā ringa hāpai literally means the hands that lift or supporting hands. In the context of this research, it connects to Kahu Pōkai in the sense that both terms relate to the roles and responsibilities to supporting childbirth. However, ngā ringa hāpai relates to the support Kahu Pōkai have given to this research, reinforcing their distinct role here.

I use ‘birthing whānau’ to describe wahine who are pregnant or birthing. This incorporates my ideology that once a wahine is hapū, she becomes ‘whānau’ within herself. It also locates my practice of being a Kahu Pōkai to a whānau centred worldview and approach. It is not used to take away or diminish the mana of wahine who are hapū but acknowledges this sacred period and the developing pēpē. Some of the reo, like Kahu Pōkai, will be further clarified as part of the research discussions.

Terms such as Kahu Pōkai, ngā ringa hāpai, and birthing whānau are used as a restorative approach to te reo Māori and kupu that are in general use. Much of the mātauranga⁵ that I have had the privilege to be exposed to, and use in this research, comes from tohunga⁶ Papa Hohepa De La Mere. I have been guided in the use of this mātauranga by Paraone Tai Tin. He learned from Papa Hōhepa kaupapa⁷, such as pōkaitanga. An immense amount of mātauranga has been shared during times of kōrero and wānanga specifically about the kaupapa of this research. The essence of being in ‘wānanga’ with someone encompasses the idea of reciprocity and learning

⁵ Mātauranga – knowledge, wisdom. “Mātauranga Māori is knowledge stemming from Maori traditions, understandings, and ways of knowing” Ruru, J., & Nikora, L. W. (Eds.). (2021). *Ngā kete mātauranga: Māori scholars at the research interface*. Otago University Press Te Whare Tā o Te Wānanga o Otākou.

⁶ Tohunga – skilled person, chosen expert, priest, healer; a person chosen by the agent of an *atua* and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation (Te Aka Dictionary).

⁷ Kaupapa – agenda, plan, objective. “Kaupapa Māori means a Māori way of proceeding”. Ruru, J., & Nikora, L. W. (Eds.). (2021). *Ngā kete mātauranga: Māori scholars at the research interface*. Otago University Press Te Whare Tā o Te Wānanga o Otākou.

from oral sources of mātauranga. Therefore, in line with this stance, I reference any verbal source by using ‘wānanga’ rather than ‘personal communication’.

Whakapapa o Tēnei Rangahau (Background and Rationale)

I began this journey of academia in the early 2000s after graduating a Bachelor of Health Sciences (BHSc) Midwifery. I then went on to complete the MHSc Midwifery and, at that point, decided I wanted to achieve a Doctorate of Midwifery; this is my attempt. However, like Simmonds (2021) talked about there are being many beginnings. The beginning of this research could go back to the landing of my waka, Nukutere, on the shores of Kawakawa-mai-tāwhiti; or the landing of the Endeavour on the shores of Tūranga nui a Kiwa; or the experience of parents who were bought up being punished for speaking their native reo; or with the passing of the Midwives Act 1904 or the Tohunga Suppression Act 1907. All these moments hold a beginning for myself and my life as a midwife, they all contribute to my story; albeit the story of many. My youngest daughter asked me recently, “Why do you need to write? Will you not be a midwife if you don’t write?” I answered, “No, I will always be a midwife!” But the question did beg some contemplation as to why I write this thesis, why is it important? My simplest answer is, I want to contribute to keeping birth safe for whānau Māori. I do not want whānau to continue to endure racism, inequitable healthcare, and stories that do not belong to them. I want mokopuna to be born in an environment that respects te ao Māori and nurtures the sacredness of whakapapa. So, if this research identifies, demystifies, and creates better pathways for understanding what counts for Māori, particularly in childbirth, then it does not really matter where the story begins but how the stories continue to be told to our mokopuna.

My Master’s thesis (Leatham, 2014) was a personal experience that, as well as achieving the tohu, gave me the gift of hearing kōrero from my Ngāti Porou kuia that otherwise may not have been recorded. Sadly, of those kuia, only one is still with us. Losing tipuna⁸ reminds us of the uniqueness that is Māori, and how easily our pūrākau can slip away. Disappointingly, health outcomes for tangata whenua have not shifted in any great way since I wrote my Master’s thesis in 2014, and we continue to endure some of the poorest health across the life span (Ministry of Health, 2019, 2022; Perinatal and Maternal Mortality Review Committee, 2018). So, after documenting the birthing experiences of my kuia it seemed a natural progression for this

⁸ Tipuna – ancestor, grandparent, grandmother or grandfather (singular); Tīpuna – macron over the ‘i’ indicates ancestors, grandparents (plural)

research to hear from those, like myself, on the other side, guiding whānau through those moments, Kahu Pōkai.

Firstly, there is very little written specifically about Kahu Pōkai, and even less dedicated to telling the stories of Māori midwives by a Māori midwife. Once again, like my Master's research, it is a privilege to be given the opportunity to share their pūrākau⁹. However, as with most privilege comes responsibility; hence my responsibility is, first and foremost, to the whānau of those who have allowed me to hear their stories. This thesis will tell their pūrākau, of what it is to be a Māori midwife. It will become documented 'evidence' so it is crucial to convey their pūrākau with integrity and respect of their lived experiences.

The cohort of Māori midwives is relatively small, approximately 13% of the total midwifery workforce. Therefore, as the researcher, I was aware that one way or another, I potentially would have a relationship with the midwife. This is not unusual for research that is done by Māori, with Māori, and for the purpose of Māori advancement. Considered an 'insider' researcher, Smith (2012b) advised this position places higher expectations of being respectful, ethical, and maintaining humility. Additionally, there may be other roles that the researcher will need to navigate within the shared community. In this situation, Chilisa (2012) emphasised the need for reflexivity and remaining critical to maintain a level of stability and accountability to the bias of the researcher. These elements were forefront and taken into account throughout the research process. Over and above this, Kahu Pōkai entrusted me with their pūrākau; therefore, it is my responsibility to accurately represent them as they intended.

Kahu Pōkai expressed that being a Māori midwife is not just a job; it is a way of life. They acknowledged that birth is a remarkable life event and, for most, being a midwife is a career that they felt was a 'calling'. This idea will be explored further; however, the title of this research 'He Matatauihi i Ngā Ururei Whēako hei Kahu Pōkai' brings with it an awareness of an undeniable Māori worldview and resonates the focus of this study. 'Matatauihi' refers to the sacred role of calling spiritual and physical energies to kaupapa by the female voice. 'Ngā Ururei', denotes the ancient practices that are guided by the knowledge of deities. 'Whēako' is the experiences gained by the being, that is human; and 'Kahu Pōkai' refers to the absolute commitment, unique passion and purpose that is activated for mothers and their babies. This title locates the study to the nature of Māori midwifery and childbirth. It exerts traditional knowledge systems, acknowledges the responsibility of nurturing whakapapa and offers an

⁹ Pūrākau – ancient legend, story. It is also used in this thesis to describe the stories of Māori midwives.

insight to the privileged potential of this position. This gives insight to my understanding as a Kahu Pōkai and the unique role we uphold.

Aims and Approach

By asking the question ‘what are the experiences of Māori midwives?’, this research aims to reveal the distinctive elements of Māori midwifery in contemporary society and the difference these make for birthing whānau. Hickey et al. (2021) pointed out key factors to meaningful practice for Indigenous maternity health include privileging Indigenous knowledge and solutions, embedding Indigenous governance within practice thinking, valuing continuity of carer, embracing whānau well-being, and inadvertently improving the cultural awareness of non-Indigenous colleagues. This research expects the unacceptable oppressive environment many whānau birth amid will be made visible and hypothesises that Māori midwives will show how they excel in critical elements, such as Hickey et al. (2021) expressed, to make birthing safer for whānau.

The approach to this study sought to allow Kahu Pōkai to tell their stories of what it is (for them) to be a Māori midwife. Nine interviews were undertaken. Kaupapa Māori and Mana Wahine were the theoretical foundations of this research. These methodological platforms allow Māori researchers to reflect mātauranga that has evolved from within te Ao Māori. It is the taken-for-granted of being Māori that adds the essence to this research. As such, the interviews were conducted in a place of their choice with whomever they chose to be present. Certain tikanga (protocols), such as karakia (prayer), was guided by ngā ringa hāpai, allowing their tikanga for the telling of their stories.

Mana Wahine theories maintained the focus of thinking to bring attention to the mana of wahine. Smith (2019) and Pihama (2019b) advised that Mana Wahine covers a wide range of viewpoints taking into account the complexities of Māori women’s experiences, while acknowledging the cultural and historical realities of wahine Māori. Pihama (2019b) went on to say it is critical that wahine Māori take control of their stories, emphasising the need to re-affirm our (wahine Māori) positions, understandings and theories from a Māori worldview. Hence, Mana Wahine provided the platform to express what it is for Kahu Pōkai to practice within the context of a colonised, Eurocentric, medical dominant society.

Originally a hermeneutic approach was intended to be integrated in the theoretical stance. However, as the research process commenced, and particularly once interviews started, it was clear that Kahu Pōkai held some reservation about a methodology that did not align with their

worldview. Simply stated, as the researcher I felt like hermeneutics was the square peg trying to fit into a round hole, and it became a conceptual grapple between the foundational basis of hermeneutic theories and a Māori worldview. Jahnke (2019) advised:

In order to make sense of the reality of Māori women's lives and find relevant ways to explain the nature of Māori women's experiences in contemporary contexts it is necessary to employ an analysis that is grounded in te ao Māori. (p. 192)

Along with the philosophical difference, Māori theories are extensively acknowledged (Hoskins & Jones, 2017; Pihama et al., 2019a, 2019b; Ruru & Nikora, 2021; Smith, 2012b) and hold more relevance to exploring what matters to whānau and the evolution of our mātauranga. It is in these spaces that Māori academia thrive. Consequently, and in consultation with supervisors, it was decided to release hermeneutics as a methodology for this research.

Significance of the Research

The birthrate for Māori women is 1.7 times higher than non-Māori (MOH, 2019c). In 2017, approximately 25% of birthing women were of Māori descent and many were considered higher risk pregnancies; hence, higher healthcare need. Statistical population projections indicate Māori demographics are progressively increasing (Durie, 2005). The Māori population is forecast to grow approximately 16% by 2030, a 3% greater increase than non-Māori, explained by higher fertility rates of Māori and a younger population (MOH, 2015).

The annual PMMRC (2017, 2018, 2022) reviews repetitively show that current maternity services inadmissibly fail to meet the needs of tangata whenua, demonstrating persistent inequities that has had very little movement in decades (Health Quality & Safety Commission, 2019; MOH, 2002; 2019a; Waitangi Tribunal, 2019). These overwhelming negative health outcomes have a domino effect in childbirth. For example, birthing that occurs within economic deprivation increases the chances of being young, a smoker, premature birth, and a low-birthweight baby. All of these factors elevate chances of medical intervention and ongoing morbidities (MOH, 2019b, 2022).

As mentioned, whānau Māori typically birth with complex health needs that often have an influence across the life spectrum. This leads to greater clinical and cultural requirements and, at times, notable exposure to potentially traumatic events. Inter-related health consequences within the childbirth continuum also significantly impact upon infant and childhood morbidity. Therefore, the importance that timely, culturally, and clinically appropriate pregnancy care has across infancy, childhood, and into adulthood cannot be underestimated. The positive

impact that good maternity care will have upon Māori health outcomes is immense. Multiple maternity clinical indicators, such as registration with a lead maternity carer (LMC), type of birth, small and or preterm babies, demonstrate a direct correlation to getting pregnancy care right (Te Whatu Ora, 2023). So, along with a growing Māori population, Māori are more likely to require maternity care that is clinically competent and culturally safe.

In the past, discussions identified strategies required to increase whānau capacity which included, Māori workforce development, governance, and leadership (Durie, 2009; Ratima et al., 2006; Russell et al., 2013). In 2011, Durie identified the incorporation of Indigenous practices into mainstream structures would enhance Indigenous well-being locally, nationally, and globally. Hickey et al. (2021) supported similar actions within maternity. It is intended that this research will show how Kahu Pōkai promote these aspects in reality for birthing whānau.

The Waitangi Tribunal's (2019) recent publication 'Hauora: Report on Stage One of Health Services and Outcomes Kaupapa Inquiry' influenced the remodelling of the way in which health care in Aotearoa is presented. The Waitangi Tribunal (2019) found that, despite apparent efforts, Māori continue to sustain health inequities. Although the Crown is not completely responsible for these failings, it was confirmed that the primary health care framework, in its current state, was not consistently Te Tiriti compliant. There were severe shortcomings in areas such as appropriate funding allocation, data collection and dissemination, and representation of Māori within the workforce. It concluded that, as it was, the primary health care framework did not promote "tino rangatiratanga¹⁰ and mana motuhake¹¹ of hauora Māori" (p. xv). This means the primary health care system did not support or endorse Māori to have autonomy or self-determination over their own health. In part, this report was the catalyst for the establishment of TWO (New Zealand Health Authority) and Te Aka Whai Ora (Māori Health Authority) in 2022, replacing the 20 District Health Boards (DHBs) to become the public health agencies for Aotearoa. These health reforms have since been over-ridden by the current National-NZ First-Act Coalition government. As primary health care providers, Kahu Pōkai are directly implicated by any political and systemic changes, and in an evolving health environment the relevance and contribution of this research to practice is immense.

¹⁰ Tino rangatiratanga – self-determination, sovereignty, autonomy, self-government, domination, control, rule, power.

¹¹ Mana motuhake – separate identity, autonomy, independence, sovereignty, control over one's destiny.

Despite strong evidence based guidance for change in health service delivery (Cram, 2014; MOH, 2011; 2020b), embedded health inequities and dissatisfaction in health care continues to be reported by Māori (National Maternity Monitoring Group, 2019; PMMRC, 2022). Buchanan and Magill (2015) found that whānau Māori are more likely to choose a Māori midwife; but, with an increasing Māori population, coupled with a low cohort of midwives who ethnically identify as Māori, and in a system that is yet to yield positive health experiences for Māori, whānau are unlikely to receive culturally appropriate maternity care (MOH, 2015).

Maternity services are a critical feature of primary health in Aotearoa and are often an indication of overall population health. The Pae Ora (Healthy Futures) Act 2022 (New Zealand Government, 2023b) is a response to the stark inequities that exist particularly within Māori maternity outcomes and this area of health has been identified as a priority. As a result, in a joint approach of TWO and the then, Te Aka Whai Ora, now Hauora Māori, Kahu Taurima was established. Their focus is to review services from conception through to 5 years, inclusive of maternity to create a cohesive approach that makes a positive difference for whānau.

The World Health Organization (WHO) identified that pregnancy is often the first time a woman and her whānau source health care (Ratima, 2001), and is more common among Indigenous populations. It is also well understood that cultural identity is necessary for optimal Indigenous health and well-being (Ratima, 2010); and, optimal infant well-being is dependent on maternal health. This research is timely, it offers the ideal opportunity to explore the intricate nature of the relationship between the Kahu Pōkai and birthing whānau, and the impact Māori midwifery has upon Māori maternity outcomes.

Context of Midwifery in Aotearoa

Despite an 11% increase in the midwifery workforce over the past 10 years, there is currently a significant workforce shortage. Approximately 46% of midwives work in core midwifery, and 34% are employed case-loading or self-employed LMC midwives. Some midwives work in education, professional, advisory, or management roles. Encouragingly, since 2016 there has been a slight increase in the number of Māori midwives in midwifery education. Most midwives identify as female, five identified as gender diverse, and eight midwives in Aotearoa are male (Te Tatau o te Whare Kahu Midwifery Council of New Zealand, 2023a).

Kahu Pōkai currently makes up about 13% of the entire midwifery workforce in Aotearoa. There has been a steady increase over the last 6 years, from 285 who identify as Māori either their first,

second, or third ethnicity to 425 from a total of 3,298 registered midwives in 2023 (NZMC, 2023a). In 2015, 92% of Māori women registered with an LMC midwife (MOH, 2017).

The LMC provider can either be a midwife, general practitioner with a diploma in obstetrics, or an obstetrician. For the purpose of ongoing discussions in this thesis, the LMC is assumed to be a midwife. The structure of LMC midwifery care aims to provide continuity of care; meaning birthing whānau have a consistent maternity provider throughout their pregnancy, labour, birth, and postnatal period within a partnership model. In 2021 there was a change to the structure of the Primary Maternity Services Notice: pursuant to Section 88 that was issued under (section 88) of the New Zealand Public Health and Disability Act 2000 (MOH, 2020a). The Primary Maternity Services Notice (the Notice) became Section 94 pursuant to the Pae Ora (Healthy Futures) Act 2022 (New Zealand Government, 2021). The Notice is the avenue by which LMCs are paid. This means LMCs are directly contracted by the MOH to provide maternity services. The new Notice acknowledges a whānau centred approach, including the rights and needs of whānau, the fairness of pay for work done, allows an adaptable approach to providing maternity services, and supports sustainability of community-based care (MOH, 2020a).

Buchanan and Magill (2015) found most wāhine chose their LMC either based on the midwife's knowledge and professionalism or because they were recommended by friends or whānau. Buchanan and Magill (2015) also noted that LMCs were ranked highly if they were warm and caring, had been their previous midwife, or because of their locality. In accordance with Buchanan and Magill (2015), de Bonnaire et al. (2023) also expressed that Māori are more likely to choose their LMC based on the extent to which their culture, beliefs, values, and background are respected. The LMC role provides an opportunity to understand the primary health needs of birthing whānau and examine current service provision in the maternity sector (MOH, 2002).

Midwifery Autonomy

The political partnership between women and midwives during the 1990s led to the 1990 Nurses Amendment Act. This legislative change meant the profession of midwives could legitimately practice autonomously from other disciplines, define its own scope of practice, and regulate its standards of practice and education. It also meant the profession could hold its members accountable for the quality of their practice (Guilliland & Pairman, 1994).

Midwives are expected to uphold clinical competence, provide care that is clinically and culturally safe, maintain annual requirements for practising certificates, and uphold a good standing in the community. As autonomous practitioners, the midwives' practice is their

responsibility. These obligations are set out in multiple legislative and ministerial documents including; Nurses Amendment Act 1990 (New Zealand Government, 1990), Health Practitioners Competence Assurance Act [HPCAA] 2003 (New Zealand Government, 2023a) and Primary Maternity Services Notice 2021 (New Zealand Government, 2021).

MCNZ (the Council) is the regulatory body for midwifery in Aotearoa. The function of the Council is defined by the HPCAA 2003 (New Zealand Government, 2023a) which provides the framework for all regulatory bodies and is about protecting the health and safety of the public. The Council's role is to enact the HPCAA legislation, primarily safeguarding the well-being of all those who receive midwifery care. They do this by ensuring midwives practice within the midwifery scope of practice, monitoring midwives' practice is safe and competent, and ensuring midwives are fit to practice.

Partnership Model

In 1994, Guilliland and Pairman presented a model for midwifery practice. The idea of partnership emerged from the constitutional foundations of the Treaty of Waitangi. The Partnership model acknowledges pregnancy and birth as normal physiological events, positioning the childbirth experience within its socio-cultural context (Guilliland & Pairman, 1994, 2010). The central tenets of the Partnership model is based upon power sharing, reciprocity, women-centeredness, continuity, and autonomy. Partnership has gained international recognition as a midwifery model of care and has become part of the identity of New Zealand midwives. It has been interwoven throughout New Zealand maternity legislation and documents (Guilliland & Pairman, 2010; MOH, 2020a; New Zealand Government, 2021)

The Partnership model was developed in a political era where birthing was controlled by a medicalised environment that did not allow for the voice of women to be heard. It was a pivotal time; women and midwives came together to demand the control of birth return to women. Collectively they succeeded in gaining autonomy for midwives. This was the impetus for the formation of the New Zealand College of Midwives (NZCOM), and soon after the Code of Ethics and Standards for Midwifery Practice were published (Guilliland & Pairman, 1994). The philosophy of partnership and midwifery code of ethics is the foundation for practice in Aotearoa (Pairman, 1999).

Providing continuity of midwifery care within the Partnership model has been shown to enhance the processes of childbirth, promoting positive experiences. However, the practice of

being with whānau and caring for them during this period has mostly been articulated by others who do not share a common worldview with that of Māori. In 1999 Sally Pairman said, “the one constant is the fundamental relationship between one woman and one midwife in the shared experience of childbirth” (p. 7). This statement directly contradicts te ao Māori, the significance of whānau and a collective worldview. Kenney (2011) critiqued the Partnership model as “mono-cultural” (p. 123) and void of any Māori worldview; therefore, contextually insufficient to promote whānau ora. The principle of partnership, as outlined in He Korowai Oranga guide (MOH, 2014), is defined as; “Working together with iwi, hapū, whanau and Māori communities to develop strategies for Māori health gain and appropriate health and disabilities services” (p.12). It is fair to say that the voice of wāhine, whānau Māori, hapū, and iwi is still (at best) muffled amid this centralised mainstream, non-Māori discourse.

Te Kāretī o Ngā Kaiwhakawhānau ki Aotearoa | New Zealand College of Midwives

Formalised in 1989 (Donley, 1998), the NZCOM is the professional body for midwives and midwifery students in Aotearoa. They are a recognised organisation representing more than 90% of practising midwives. The College developed the philosophy, Code of Ethics and Standards of Practice for midwifery. The midwifery philosophy places midwifery care in partnership with women. Accordingly, it outlines continuity of midwifery care enhances and protects the normal process of childbirth (NZCOM, 2015).

The Code of Ethics for midwifery includes the responsibilities to the woman, the wider community, and to colleagues and the profession. The Code is detailed, including working in partnership, accepting the rights of women to have autonomy over their childbirth experiences, the right to informed consent, the right to express their worldview in all that is, the right to confidentiality, no action of the midwife that puts the woman at risk, and the midwife’s worldview does not deprive the woman of essential health care. Included in a midwife’s responsibility to the broader community is that midwives recognise Māori as tangata whenua and, therefore, honour the principles of the Treaty of Waitangi—partnership, protection, and participation. Midwives also advocate for policies and legislation that support social justice, and equitable resource distribution. Within the profession, the code outlines midwives’ responsibility to support and sustain their colleagues, uphold professional standards of practice, and promote the advancement of midwifery knowledge that protect the rights of women (NZCOM, 2015).

Importantly, the Waitangi Tribunal Hauora Report (Waitangi Tribunal, 2019) noted the articulation of the Crown's Treaty principles (three Ps) are outdated and need amending. The Tribunal recommended the primary health system adapt the principles to include; "the guarantee of tino rangatiratanga, the principle of equity, active protection, principle of options and principle of partnership" (pp. 163-164). This significantly extends on the original principles to include autonomy over design, delivery, and monitoring; a commitment to equitable health outcomes; assurance Crown agents achieve equity; resourcing for culturally appropriate models of care; and tangata whenua as equitable partners in the design of primary health services. In response, it would be reasonable to expect the midwifery professional bodies review the current code of ethics to align with these principles. As yet this has not been done.

The midwifery philosophy and Code of Ethics provide the basis for the Standards of Midwifery Practice (NZCOM, 2015). Again, partnership features as a competency for entry to the midwifery register. The 10 Standards of midwifery practice identify actions that are integral to the relationship with women. They are:

- **Standard one:** The midwife works in partnership with the woman
- **Standard two:** The midwife upholds each woman's right to free and informed choice
- **Standard three:** The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing
- **Standard four:** The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons
- **Standard five:** Midwifery care is planned with the woman
- **Standard six:** Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk
- **Standard seven:** The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice
- **Standard eight:** The midwife evaluates her practice
- **Standard nine:** The midwife negotiates the completion of the midwifery partnership with the woman
- **Standard ten:** The midwife develops and shares midwifery knowledge and initiates and promotes research. (NZCOM, 2015, p. 17)

Midwives are supported to meet the Standards of Practice through a review process, the Midwifery Standards Review. NZCOM also develops consensus statements that provide guidance on topics that are pertinent to midwifery practice and provide resolution support for

consumer complaints. By membership, registered midwives have indemnity insurance that includes legal support for any extenuating midwifery events or complaints.

Recently NZCOM undertook a cultural review (Milne et al., 2023). The findings included much of what many researchers and Māori agents have advised within the health sector. Recommendations included: a call for a change and restructuring of the organisation, application of Te Tiriti o Waitangi and commitment to equitable outcomes, the importance of addressing racism across the organisation, the request for a cultural framework for NZCOM that includes; “kawa whakaruruhau (cultural safety), ngā tangata (Māori midwives) and mātauranga (Māori knowledge)” (p. 14).

The cultural review has provided NZCOM with clear directives, including the inaugural co-presidency tangata whenua and tangata tiriti roles, which were established along with two Māori-specific advisory roles, and to create co-leadership and co-governance within a Tiriti-led framework. This mandate would be challenging for a historically white-women-led organisation to attain. However, with the implementation of a partnership agreement with Nga Maia, signed on 21 February 2024¹², and the demand for transformative change from whānau, tangata whenua must be prepared to promote positive advancements within the organisation. This research intends to support current evidence (Milne et al., 2023) for systemic integration of Māori praxis within maternity organisations such as NZCOM.

Nga Maia o Aotearoa

Established in 1993, Ngā Maia o Aotearoa me te Waipounamu, now known as Nga Maia o Aotearoa (Nga Maia) was a group of Māori midwives, Māori midwifery tutors, and students who came together to support, debate, and acknowledge whānau Māori birthing and traditional birthing practices. Ngā Maia is dedicated to traditional Māori birthing practices that promote the well-being of whānau. They support Kahu Pōkai to provide whānau with high-quality, tikanga-based midwifery care and are considered the Tiriti partner to NZCOM.

Ngā Maia became a charitable trust in 1994 and is now recognised as the national voice for Māori midwives, Kahu Pōkai. In 2008, Ngā Maia was endorsed by NZCOM, the Midwifery Council of New Zealand, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Over the years, Ngā Maia has had a variable relationship with NZCOM, which ultimately reflects the nature of conflicting worldviews and priorities.

¹² See Appendix A - Partnership and Mutual Agreement between Ngā Maia (Tangata Whenua) and NZCOM (Tangata Tiriti).

Historically Ngā Maia has had agreed memorandums of understanding with the College. However, the NZCOM's cultural review expressed that the organisation has yet to realise the true nature of working in partnership with tangata whenua. Hence, Ngā Maia and the College recently engaged in an official "Partnership and Mutual Understanding" (NZCOM and Ngā Maia, 2024). It is expected that with the guidance and continued implementation of the cultural review recommendations (Milne et al., 2023), the relationship between Nga Maia and the College will strengthen to reflect a Tiriti honouring framework.

Turanga Kaupapa

The Turanga Kaupapa is a cultural framework developed by Nga Maia o Aotearoa in 2006. It acknowledges Māori ideologies to further strengthen the partnership model and the how midwives work with whānau. The principles of Turanga Kaupapa:

- **Whakapapa:** The wahine and her whanau is acknowledged
- **Karakia:** The wahine and her whanau may use karakia
- **Whanaungatanga:** The wahine and her whanau may involve others in her birthing programme
- **Te Reo Maori:** The wahine and her whanau may speak Te Reo Maori
- **Mana:** The dignity of the wahine, her whanau, the midwife and others involved is maintained
- **Hau Ora:** The physical, spiritual, emotional and mental wellbeing of the wahine and her whanau is promoted and maintained
- **Tikanga Whenua:** Maintains the continuous relationship to land, life and nourishment; and the knowledge and support of kaumatua and whanau is available
- **Te Whare Tangata:** The wahine is acknowledged, protected, nurtured and respected as Te Whare Tangata (the "House of the People")
- **Mokopuna:** The mokopuna is unique, cared for and inherits the future, a healthy environment, wai u and whanau
- **Manaakitanga:** The midwife is a key person with a clear role and shares with the wahine and her whanau the goal of a safe, healthy, birthing outcome. (NZCOM, 2015, p. 18)

Currently, midwives are expected to show how they reflect upon the tenets of the Turanga Kaupapa alongside the Standards within their practice as part of their mandatory midwifery

standards review (NZCOM, 2018). The Turanga Kaupapa has been adopted by NZCOM and the Midwifery Council of New Zealand as:

One mechanism to give life and meaning to the midwifery profession's recognition of Māori as tangata whenua and to the profession's obligations under the Treaty of Waitangi. Turanga Kaupapa are integrated into the midwifery standards for practice and the competencies for entry to the register of midwives. (MCNZ, n.d, p. 5)

It is evident in maternity reports that the majority of midwives are yet to recognise the value of the Turanga Kaupapa as central to their practice mode (MOH, 2017). To date, education has been ad hoc and not formalised outside of the undergraduate midwifery programme. However, the Turanga Kaupapa has recently become part of the mandatory recertification programme. Appropriately, Ngā Maia has taken the role of providing the education for this programme. Now mandated, all midwives will be required to undertake formal Turanga Kaupapa education and show evidence for recertification each year.

The incorporation of all the concepts of the Turanga Kaupapa will facilitate the spiritual, emotional, physical, and mental well-being of wāhine and whānau. Each principle provides a baseline of understanding. These elements encompass aspects that are both tangible and intangible. For example, whakapapa acknowledges wahine and her whānau. For Māori the meaning of whakapapa goes far beyond wahine and her whānau, extending to hapū and iwi. Mahuika (2010) added that the significance of whakapapa is a determinant of mana and cannot be underestimated. For most Māori midwives, the Turanga Kaupapa is a natural extension of who and how they are with birthing whānau. This research intends to show how Kahu Pōkai enables whānau to define their tikanga surrounding these dimensions.

Overview of Thesis

This thesis is presented in two parts. Part One, Ngā Uranga ā Te Kahu Pōkai introduces the whakapapa of the research project. It provides an overview to the background and mechanics of study emphasising the foundational thinking that influenced its approach. Uranga resembles the evolution of this research, like baby emerging from Te Ao Marama into Te Ao Tūroa. This research has finally come into fruition. Part Two, Te Whare-Kōrero ā Kahu Pōkai is the heart of the research. It presents the pūrākau shared by Kahu Pōkai. It then goes on to show how the pūrākau were interpreted in the findings chapter. Finally, Part Two brings the thesis to a close.

Chapter One has outlined the purpose of this research, which is to give voice to Māori midwives. It revealed the maternity system in Aotearoa is dominated by a Western worldview which

provides the rationale to ground the research in Kaupapa Māori and Mana Wahine. These theoretical approaches challenge hegemonic practices and exposes the reason this research is imperative in the context of Aotearoa midwifery. The chapter also provides an overview of the present context of midwifery including an outline of the professional bodies and frameworks that guide the maternity sector. Finally, the chapter clearly indicates the unique opportunity for this research.

Chapter Two provides a description of Te Tiriti o Waitangi and significant legislation during the colonial period. Broadening this awareness brings attention to the ongoing impact on Māori maternity demographics and, particularly, the demise of traditional birthing practices. The conversation moves into the 20th Century further highlighting areas such as the significance to the loss of birthing autonomy, the impact cultural assimilation and land alienation. The chapter ends by bringing the relevance of Te Tiriti forward to contemporary society, particularly within midwifery. Attention is given to misinterpretations between Te Tiriti and the Treaty of Waitangi, emphasising the significance to maternity practice in Aotearoa.

Chapter Three is the literature review. The purpose of which was to bring forward literal resources that give evidence to the research itself. It encompassed a search method that elevated Indigenous health academia, in particular sources that focused upon Indigenous maternities and childbirth. Research that has been conducted by Māori midwives were prioritised to further contextualise the study. Indigenous academia confirmed the critical nature of challenging dominant discourses that do not reflect an Indigenous worldview or respond to Indigenous need. A total of 58 articles were reviewed. The majority were produced by Māori academics; however, most of these were not Māori midwives. Hence, as well as drawing attention to the context of Indigenous birthing, the review provided further justification to the relationship and nature of the research itself.

Chapter Four is an important chapter that defines the theoretical foundations that guided this research. It describes the intricate nature of traditional Māori pedagogy such as Whare-wānanga and Te Whare-tangata. These discussions clarify the use of Māori systems of learning in relation to the analysis process of this study. It also located the worldview and philosophical underpinnings that Kahu Pōkai have exposed. Therefore, this chapter is crucial in developing an understanding and appreciation to the mātauranga that will follow. It also introduces Papa Hōhepa De La Mere. His expertise and mātauranga has been critical to informing much of this research.

Chapter Five goes on to explain the methodology, methods, and analysis used in this study. Epistemology, ontology, and methodology are made clear, pointing to the integral nature of Māori research. The key question draws out the experiences of Māori midwives; thus, the basis of the research needed to align with the worldview of those taking part. This meant a Kaupapa Māori and Mana Wahine theoretical approach was most relevant. Evidence is provided to justify the way in which the research was conducted and why the data analysis encapsulated Indigenous positioning. In response to Kaupapa Māori and Mana Wahine it was important to promote Māori systems of knowledge that recovered and reclaimed wāhine Māori ideologies. Therefore, principles of tino rangatiratanga, whakawhanaungatanga, and tikanga guided the research process, prioritising wāhine Māori knowledges. The chapter outlines how the pūrākau were gathered and describes Te Whare-kōrero ā Kahu Pōkai as an extension of the Whare-wānanga learning environment. This part of the discussion gives detail to Te Whare-kōrero ā Kahu Pōkai as a conceptual model, including defining the Pou and Rauru to clarify the process of analysis. Diagrams are offered to aide understanding. Ethical issues are considered along with the principal limitations. The trustworthiness or integrity of the research finalises the chapter. The CONSIDER statement is included further validating the strategies used in this research project. This chapter brings Part One of the thesis to a close.

Part Two, Te Whare-kōrero ā Kahu Pōkai begins with the telling of the stories, the pūrākau. Each Kahu Pōkai is introduced and is given space to tell their story. The uniqueness of these pūrākau have been emphasised in keeping them whole. By doing so, the validity of their voice is respected, providing a depth of understanding that disappears in the process of data deconstruction.

Chapter Six presents the findings of the research. He Matatauihi i Ngā Ururei Whēako hei Kahu Pōkai offered the mātauranga necessary to examine the pūrākau. These platforms of mātauranga are explored separately. Matatauihi, Ngā Ururei, Whēako, and Kahu Pōkai highlight the relationship of each to the experience of being a Māori midwife. This distinct mātauranga exposes the unique nature and qualities of being a Kahu Pōkai. Finalising the discussion are profound quotes taken from the pūrākau to highlight each dimension.

Chapter Seven summarises the key themes. Four areas of mana guide the discussion; Mana Atua, Mana Tipuna, Mana Whenua and Mana Tangata. Utilising the concept of mana emphasises unique characteristics of Kahu Pōkai that go beyond Western ideas of maternity care. The

discussion brings together the findings to show how Kahu Pōkai practice in a transformative way and make birthing safer for whānau.

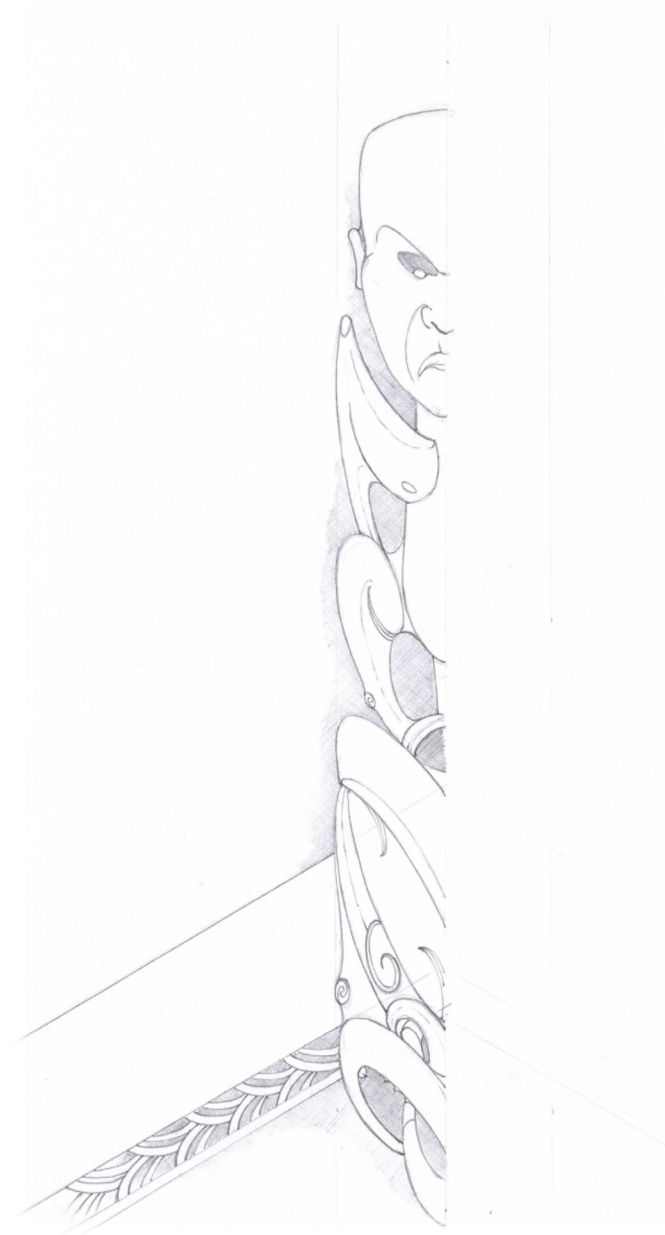
Chapter Eight closes this thesis and brings the research to an end. The objectives of the research are brought back into focus and highlight the significance of Indigenous kōrero. The relevance of midwifery practice models is further examined in consideration of the findings of this research. Examination of contemporary Māori midwifery practice has illuminated the need for change. These recommendations and proposal for further research is detailed in this chapter. Finally, this thesis draws attention to the relevance of comprehensive knowledge gathering, examination and expression to further inform the health of Indigenous peoples. It highlights the valuable contribution that research conducted by Māori, for Māori, in a Māori way, will make.

Conclusion

This chapter outlined the aims, approach, and justification for the research. It gave some context to the current maternity sector and the environment in which Kahu Pōkai and midwives work, along with the regulatory and professional bodies, including the legislative documents that guide midwifery care provision. It outlined the health of an individual is significantly influenced by broader determinants that go beyond health or maternity sectors (Ratima, 2001). So, although partnership has been the platform for significant changes to the midwifery profession, the Partnership model, in its current understanding, is not changing health outcomes for whānau Māori. The profession is failing to have a positive impact on Māori maternity experiences. Therefore, if midwives are to shift negative statistics, there needs to be a broader understanding and practice recognition of the determinants of health, including the Turanga Kaupapa, in partnership with the Midwifery Standards of Practice.

Kenney (2011) drew attention to the perceived individualised model of care present in the midwifery sector. She warned that when the woman is the sole focus, it ignores the relevance of childbirth within the familial context, as such a Māori worldview of birth. Adding to this perspective, enduring inequitable maternity outcomes and chronic workforce shortages will make coordinated action for change challenging. As key stakeholders, Kahu Pōkai are directly implicated in any systemic changes. It is, therefore, crucial that the Māori midwifery voice is influential in regulatory and professional bodies, including legislation that guides midwifery care provision. Shifting outcomes must be driven by and accountable to the populations most affected, tangata whenua.

Those who participated in this research are skilled practitioners who excel in caring for whānau. Their excellence has mostly been achieved in a system that discourages cultural safety while promoting implicit bias and privileging non-Māori. In general, Kahu Pōkai have endured systemic resistance to a Māori way of being since before the Tohunga Suppression Act 1904. So, although health reforms and changing governments create new challenges, there remains an unrelenting determination within the Māori midwifery community toward tino rangatiratanga. This research is part of that movement.



CHAPTER TWO

Toitū te Tiriti

This chapter gives reference to Te Tiriti o Waitangi in midwifery practice. Principles of partnership, protection, and participation have, in the past been frequently adopted and appear within health policy. However, little attention has been given to the application and relevance of these principles in practice, particularly since they were deemed outdated and insufficient to promote equitable outcomes for Māori (Waitangi Tribunal, 2019). So, while this research is inherently underpinned by Te Tiriti, it is important to explore the notion of partnership, particularly due to its prevalence within maternity. Providing context to the historical impacts of colonisation and assimilation further supports a deeper appreciation of the current maternity sector.

To begin, an overview of He Whakaputanga, the Declaration of Independence, is offered to provide context to the political environment prior to the signing of Te Tiriti o Waitangi. Following, a brief description of the events leading up to 06 February 1840 will be presented. An outline of the Treaty articles will be offered to provide perspective to the document and the stipulations within it, particularly in reference to health. Additionally, an overview of some of the legislation instigated during the colonial period, including the overtly racist Tohunga Suppression Act 1907, will be explored to give political context to Aotearoa during this period. Alongside, the Midwives Act 1904 provides background to the maternity sector at that time. This is by no means an exhaustive account, but highlights the historical challenges that have led to the demise of traditional Māori birthing practices and mātauranga. From there, an exploration of te Tiriti in the contemporary maternity setting will be offered.

It is expected that as the thesis unfolds, this research will explicitly reveal how Māori midwives achieve integrating Te Tiriti in practice, the idea of partnership, and, more importantly, tino rangatiratanga. While it is important to focus upon solutions, having a critical awareness and understanding to the history of Aotearoa is crucial to plan for Māori health advancement. Examination of Māori midwifery history and colonisation will be enhanced with the theoretical position of Mana Wahine.

He Whakaputanga o Te Rangatiratanga o Nu Tirene 1835

The Declaration of Independence

He Whakaputanga o Te Rangatiratanga o Nu Tirene, the Declaration of Independence of New Zealand, was reported to be signed by 35 chiefs; most were from Northern hapū but a few from

further South also signed, on 28 October 1835. The United Tribes of New Zealand, Te Whakaminenga, declared Aotearoa an independent State affirming its kingitanga and mana to the world (Durie, 1998a; He Tohu, 2017; Salmond, 2017). Māori were politically astute and already engaging in treaties with each other as iwi and hapū. They were also very aware of the need to develop relationships with other political entities, including the Crown (Durie, 1998a).

He Whakaputanga proposed to govern by Māori legislature and a Parliament made up of Rangatira. Māori aspirations, values, and practices would determine future directives for the emerging nation. It declared to the world that power and authority in Aotearoa (or then Nu Tireni) resided with hapū. The constitution created the avenue for hapū to come together to make decisions on matters of common interest while maintaining their individual mana or Māori sovereignty. It is important to note that given the short turn-around between He Whakaputanga and Te Tiriti of only 5 years, not all hapū had the opportunity to be involved in He Whakaputanga. However, the foundation of autonomy, along with the essence of being inter-dependent when needed, created an acceptance of this constitution among Māori. As such, He Whakaputanga declared the political and constitutional capacity of Māori, and became the prerequisite to Te Tiriti o Waitangi (Durie, 1998a; He Tohu, 2017).

Te Tiriti o Waitangi 1840

Treaties were part of the political landscape of Aotearoa prior to 1840. Important decisions like going to war, making peace, or entering treaties were made at the hapū level. Moana Jackson (He Tohu, 2017), along with many others (Durie, 1998a; Salmond, 2017; Smith, 1999), pointed out (and in contrast to what some historians have stated) that as an independent society, Māori were very aware and versed in the appointment of a treaty as a necessary process of engagement with other iwi, hapū, states, and, in this case, the Crown. The prospect of entering into a treaty with the Crown meant that hapū needed to come together to consider the advantages and disadvantages. These debates occurred over a relatively short period of time.

During this time, settlers residing in Waitangi were outnumbered 20 to 1 by Māori. The prevalent language and tikanga was Māori. A Māori way of living dominated (Salmond, 2017). Māori were also thriving in business both nationally and internationally; for example, between 1842 and 1858 it is recorded that Māori were trading in wheat, fish, and cattle in large profitable amounts. Whanganui-a-tara iwi processed up to £150,000, which they invested into farming equipment. Up to 18 flour mills in the Waikato region were owned and operated by tangata whenua and 53 Māori trading ships were registered in Auckland. Only 9 of 443 convictions for petty crime were Māori. Fifty percent of settlers could not write and 33% could not read; yet,

Northern missionaries reported nearly all Māori were literate (Simpson, 1986). Other authors such as McLay and New Zealand Institute of Advanced Legal Studies (1995) have also documented evidence of the prosperity of Māori, including settlers' accounts of the wealth of agricultural products and in particular, fishing practices. Durie (1998a) highlighted well prior to the signing of Te Tiriti Māori held sophisticated fishing technology and commercial interests. Therefore, Māori had a vested interest in securing land autonomy and protecting their lucrative industries, as well as imposing control upon the lawlessness that was occurring among settlers.

From the Crown's perspective, the intention of the Treaty was threefold: to address the serious health concerns that had already emerged, threatening the existence of the Māori population; to safeguard Māori from being unduly marginalised by British settlement; and to protect the well-being of Māori. Some Crown representatives, like Lord Normanby, were somewhat cognisant of the impact colonisation could have upon tangata whenua and in the prelude to the Treaty urged,

The acquisition of land by the Crown for the future Settlement of British Subjects must be confined to such districts as the Natives can alienate without distress or serious inconvenience to themselves. (Durie, 1998b, p. 82)

On 06 February 1840, Te Tiriti o Waitangi countered He Whakaputanga and was signed by representatives of the Crown and Rangatira of Aotearoa. In short, kawanatanga or governance was surrendered whilst rangatiratanga or autonomy was not ceded. Māori maintained authority over lands, estates, forests, fisheries, and treasured possessions or taonga. Māori were to presume equity between themselves and settlers. The intention of the Treaty was to acknowledge an equal partnership as the basis for ongoing relationships between tangata whenua and the Crown (Orange, 1989). Devastatingly, and relatively quickly, colonisation ensued.

Legislation and Assimilation

Loss of land autonomy occurred with the instigation of multiple and continuous legislation. Some of these included the 1841 Land Claims Ordinance targeting land sales that had occurred up to 1840. If Commissioners found 'invalid sales', they were cancelled, and surplus land held by the Crown not returned to the rightful Māori owners. The 1860s New Zealand Settlement Act meant that if Māori were believed to be in rebellion against the Crown, particularly in large numbers, the land would be confiscated whether or not it belonged to the so-called 'rebels'. Three million acres were taken in this way alone. The Suppression of Rebellion Act 1863 suspended basic rights for those thought to be rebels, and the penalty included land

confiscation and death. Acts such as these manipulated the control over land sales to benefit the government. The Crown succeeded in reducing land ownership of tangata whenua, rapidly transferring the majority of land ownership into non-Māori hands (Simpson, 1986).

Other significant legislation included the 1847 Education Ordinance. Missionaries set up boarding schools to educate Māori children in Methodist, Anglican, or Catholic religion and the English language. These schools were financially supported by the government. Twenty years later, the Native School Act vigorously enforced teaching in English only. The 1907 Suppression of Tohunga Act prohibited Māori spiritual leaders and healers from practising. This was an attempt to replace traditional Māori healing approaches with “modern medicine” (Kingi et al., 2018, p. 194). Legislative Acts such as these were devised to create assimilation into a non-Māori world. Disease and land wars would cause the near genocide of the Māori population. Transfer of land ownership from tangata whenua to the Crown and cultural assimilation led to the demise of Māori prosperity, reinforcing the loss of land and alienation from cultural practices and language.

Midwives Act 1904

During the 1890s the maternal death rate in England was as high as 65 per 10,000 births. Women across all classes understood and accepted pregnancy, labour, and birth to be a dangerous, potentially life-threatening, time. Having a child was seen as a necessity that built character. Several prominent maternal deaths ignited the debate to enforce legislation to control who attended women in childbirth. England passed the Midwives Act in 1904 and it was enforced in 1905 (McIntosh, 2012). At the same time, the New Zealand Government mirrored this legislation in Aotearoa (Clarke, 2012).

The Midwives Act was created to stem the high degree of maternal deaths and enforce an expected level of formal training. Notably, the Act assumed midwives or those that attended births to be female. Women also had to be of certain standing to be on the register of midwives (McIntosh, 2012). In Aotearoa 1905, Saint Helens Hospital commenced a 12-month midwifery training course. If women had already obtained nursing qualifications they only needed to do 6-months. Midwives who were already practising came under one of two categories; Class A or Class B. Class A were midwives who had already completed formal midwifery training that had been sanctioned by the registrar. Class B midwives had to satisfy the registrar that they were of

good character or a bona fide¹³ midwife, for at least 3-years (Clarke, 2012). This was the beginning of the Eurocentric domination over childbirth in Aotearoa (Kenney, 2009).

The Midwives Act instigated control over those who attended women in childbirth and directly impacted the right of Māori to give birth within their own pedagogical worldview. The Act made it illegal to practise as a midwife unless the midwife had appropriate certification and was accredited by a physician. Although it was difficult to police, particularly in remote areas, anyone found to be breaching this legislation was imprisoned (Kenney, 2009).

Tohunga Suppression Act 1907

The passing of the Tohunga suppression Act in 1907 significantly interrupted the efforts of Māori to maintain authority over their health. It declared the health system of New Zealand was to be firmly based upon Western modalities of health. The Act prohibited:

Every person who gathers Māoris around him by practicing on their superstition or credulity, or who misleads or attempts to mislead any Māori by professing or pretending to possess supernatural powers in the treatment or cure of any disease, or in the foretelling of future events. (Durie, 1998b, p. 44)

The last point in this Act was to give authorities the power to shut down renowned prophet Rua Kēnana. Kēnana had a strong influence and was prophesying a Māori epoch that included the eviction of Pākehā. His arrest eventuated in 1916. By then, Māori healers had been forced underground, and although their practices had not been lost altogether, transmission had been significantly interrupted (Durie, 1998b).

Although the Tohunga Suppression Act was supposedly about health promotion, it built on the levels of assimilation, removing access to unique Indigenous methodologies and those who were experts in this knowledge (Durie, 1998a). The Act not only outlawed the practice of traditional Māori healing and medicines, it marginalised traditional knowledge. It also consolidated the Midwives Act (Kenney, 2009), and mātauranga was effectively lost in the vast ether of Western ideology (Bennett, 2018).

¹³ Bona fides were those who were considered to be of sufficient local standing and expertise to continue to practice (McIntosh, T. (2012). *A social history of maternity and childbirth: Key themes in maternity care*. Routledge Publisher.

Birthing in the 20th Century

The inherent ability wāhine Māori had to cope with childbirth and the mindset that birth was not an event to fear encouraged wāhine Māori to continue birthing in their traditional environments. Along with access to expert care, a Tohunga (who may have been male or female) and the attendance of their hoa rangatira¹⁴, the care of wāhine was skilled and attentive. Tohunga would perform birth rites to ensure the spiritual and physical safety of both mother and baby (Kenney, 2009; Palmer, 2002). Christine Kenney, a midwife and researcher, descends from Rangatira of Ngāti Toarangatia, Te Atiawa and Ngāi Tahu. Her great-grandmother was one such person who, in direct defiance of Midwives Act 1904 and Tohunga Suppression Act 1907 provided birthing care to whānau of Kapiti (Kenney, 2009).

Established tikanga ensured the physical and spiritual well-being of both the mother and unborn baby. These practises were part of birth being considered tapu. Therefore, access to the birthing area was restricted. For some wāhine, particularly those of higher ranking, special structures commonly recited as whare-koohangā (also known as whare-puhi or whare-oohangā) were erected for the birth and the period after the birth (Melbourne, 2009). Once its purpose had been completed, the structure would be destroyed, usually by burning (Clarke, 2012; Melbourne, 2009). Practically this ensured appropriate disposal of bodily excretions, and provided a level of infection control (Melbourne, 2009).

During the early period of the 1900s, most Māori were still birthing within their traditional environments, particularly those who resided in isolated or rural communities. Multiple factors influenced the resistance of Māori entering the hospital to birth. Hospitals were regarded by both Māori and non-Māori, as dangerous places to be and considered to be mostly for the poor. The spread of disease and in particular, the risk of puerperal fever was extremely high up until the introduction of antibiotics in the 1930s. Therefore, those who could afford in-home professional assistance remained at home to birth as it was the safer environment.

Māori were particularly resistant to entering maternity units due to staff not being of the same worldview, mandatory use of the lithotomy position, being told when and how to push and the higher chance of puerperal sepsis. Over and above these factors, the spirituality surrounding birth was not acknowledged, whānau members were not allowed to attend the birth, and the violation of tapu created a hostile environment that was in direct opposition to a Māori worldview. Therefore, culturally unsafe and dangerous to the well-being of tangata whenua.

¹⁴ Hoa Rangatira – husband, wife or partner.

Māori were also very aware of the prejudice Pākehā had toward them (Palmer, 2002). Sadly, these issues are still apparent within the contemporary maternity sector and many of these elements have been experienced in childbirth by the Kahu Pōkai in this research. However, as multifaceted as it was for Māori to remain within their hapū to birth, so too were the reasons for wāhine Māori to move to birth within the maternity hospitals. Much of this transition was manipulated by legislation and acts of assimilation.

The Native Health Act 1909 made it illegal for wāhine Māori to breastfeed in public and in 1924 the 'Campaign for Safe Maternity' led to the government introducing legislation to abolish unqualified midwives all together. Exhibiting the belief that all women (Māori and non-Māori) had the right to quality maternity care, the government moved to supposedly incentivise access. The Health Act 1935 opened the doorway for Māori to participate in childbirth, and the Social Security Act 1938 eventuated free maternity care. In 1963 the government linked birth registration to eligibility for a family benefit, evidently influencing the place Māori birthed (Palmer, 2002). By 1935, 85% of Pākehā were birthing within maternity hospitals; Māori did not get to this level of institutionalised birth until the mid-1960s (Clarke, 2012; Palmer, 2002).

Since the Tohunga Suppression Act, the State has neglected and undermined processes by which Māori maintain tino rangatiratanga over their health and well-being. The misinterpretations and misdirection of mātauranga Māori since colonisation has consistently under-advantaged tangata whenua (Durie, 1998a). During this era, loss of autonomy over the environment, those that attended, and the way in which Māori birthed was entrenched. Māori became cautious and guarded in what and the degree of mātauranga that is shared in the public non-Māori arena (Melbourne, 2009). The contribution of mātauranga by tohunga such as Papa Hōhepa within specialised whare-wānanga space has protected knowledge, maintained its integrity, and avoided misinterpretations by non-Māori anthropologists.

Mana Māori

At the 2010-2011 Te Paparahi o Te Raki Tribunal Hearing, prominent Hokianga leader, Dr Patu Hohepa, quoted the rangatira of 1840, Mohi Tawhai, who had prophesied during the Treaty debates:

...our sayings will sink to the bottom like stone, but your sayings will float light, like the wood of the whau-tree, and always remain to be seen, Dr Hohepa added;
the stones have now come up and they want to talk. (Salmond, 2017, p. 247)

Both statements, could not be more relevant than they are today in 2024. Durie (1998b) outlined various significant factors during a phase he termed “Te Hokoinga Mai o te Mauri, Twentieth Century Recovery and Growth” (p. 40). The Māori population was not only starting to recover from past insults but also showing signs of such significant growth that the reality of eradication was a thing of the past.

Termed Mana Rangatira, the 1900-1930s presented Māori leadership and professional guidance strongly emerging within health and the political arenas. Following on, Mana Wahine 1931-1975, summarises the rise of wāhine Māori, specifically support networks and the Māori Womens Welfare League (MWWL). Wāhine Māori were notably present in healthcare. More broadly, the era between 1975-1992 marked Mana Māori. The first president of the MWWL, Dame Whina Cooper, led the hikoī from the far North, Te Hapua to Parliament. Dame Whina and 5,000 supporters marched to petition against further land alienation of Māori land. Together with the then Minister of Māori Affairs, Matiu Rata, the Treaty of Waitangi Act 1975 was passed. Māori were leading in areas of politics, health, and law, asserting te ao Māori within professional domains. Health hui during the 1980s and 1990s, including the Hui Whakaoranga and Hui Taumata in 1984, debated issues regarding the health of tangata whenua. Recognition was made to the importance and application of the Treaty of Waitangi to health (Durie, 1998b).

Near the end of 20th Century, Māori had made a remarkable turn around in terms of survival, with relatively rapid population growth increasing over 500,000 in a century. By 1975 maternal and infant mortality rates had dropped dramatically and life expectancy had doubled to what it was 75 years earlier. Although Māori were now better placed than they were a century ago, new health disparities were emerging including heart disease, cancers and mental illness. The impacts of urbanisation, social and economic disruptions were reflected in Māori realities. Determinants of health, including cultural, historical, and political, crucially influenced the overall well-being of the individual, whānau, hapū, and iwi. Māori were mostly birthing in hospitals, breastfeeding rates were low, and the application of traditional maternity practices were practically non-existent, particularly within urban areas (Clarke, 2012).

Te Tiriti O Waitangi 2024

The Māori and Crown relationship inferred within Te Tiriti, signals a responsibility by health providers to adhere to its principles as woven through health strategies in Aotearoa (New Zealand Government, 2012; MOH, 2000, 2001, 2002a, 2006). Increased Māori participation, leadership and expertise in health, continually challenge the health system including the maternity sector to address entrenched negative Māori health outcomes. It has included

considerable workforce development to enforce the action of incorporating the intent of Te Tiriti to healthcare practice.

Essentially, Article One in Te Tiriti outlines the Crown's authority to govern. Article One of the Treaty (English version) talks to Crown sovereignty. This provided for the Crown to establish a government. Article Two of Te Tiriti stipulates tribal authority over cultural, social, and economic resources. Article Two of the Treaty, the Queen guaranteed to the chiefs, "the full exclusive and undisturbed possession of their lands and estates, forests, fisheries and other properties". In turn, they (Māori), yield to her "the exclusive right to pre-emption in land sales". Article Three of Te Tiriti and English text give "Royal protection and citizenship rights". It stipulates the statutory promise of equity between Māori and other citizens of Aotearoa. This meant Māori should experience equally the benefits of New Zealand citizenship, which implied the inclusion of good health (Durie, 1998b, p.82-83; Salmond, 2017).

Although much debate has occurred surrounding the interpretations of Te Tiriti o Waitangi and the Treaty of Waitangi, one fact remains: Rangatira¹⁵ only signed Te Tiriti o Waitangi. As such, our ancestors never ceded sovereignty to the Queen of England. Over 180 years later, the Crown's objectives outlined in Te Tiriti of good health, equal status, and the overall well-being for Māori is yet to be achieved.

Regardless of the misinterpretations and misunderstandings between the two texts of the Treaty, at the time of the signing iwi Rangatira were experts in the process of treaties. They were not confused over what they were signing. Moana Jackson offered an easy analogy to understand the foundation of Te Tiriti from the perspective of tangata whenua (cited in He Tohu, 2017). He explained in this way: when manuhiri (visitors) come to the marae there are the kawa (protocols) or the constitution of the marae that are expected to be followed. The old people that bring the manuhiri are expected to ensure the kawa of the marae are followed. When foreigners started to arrive in Aotearoa it was like they were arriving to our marae. Hence, there was the expectation that their political authority (their old people) would ensure their people accepted and behaved in accordance to our kawa.

The intention of signing Te Tiriti was driven by the desire to establish a relationship with those who were coming to our marae. It recognised the Crown as the authority or Rangatira for non-Māori. It gave the Crown authority to govern and keep control of their peoples. It established

¹⁵ Rangatira – to be of high ranking or noble. Chief.

the framework for newcomers to have a relationship with tangata whenua and Māori were free to exercise their mana. In other words, “what the essence of the relationship would be, on the marae that is our land” (Moana Jackson, 08 June 2017). However, colonisation disrupted the action of the agreement made between these two parties, tangata whenua and the Crown. Moana Jackson so eloquently stated:

The key of the Treaty discourse, is not a esoteric debate about what the words mean, it's not a political competition about who has the most power, it's about a promise made for two people to honour each other in a relationship of equality. Colonisation has denied that. Constitutional transformation in the end is the political structural way in which that is addressed, but that comes based upon that change in the hearts, that pursuit of that arc of history. (Moana Jackson, 08 June 2017)

Moving into the 20th Century, the implications of the Treaty and Te Tiriti toward health are broadly outlined as: “Parliament has the right and authority to govern; Iwi have the right to exercise tino rangatiratanga and Māori individuals have the right to expect a fair share of society's benefits” (Durie, 1998b, p. 84).

Te Tiriti in Maternity Practice

Māori models of health have been widely integrated and have been shown to enhance Māori health outcomes. However, Māori health statistics remain intolerable and unacceptable inequity continues. Likewise, whānau Māori expressed satisfaction in the LMC model of care (MoH, 2017); although statistically Māori experience enduring disparities within maternity (MOH, 2002c, 2015). So, while the Partnership model provided a platform to provoke change in maternity services, healthcare provision continues to maintain undesirable outcomes for Māori (Kenney, 2011). Inherently problematic within this model, and other models of health, is a lack of understanding of how Te Tiriti has significant relevance to health.

Development and implementation of any government policy or strategy will need vigorous monitoring to guarantee positive health advancement for Māori (MOH, 2002, 2014, 2016). However, the complexity of these directives has led to stagnant health outcomes for tangata whenua. In an attempt to address this issue, in what has probably been the most significant change in Aotearoa's health environment, the previous government implemented Te Aka Whai Ora, the Māori Health Authority, charged with the mandate to lead a Māori health system specifically. The current National-NZ First-ACT coalition government (2024) has rapidly introduced an agenda of transferring Māori-specific programmes to more generic policies based

on 'need'. They have dismantled Te Aka Whai Ora, the Māori Health Authority and, unfortunately, their stance on issues such as health and te reo Māori is unequivocally discriminatory. The current National-NZ First-ACT coalition government (2024) is attempting to erase the status of Te Tiriti o Waitangi and, thereby, reduce the status of tangata whenua. However, Māori have shown extreme resilience and, as Moana Jackson has said in the past, although the agreement has been overpowered in the course of genocidal dispossession it does not annul the promises made. "The promises that are made in the course of human events, in the end are meant to be honoured" (Moana Jackson, 08 June 2017). Margaret Mutu added:

My current translation of kawanatanga is, the controlling mechanism to enable self-management of those that come in under the Treaty. It is not governance, that is too powerful. It is controlling tangata tiriti, those that came in under the Treaty. That is what Te Tiriti is about. Also that we (Māori) have access to the British culture and to British law, but we will continue to live under our mana, our tino rangatiratanga and we will never give that up. This is a Māori country. Mokopuna will not tolerate racism at all. Their minds are free of the colonial shackles. (Wānanga via Zoom, February 2024)

The Aotearoa Project

Recently, the MCNZ undertook the process of revising the Midwifery Scope of Practice to reflect a Te Tiriti honouring document. This was the Aotearoa Midwifery Project. Key maternity stakeholders, including consumers, were contracted by the Council, forming the Collaborative Reference Group (CRG) to expertly guide this project to re-write the Scope. The CRG comprised of tangata whenua and tangata tiriti with co-leadership by Dr Hope Tupara and Dr Judith McAra-Couper, both midwives. The Council has stated that it is:

Committed to embedding Te Tiriti o Waitangi in midwifery practice... committed to the learning that is required to develop Te Tiriti-honouring ways of working that will meaningfully impact the safety of midwifery care for Māori and all whānau across Aotearoa. (MWC, 2023b)

The revised scope has been gazetted (MWC, 2024). Although it is not entirely the original wording given to the Council by the CRG, it does express more of a Māori worldview than the previous scope. As a member of the CRG and then the Council, I have had the perspective of both groups. It was a tumultuous process that challenged monocultural worldviews, spanning from the regulatory and professional organisations to midwives in practice. Specifically, the document in its original wording, used *whānau* to describe who a Kahu Pōkai or midwife cares for. This included a footnoted definition of the use of *whānau* within this particular document.

The intention of the definition was to clarify the purposes of the HPCAA (New Zealand Government, 2023a) and satisfy regulatory obligations:

The primary obligation of kāhu pokai | midwives is to wāhine hapū/pregnant person and pēpē/baby. For the purpose of this Scope of Practice, specified under section 11 of the Health Practitioners Competence Assurance Act 2003, Whānau refers to the wāhine hapū/pregnant person and, pēpē/baby in their social context, enabling care as it relates to pre-conceptual care, pregnancy, childbirth, and newborn care. (MWC, 2023b)

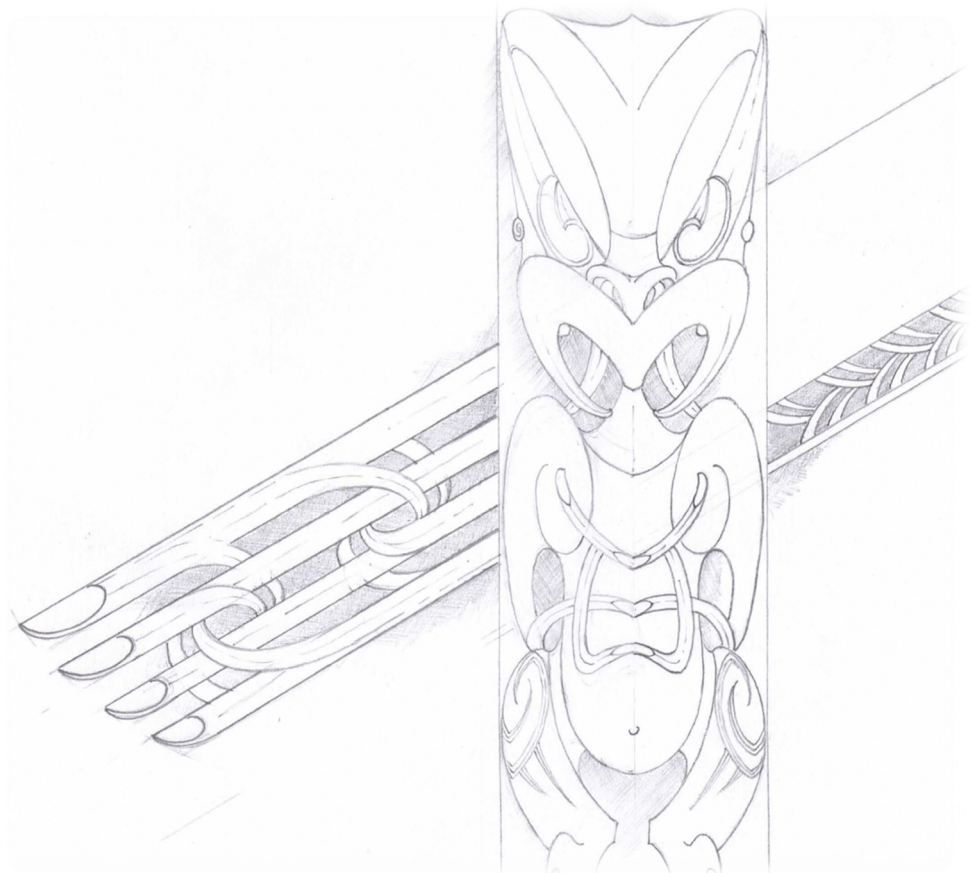
The change from woman to whānau created much debate amongst the midwifery profession. It directly challenged the stance of midwives who they see that they care for, and how they practice. The document presented an ideological shift from the individualised Eurocentric model of care to a whānau-centric worldview. Many midwives made it clear they were not ready for such a dramatic move and publicly expressed negative, prejudiced critiques; overtly exposing the nature and depth of discrimination within the midwifery workforce. There has also been broader public debate and petition put to the Ministry specifically aimed at the use of ‘whanau’ rather than woman or wahine.

The process to get to the understanding that, in its simplest is, once wahine are hapū, they are whānau (mama and pēpē within te whare ahuru mōwai) was robust and included experts in te reo, mātauranga Māori, and midwifery. Although this thesis does not want to revive the contextual conversation, it is important to highlight the intention was never to undermine the power and uniqueness of wāhine hapū or the mana of wāhine. This is an example of the complexities of a restorative strategy that aimed to liberate an Indigenous worldview. It also brings to light the depth of the colonised mindset which both Māori and non-Māori are challenged to acknowledge and reminds the profession of the work that must be done if equitable outcomes are achieved. Milne et al. (2023) advised shifting systemic cultural and social norms to address racism requires courage, leadership, and commitment to a process that takes time. In this research, it is argued that systemic change first needs those in power to trust the process, guidance, and Indigenous knowledge presented.

Conclusion

This chapter has examined the influence historical constructs have had upon the current maternity sector of Aotearoa. The background to Te Tiriti o Waitangi provides the context which Rangatira considered prior to putting their signature to the document. Tangata whenua were thriving in all aspects of life; health, social, cultural, and economic standards were

extremely high. Colonisation resulted in the destruction of key health, social, and economic structures, including land, culture, and language alienation. Legislation, such as the Midwives Act and Tohunga Suppression Act, imposed Western ideology as superior to any other societal constitutions. Maternity care became firmly rooted within a medical model predominately dictated by males. Traditional Māori birthing knowledge and skills were lost. These acts of assimilation interrupted the transmission of mātauranga Māori, particularly for birthing whānau. In addition, this chapter outlined the complexities of challenging dominant maternity philosophies that do not equally benefit whānau Māori. This research aims to show how Kahu Pōkai achieve positive practice outcomes amid a maternity sector that has yet to reflect a functional partnership inherent to Te Tiriti o Waitangi.



CHAPTER THREE

Literature Review

Prelude

The context of this review outlines the nature of Indigenous health care with an emphasis on the maternity sector and draws focus to the impact Indigenous providers may have upon the health of tangata whenua. Qualitative research is often stimulated by an observation to then generate theory. However, before a theory is devised, there must first be an understanding of the relevant hypotheses in the area of interest. What can become challenging is when the area of interest has sparse information sources; for example, as indicated previously, research that focuses on Māori midwifery that is conducted by a Māori midwife. Tolich and Davidson (2018) advised that a literature review is to gain a broad understanding of the context of the research area. By doing this the researcher will justify both the research itself and the approach taken.

This literature review included searching international journal databases and grey literature, initially with no year limits. Databases included CINAHL, Scopus, Google Scholar, and EBSCOhost. Search terms included Māori maternity, Māori birthing, Indigenous birthing, childbirth, Māori health and birthing, midwifery, Māori midwifery and Māori midwives. A total of 58 articles published between 1992 and 2023 were used to inform this review. The articles were primarily sourced from within Aotearoa; however, there were a few from other Indigenous communities.

Initially, a literature search was undertaken based on known Māori midwives who had completed academic research, particularly at the doctorate level. These sources of academia are relatively small. Additional Māori midwifery investigative reports were included before broadening the search to contemporary Māori maternity sources. After that, sources were contextualised within the landscape of Māori and Indigenous maternity healthcare. Once the relevant literature had been gathered, analysis began. Tolich and Davidson (2018) emphasised that in addition to providing context, a literature review promotes the thinking in the area of interest. In this case, the main focus was to formulate an understanding of Māori maternities within Aotearoa.

Background

Western worldviews inform the dominant knowledge system that circulates within the maternity sector of Aotearoa. For too long, this has detrimentally influenced how Indigenous peoples value their heritage and ways of knowing, and how these are reflected in societal constructs. As Berryman et al. (2022) cited:

For too long, the interrelationships and subtleties of Māori culture, language and identity, generated from Indigenous epistemologies have been eroded, belittled and overlooked by a system and associated policies that continue to promote assimilation into the worldview of the coloniser. (p. 173)

Berryman et al. (2022) stressed the importance of challenging these current norms and practices by providing alternative approaches that reflect the mātauranga of our tīpuna. Midwifery practice in Aotearoa is primarily based upon a bio-scientific paradigm that privileges empirical knowledge, as reinforced by Stevenson et al. (2020):

Today, the maternal-infant healthcare system continues to be designed and delivered through mainstream, monocultural and biomedical processes that tend to be inflexible for accommodating te ao Māori. In 1988, Puao-te-ata-tu clearly stated that national structures have been developed from values, systems and views of the majority culture only. Participation of the minority cultures is conditional on them subjugating their own values and systems to the power system. Today this has not changed. (p. 70)

Kenney (2009) emphasised the importance of scrutinising the relationship between knowledge and the power agents relating to disseminating midwifery knowledge. These power relationships are also found as part of a neo-colonial system of midwifery education promoting stereotypical constructs that are deeply embedded in Aotearoa society. As it is, Māori are not equally contributing to their development as midwives. It is hoped that this research can become part of the discourse of a decolonising process and build upon Māori maternity knowledge.

Māori Midwives Literature

In accordance with what Tupara (2001) found, little has been documented by and from the perspective of midwives who identify as Māori. Some that are available are part of this literature review. Hope Tupara (2001; 2008), Christine Kenney (2009; 2011), Nicole Pihema and Jean Te Huia (with other non-Māori) (2023), and Beverley Te Huia (2020) are some of the few that have contributed to the scarce, yet valuable, body of knowledge written by Māori midwives.

Jacqueline Martin (2023) has also very recently published her research, 'Our First Mothers', a story that brings forward the voice of Indigenous midwifery, a beautiful articulation to the multifaceted implications of colonisation upon childbirth in Aotearoa. It is also important to note that after 24 years of practising as a Māori midwife and, for the most part, being actively engaged in Māori academia, there seem to be more Māori midwives now participating in a postgraduate pathway. Two such Māori midwives are Waimarie Onekawa and Aroha Camille Harris. They have commenced their doctoral research journey and we await their theses to be published.

Beverley Te Huia (2020) and Jean Te Huia (2020) have contributed research that aimed to inform Māori health workforce priorities. These research projects were commissioned by the MOH and done in partnership with the national organisation representing Māori midwives and Māori birthing whānau, Ngā Maia, Te Rau Ora (Māori workforce organisation), and (the then) Counties DHB. Whaia Te Aronga a Kaiwhakawhanau Māori (J. Te Huia, 2020) and Whaia Te Aronga a Hine Ngā Māmā (B. Te Huia, 2020) built upon the knowledge gained from Rapua te Aronga o Hine: the Māori midwifery workforce in Aotearoa (Tupara & Tahere, 2020), a literature review that described the Māori midwifery workforce and its nuances.

Jean Te Huia (2020) undertook research to capture the experiences of Māori midwives. The aim was to explore the aspirations of the Māori midwifery sector to then inform future opportunities to improve overall workforce capacity. Many of the findings were echoed from Tupara and Tahere (2020) such as the under-representation of Māori midwives across all platforms within the maternity sector and the lack of Māori leadership, including opportunities for professional development from a te ao Māori lens. This research also identified the parallels between birthing wāhine and Māori midwives' experience of racism and disparities, particularly within the hospital settings. The report has a strong emphasis on Ngā Maia building capacity to represent birthing whānau and Māori midwifery as an organisation that is kaupapa Māori based and Te Tiriti-led.

Beverley Te Huia (2020) conducted the last part of a series of projects that examined the urgent need to address entrenched health inequities and a maternity system that was not meeting Te Tiriti obligations. However, this qualitative study exposed the maternity workforce experiences from the perspective of Māori māmā. Unsurprisingly, along with uncovering more examples of a health system that does not treat whānau Māori equally, it highlights a system built upon policies that encourage assimilation to a mainstream worldview and racism. Te Huia also

pointed out that tangata whenua have been excluded from discussions, are under-represented and under-resourced by the professional bodies of maternity since the inception of its partnership model of care, a model that New Zealand midwives are held accountable to and, ironically, bases its foundations upon the partnership affirmed in the Treaty of Waitangi.

The maternity sector of Aotearoa is an example of the results of colonisation. The domination of Western worldviews has created an environment that severely overlooks the aspirations, capacity, and well-being of the whānau Māori that it serves. By exploring the interconnectedness of midwifery education, workforce development, the overall under-representation of Māori, and the absence of a Tiriti-led partnership. B. Te Huia (2020); J. Te Huia (2020), and Tupara and Tahere (2020) highlight the consequences of these infrastructural deficiencies upon whānau Māori and their birthing experiences within the maternity sector. Tupara and Tahere (2020) articulated the cruciality “for revolutionary change” (p. 110) so that the midwifery workforce may better support the needs of tangata whenua.

Rapua te Aoranga a Hine (Tupara & Tahere, 2020) provided a comprehensive examination of the Māori maternity sector, providing an in-depth overview highlighting specific distinctions that impact upon Māori within the maternity sector. This was the first time a comprehensive review of Māori midwifery had been done. These reports are a collective from the perspective of whānau Māori, Māori midwives, and midwifery (B. Te Huia, 2020; J. Te Huia, 2020; Tupara & Tahere, 2020).

Pihema et al. (2023) examined the perspectives of Māori mentor midwives. They aimed to articulate the tangible benefits of a decolonising approach to mentoring for Māori midwives and Māori midwifery. This research is unique in that the focus is on the mentors, not the mentees, and explicitly explores the relationship from the perspective of Māori midwives. Currently, the midwifery mentorship structure in Aotearoa is directed by NZCOM and is known as the Midwifery First Year of Practice (MFYP) programme. Recently, a formal partnership between NZCOM and Ngā Maia was established to re-write the MFYP mentorship programme. In particular, the intention is to create a mentorship programme that better supports new graduate Māori midwives. The MFYP review has been completed, recommendations made, and is now awaiting Ministerial approval.

Pihema et al. (2023) found a correlation between international Indigenous mentors and Māori midwife mentors that included role modelling an Indigenous ontology of interpersonal reciprocity and trust, the importance of whanaungatanga, and creating culturally safe spaces.

Māori mentors promote an environment that addresses power imbalances, brings to light colonisation's negative impacts, and reclaims te ao Māori. Māori midwives in this study expressed a responsibility to nurture the next generation of Māori midwives and, without structural support, applied a decolonising approach. Mahuika (2012) described this approach as “a theory of change, liberation, and transformation, and the practice of being Māori” (p. 59). Māori midwifery mentorship aligns with Kathie Irwin's (1992) characterisation of kaupapa Māori research, that it is culturally safe and culturally relevant. Importantly, Pihema et al. (2023) showed the impact Māori midwifery mentorship can have upon the sustainability of the Māori maternity workforce for both new graduates and mentor midwives.

Indigenous Maternities

Chamberlain et al. (2016) examined models of leadership and, in particular, looked at ‘traditional’ or Indigenous midwives as a domain of leadership. Again, very little has been documented from the perspective of traditional midwives. They found that the role of traditional midwives, such as those who are Indigenous, is integral to the flourishing of healthy societies. Like Pihema et al. (2023), they described how Indigenous midwives employ mentoring models that foster wisdom and skills that consider physical, spiritual, and cultural dimensions of well-being. These leadership roles have survived the colonial and patriarchal structures that typically undermine Indigenous knowledge and often become a multigenerational source of cultural knowledge (Chamberlain et al., 2016).

Berryman et al. (2022) highlighted the impact colonisation has had upon traditional Māori maternities, eroding the value and legitimacy of pregnancy, childbirth, and parenting knowledge systems and practices. They emphasised the importance of challenging ideologies that promote a colonising agenda which entails first being prepared to understand the persuasive colonial constructs that influence midwives' way of being. Transformative praxis will include the relearning and reclaiming traditional values and practices, as well as the articulation of knowledge, that challenge the colonial norm. This will provide a foundation for decolonising approaches.

In line with the above literature, Ratima et al. (2019) talked about the barrier ethnocentric thinking creates to the engagement of decolonising practices. The potential of Indigenous philosophy and knowledge to health promotion will require self-reflection by health providers to be genuinely inclusive of Indigenous worldviews. Hickey et al. (2019) added that recognition

of obstructionist behaviour will challenge non-Indigenous practitioners to understand their privilege influences clinical practice and, therefore, cultural safety.

Along with research that has been done by Māori midwives, there has been a surge of literature by Māori academics on traditional Māori childbirth or Māori maternities. Some of these studies have outlined discussions with Māori midwives; however, the focus has been from the perspective of birthing wāhine (Lawton et al., 2013; Palmer, 2002; Simmonds, 2014; Tikao, 2012)

Māori academics, Ellison-Loschmann (1997), Fox (1997), and Palmer (2002), focused upon various aspects of whanaungatanga. They postulated that health services provide inadequate alternatives to a dominant health structure. Unfortunately, more than a decade later, research findings continue to report inadequacies in the health and maternity sector for Indigenous peoples (PMMRC, 2022; Stevenson et al., 2016; Stevenson et al., 2020; B. Te Huia, 2020; J. Te Huia, 2020). These authors advocate for research that recognises Māori aspirations and moves toward Māori advancement. Research of this nature has been broadly supported by Māori commentators such as Durie (2003, 2004, 2011), Ratima (2003), Smith (2012b), Cunningham (1998), and Bishop (1996).

Maternity Paradigm

Examining a health environment that relentlessly overlooks the needs of tangata whenua evolved from a culture of midwifery education that overwhelmingly promotes a dominant way of knowing and doing (Leatham, 2014). Tupara (2001) emphasised that while midwives of Aotearoa acclaim their autonomy of practice, Māori strive for autonomy of identity, and caution that midwifery education has not afforded accurate information representative of Māori diversity. She identified the need to extend the partnership of midwifery to be incorporated between midwifery education and Māori. Pihama (2019a) warned of the misrepresentation wāhine Māori have been subjected to in the colonial discourse. Western ideas continue to be embedded within literature marginalising the way in which wāhine Māori are regarded in society. Hence, over many generations, the sacred place of both wāhine Ātua and wāhine have been denied within the pages of white doctrine.

The absence of robust scrutiny of ideologies that support the marginalisation of Māori and perpetuate the continuance of these disparities has been widely articulated (Ajwani et al., 2003; Ramsden, 1995; Smith, 1999; Tupara, 2001). Moreover, it is now vital to document midwives' stories and ways of knowing reinforcing and building upon a capable, competent Māori health workforce. This is pivotal to improving health outcomes for Māori (MOH, 2007) and, in

particular, crucial for the sustainability of the current Māori midwifery workforce while supporting its growth.

Contributing to the Māori maternity knowledge pool is integral to birthing whānau, Māori midwives, and those who inform the systems of the maternity sector. First and foremost, it is important for whānau to hear the voices of those that align with their world and understand the intricacies of being Māori and being a midwife. It is also integral that midwives write their own story, and inform their own pathway. As Kathy Irwin (1992) said, tangata whenua do not need others to write their story.

Research must continue to challenge health environments that support deficit ideologies while creating pathways to promote culturally viable practice. Tupara and Ihimaera (2004) indicated to recognise the diverse demographics Māori midwives work within they need unique education. Palmer (2002) concluded approaches that allow tangata whenua to recreate and restore childbirth experiences that acknowledge the strength of Māori identity will be evolutionary in Māori maternity workforce development.

Simmonds (2014) found there was an unyielding blame attitude toward Māori maternal health outcomes and infant morbidities. Although research by Ryan and Wilson (2010) was not maternity focused it also drew attention to institutional and interpersonal racism experienced by Māori mothers. Negative accounts that endorse blame tactics expose apathetic health professionals and partially explain the barriers to Māori accessing services. Similar findings were identified in Tupara and Ihimaera's (2004) study that went on to promote programmes that are embedded within a Kaupapa Māori approach to enhance positive health outcomes.

Farry (2015) found that socially disadvantaged women (who are more often Māori) face barriers such as insufficient health literacy that can be exacerbated by hostile health professionals. Issues expressed in this study highlight the impact of institutional racism and adverse effects, including the diminished potential for wāhine to access appropriate maternity care in a timely manner. These issues are strongly reflected in sustained negative outcomes for Indigenous whānau and increased maternal and infant morbidities (PMMRC2017, 2018, 2022).

Iconic New Zealand midwife, Joan Donley (1993), articulated 2-decades ago that health in Aotearoa is positioned within the dominant Western culture articulated upon a medical model that concentrates on biological disorder. The failure of these notions to the health of tangata whenua were emphasised and broadly recognised by Māori (Durie, 1998b; Ratima, 2001). Ratima

(2001) went on to highlight the WHO acknowledged in the mid-20th century health was greatly influenced by physical, mental, and social well-being and not just absence of disease. What has become alarmingly apparent is that Aotearoa's maternity systems and midwifery education undervalue the imperative nature of traditional Māori practices, tikanga Māori and mātauranga Māori.

Transformative Praxis

Recently Stevenson et al. (2020) offered a culturally responsive maternity care framework as a nuanced approach to caring for whānau Māori, particularly when unexpected outcomes occur. Three components intersected to develop Te Hā o Whānau. Firstly the study was immersed in kaupapa Māori prioritising a Māori worldview. Secondly, the lived realities of whānau who have experienced negative health outcomes or the loss of their baby were explored using mātauranga Māori. Lastly, foundational elements of kāwanatanga, rangatiratanga, and ōritetanga guided the development; hence, Te Tiriti o Waitangi legitimised the conception of the model. Stevenson et al. (2020) strongly urged the uptake of creative models that address the persistent inequities that plague whānau Māori within the maternity system.

Durie (2004) has discussed the interface between this dominant global system of science and Indigenous knowledge, identifying the increasing contest between intellectual and cultural sites. This dialogue is shifting to focus on how Indigenous knowledge can prevail in modern practice for the advancement of Indigenous peoples. Studies such as Stevenson et al. (2020) highlight the need and validity of merging cultural practice with healthcare systems to achieve “transformative practice” (p. 70). Anecdotal discussions reveal Māori midwives regularly negotiate these somewhat opposing paradigms. Accordingly, it will be important to examine how this is managed and maintained in practice. Additionally, Māori midwives may expose how they maintain their cultural practices amidst the demands of midwifery.

Research has emerged appealing for urgent consideration to the exorbitant global rates of medical childbirth intervention (McAra-Couper et al., 2010). Studies linked procedures that disrupt the process of normal birth, skin-to-skin contact, and breastfeeding negatively impact adult health. Basic practices such as these have been shown to induce lifelong immune systems, significantly decrease the chance of diseases such as diabetes and respiratory illness (Harman & Wakeford, 2013).

Indigenous peoples throughout the world experience birth as a physical encounter and a spiritual process that is deeply connected to the Indigenous land. Dennis and Keedle (2019)

shared their lived experience of birthing “on country” as a traditional practice of the Aboriginal women in Australia. The intimate connection between Aboriginal peoples and the land is expressed as, “We are this country, country is us” (p. 348). Birthing as country reveals the direct relationship between land and birth; a worldview that acknowledges a mutual responsibility. Rather than living *on* the land, it is a consciousness of being *in* the land. Birthing in this way instils the values of reciprocity between the Indigenous environment and the life cycle.

However, birthing practices and traditional knowledge systems, such as birthing on country, have been altered, access limited and lost due to the imposition of mainstream worldviews (Dennis & Keedle, 2019). Concurrently, Indigenous peoples also experience excessive maternal and infant health inequities (Adams et al., 2017; Dennis & Keedle, 2019; Hayward & Cidro, 2021). These disparities inevitably lead to higher birth interventions. Hayward and Cidro (2021) acknowledged medicalisation has its place in the birthing arena. However, the negative implications and over-consumption of mainstream practices have prompted the construct of “obstetric violence”, defined as “dehumanising treatment, the abuse of medicalisation and the pathologisation of natural processes, resulting in the loss of women’s autonomy” (p. 214).

The Primary Maternity Services Notice 2021 (New Zealand Government, 2021) states;

Primary maternity service provision will achieve Māori health outcomes and reduce Māori health inequalities by facilitating Māori access to maternity services, ensuring appropriate pathways through those services and ensuring that maternity services address the primary maternity needs of Māori. (p. 27)

This is a bold statement set out in Part C: general requirement for all primary maternity services (New Zealand Government, 2021). Outrageously evident is that primary maternity services in Aotearoa are not reducing Māori health inequities (MOH, 2019a; PMMRC, 2022). Whānau Māori are experiencing dissatisfaction with maternity services, access to primary maternity care is inequitable, and when services are accessed, they are more often, not culturally safe. Although these issues along with detailed notice of disparities have been clearly articulated (Waitangi Tribunal, 2019), mainstream worldviews continue to dominate maternity care in Aotearoa.

Māori collectivism fundamentally collided with the patriarchal principles of individualism during colonisation. As Mikaere (1994) pointed out, a redefined ethnocentric society resulted in the subjugation of wāhine and ultimately the devastation of whānau well-being. Durie (1998b) highlighted negative health statistics are inevitable in wāhine, tamariki (children) and therefore

whānau, when cultural identity has been disrupted. Hence, research that promotes traditional knowledge and Māori ways of being is essential to future generations.

Kenney (2011) advised that enduring inequities in Māori maternities will require providers to understand the history, traditional practices and cultural principles that are integral to Māori childbirth. To achieve this, legislation will support maternity systems that are culturally relevant, culturally applicable as well as attainable. The full potential of this mandate may only be realised by those who intricately understand the nature of the maternity sector. The complexity of these underlying factors will require an equally multifaceted approach to truly acknowledge and remediate inequities (Dawson et al., 2019; Ratima & Crengle, 2013).

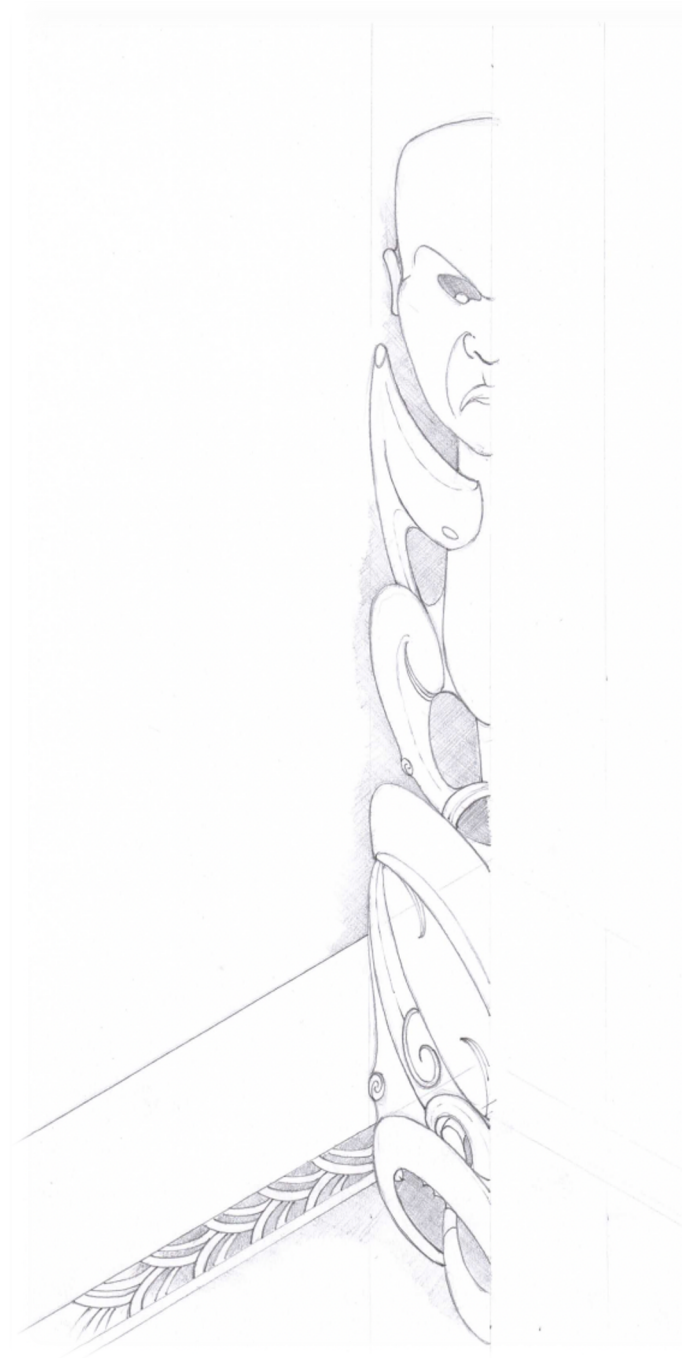
Conclusion

The midwifery Partnership model that was introduced in the 1990s, based on the principle of partnership outlined in the Treaty of Waitangi, has been revered internationally and sets the scene for midwives to provide continuity of maternity care to birthing whānau in Aotearoa. However, unsurprisingly, it is yet to substantially contribute to the reduction of Māori maternity inequities and care that is void of racial discrimination. Studies have clearly identified that whānau Māori want their childbirth to be nurtured by those who understand their uniqueness as tangata whenua, preferably Māori (Berryman et al., 2022; Palmer, 2002; Ratima & Crengle, 2013; Simmonds, 2017; B. Te Huia, 2020).

Colonialism acts to determine what counts as knowledge and how that knowledge is expressed. Reformed histories that are not from an Indigenous voice are a powerful way to isolate, diminish, and erode the value of Indigenous knowledge systems. However, Indigenous peoples have the power and potential to redefine dominant knowledge structures that inform their lived experience. Māori have the aptitude, skill, and strength to challenge that which serves to suppress our status as tangata whenua (Pihamā, 2019a; Simmonds, 2016). As it has been said, it is time for transformative praxis (Berryman et al., 2022) and revolutionary change (Tupara & Tahere, 2020). This will require reflexive maturity to acknowledge the obstructive influence of privileged positions (Hickey et al., 2019).

This research expects to expose specific practices of Māori midwifery. Smith (2012b) contended “Indigenous communities have struggled since colonization to be able to exercise what is viewed as a fundamental right, that is to represent ourselves” (p. 151). Representation in this sense is of both a political stance as well as giving voice and expression to Indigenous peoples. As such, this research attempts to contextualise traditional mātauranga to emphasise Māori midwifery

practice. Moreover, it intends to bring forth the voice of Indigenous Māori midwives, something that has yet to be explicitly achieved.



CHAPTER FOUR

Theoretical Foundations

Prelude

Education was an integral component to the intellectual, spiritual, physical, and emotional development of all hapū members, so all received some level of schooling. Oral accounts were the foundation of traditional Māori education and mātauranga exchange. Our tīpuna considered knowledge sacred, needing protection from being demeaned, distorted, or misinterpreted. Therefore, specialised learning was not given to just anyone and the process of obtaining mātauranga happened within specific wānanga (McRae, 2017; Melbourne, 2009; Sadler, 2014). Ancient Māori learning environments of Whare and Kura have endured over time; however, they are notably not as prevalent or exposed as they were at pre-colonial contact. To protect from Western indoctrination much of these knowledge systems are closely guarded by tohunga (Melbourne, 2009). These practices of knowledge exchange are utilised to ground the research in mātauranga Māori.

This chapter explains the context of these learning institutions. It will explore ancient knowledge pedagogies and the understanding of wānanga, in particular to the organisation of Te Whare-wānanga, Te Whare-tangata and Te Whare-mauokoroa. These will provide the foundational information for Te Whare-kōrero ā Kahu Pōkai, the Whare in which this research belongs. It explores the origins and contemporary use of mātauranga that derives from these ancient constructs of education.

Te Whare-tangata is discussed as an example of an encoded Whare-wānanga outside of the common whare structure. It is highlighted as a reminder to the critical role Kahu Pōkai and midwives have in enhancing this place of mātauranga. The construct of Te Whare-tangata engages physical and spiritual development. These dynamics are outlined emphasising the integral role of wāhine.

The taxonomy of Io to Ranginui and Papatūānuku provides insight to Te Ao Marama and metaphysical realms. This kōrero also connects the intimate relationship and concept of wānanga to the relevance of this research. Te Whare-mauokoroa, the Whare whereby a child's talents and aptitude were determined, is used as an exemplar of the varying levels of mātauranga learnt within these repositories of knowledge. Te Whare-mauokoroa has also been used as a template for Te Whare-kōrero ā Kahu Pōkai. The Pou of Te Whare-mauokoroa are described and will be aligned to the experiences of Kahu Pōkai in following chapters.

Early in my training as a Māori midwife I was exposed to the teaching of the late tohunga or amokura⁸, Papa Hōhepa De La Mere (Fig. 4.1). My first experience with Papa Hōhepa was at Nga Maia hui, where he and his tauira (students) shared his mātauranga and offered healing sessions to those in attendance. He would periodically visit the University and run workshops or (mini) wānanga with Māori students and midwives. At that time his teachings felt like the missing cog in a non-Māori learning environment. Like many Kahu Pōkai, my midwifery education was a period of consolidation, confirmation, and reaffirmation of my Māoritanga. Many aspects, like learning about the Treaty of Waitangi and meeting Papa Hōhepa ignited the realisation within me that being Māori and learning to be a midwife held a higher purpose and responsibility for my people.

Figure 4.1.

Papa Hōhepa De La Mere – Tohunga



Papa Hōhepa was taught ancient Māori lore by his tipuna as a child, and within the learning environment of Kura and Whare-waananga (Melbourne, 2009). This is not to be mistaken as the contemporary Māori educational facilities that are now known as whare wānanga, such as Te Whare Wānanga o Raukawa. The specific kura that Papa Hōhepa learnt in was the Kura-i-awaawa of his iwi, Te Whānau-a-Apanui, and the most revered Whare-waananga (Melbourne, 2009). Whare-wānanga was where, among many disciplines, he was taught sacred mātauranga and metaphysics. Kura-i-awaawa's main focus was Io, the progenitor in Māori cosmology. Io is a well-known entity and guarded divinity (P Tai Tin, wānanga, January 22, 2024).

Very little has been offered in academia specific to these modes of traditional learning systems. Therefore, it is with caution that I introduce this way of considering research. It is not done to

⁸ Amokura - term for anointed scholar of ancient knowledge.

reduce the value or integrity of this mātauranga but to position Indigenous knowledge within an Indigenous context (Hutchings, 2002). It offers an opportunity to consider research from a Māori perspective that is appropriate and aligns with a restorative approach. As one of the last contemporaries who was exclusively educated within these ancient pedagogies, Papa Hōhepa had a profound impact on me and many around me, some of whom are in this research. His mātauranga was literally from beyond this physical world; and, although I did not realise it then, he would continue to influence my thinking beyond his years on this earth. Therefore, like Tairahia Melbourne (2009), the knowledge that Papa Hōhepa shared has had a significant influence on this research.

Ko te Whakapapa o te Ao

Throughout te ao Māori, the acknowledgement of whakapapa is continual. It is the basis of Māori social structure and gives legitimacy to the relationship Māori have to the physical and spiritual world alike (Hudson et al., 2007). Within whakapapa, tangata whenua connect to each other, the land, and the environment that can be seen, heard, and felt. It includes “whakapapa tō te ao, he whakapapa tō ngā atua, he whakapapa tō te tangata or cosmogenic genealogy, theogenic genealogy and an anthropogenic genealogy” (Sadler, 2014, pp. 148-149). In other words, the Māori worldview is that everything between the heavens and the land are interrelated. Sadler (2014) related this connection to the umbilical cord, as something that could not be broken or severed.

These points of immemorial data directly outline the genesis of te ao Māori. This depth of whakapapa expresses the philosophical epistemology and ontology of being in te ao Māori and the authenticity of these connections. Melbourne (2020) highlighted this concept by saying whakapapa begins with the genealogies of Io and Atua, reinforcing the understanding that Māori existence is principally as spiritual beings:

The importance of retaining knowledge of the relationship between the spiritual and physical within taxonomical frameworks shows how vital that knowledge was for traditional Māori. In a modern context these taxonomies show the inherent nature of spirituality from a Māori worldview. (p. 120)

Below is an example of such whakapapa. It displays the line from Io to the physical world. Papa Hōhepa discussed Io or IO as the Internal Organiser of the energies that provide the platform for life itself (wānanga, Paraone Tai Tin, June 2024). However, this is merely one example of Io whakapapa, there are multiple, and although there are many commonalities, each iwi will have their versions of creation genealogy. Holders of this mātauranga articulate whakapapa that goes

back eons (Melbourne, 2009, 2020; Reed, 2021; Sadler, 2014). Papa Hōhepa shared whakapapa that gives descent from Io to both human matter and the taiao (environment) such as kohatu (stones) or the Whare of Atua mātauranga. Hence, whakapapa and the connection Māori have to each other, Atua, Tīpuna, the environment and all that is in it, is both ancient and intensely complex. Papa Hōhepa shared the genealogy below, described as the energies that have been stimulated by Io.

Io	Supreme Deity or Internal Organiser
Ngā Korekore	The synergetic potential in the intensive void
Ngā Kore	The indefinite potential in the extensive void
Ko te pū	The sacred energy of growth in potential
Ko te more	The sacred enveloping growth in potential
Ko te weu	The sacred manifestation of growth in potential
Ko te aka	The sacred connections of growth in potential
Ko te rea	The sacred layers of growth in potential
Ko te waonui	The sacred time, space and matter of growth in potential
Ko te whe	The sacred rhythm of growth in potential
Ngā Pō	The sacred night in potential
Te Whei Ao	The sacred chaotic world in potential
Te Whai Ao	The sacred formulae world in potential
Te Ao Mārama	The sacred world of pure energy in potential
Te Ao Tūroa	The sacred physical world in potential
Ranginui	Papatūānuku



The above offers a description to the genesis of te ao Māori. Others express this as “the light and life coming from chaos and night” (Reed, 2021, p. 23). Maori Marsden, cited in Mikaere (2017) indicated the alignment of these realms to the coming of the world, stating it is a process of creation and recreation; “Te Korekore the place of potential being, Te Po the space of becoming and Te Ao Marama the realm of being” (p. 27). These are the domains in which much of the mātauranga expressed by Kahu Pōkai were found to dwell.

Te Ao Marama

At the separation of Papatūānuku and Ranginui the first rays of light were seen; this is referred to as Te Ao Marama, the ‘world of light’. According to some, this was the time that the world passed from Te Po into the light, Te Ao Marama (Mikaere, 2017; Williams, 1975). Some call being physically on the earth, being in Te Ao Marama. This definition is different to what has been told by Papa Hōhepa and, therefore, displayed in the whakapapa above. Papa Hōhepa expressed Te Ao Marama in the following way: Te Ao Marama is being rhythmically aligned to the vibrations of deities and wheinga (ancestors who have passed away). Where spiritual unity

occurs between Atua and descendants to the universe to ensure a metaphysical balance (wānanga, Paraone Tai Tin, July 2024). It is the space that encompasses ancient ways of knowing and doing in which potential is guided by tīpuna and Atua. For many, Te Ao Marama is the place where Māori will return once their physical existence is concluded (Leatham, 2014).

Traditional Education

Sadler (2014) wrote about the human memory as a critical repository for learning and exchanging, particularly within the wānanga environment. This atmosphere allowed for errors to be heard and, therefore, quickly corrected by those who also learnt in that wānanga. This process of sharing mātauranga safeguarded it from misleading notions while allowing for further interpretation. Sadler (2014) went on to say:

Our ability to maintain our knowledge in the time of our ancestors wasn't dependent upon a quill being plucked from the anus of a duck. Our modus of retention began with fasting to help penetrate the mind, pierce the thoughts, to be embedded into the heart. But our ability to retain knowledge was also through oral traditions of wānanga. (p. 149)

McRae (2017) also talked about those that were in whare wānanga and their responsibility to listen and resolutely retain what was being taught. She quotes Moihī Te Mātorohanga, a tohunga of Ngāti Kahungunu, as recorded by Percy Smith in 1913:

Heoi ma ratou he whakarongo, he tamaua take ki te Pu ki te Weu, ki te koronga o te hinengaro i roto i o ratou ngākau.

Their business was to listen, and firmly fix in their hearts, in their very roots and origins, all they are taught, with also the strong desire to retain it. (p. 15)

As written transcripts emerged, the ancient system of orality learning and knowledge transfer would come under critique, negating the integrity of information. McRae (2017) pointed out that although many repositories were entrusted to oral dissemination and safeguarded over generations, many were eager to use pen and paper to preserve orality knowledge. Eloquently, Sadler (2014) cautioned of the errors and mistruths to be found within written accounts, but because they are marked by the *quill*, then they are trusted to be accurate and considered correct, McRae (2017) also spoke to the perceptive trepidation tīpuna had about written texts. McRae (2017) and Melbourne (2009) highlighted oral transmissions have continued with close parallels to ancient practices brought forward to modern Māori learning.

Wānanga

Tānenuiarangi transversed the celestial dwelling to retrieve the pūtea wānanga or baskets of knowledge. Kete tūātea, a basket of ritual knowledge; Kete Tūāuri, a basket of occult knowledge; and Kete Aronui, a basket of secular knowledge. These “receptacles of wisdom” (p. 158) came with our tīpuna from Hawaiki and held mātauranga of practical applications such as fishing, astronomy, and medicine to customary practices and knowledge of the supernatural, both good and bad (Barlow, 1991).

Paraone Tai Tin (wānanga, May 2024) discussed wānanga on differing levels. Papa Hōhepa was himself a whare wānanga, described as a walking library of mātauranga. His knowledge was of a degree that most would never be exposed. It intertwined with his spiritual and physical being, providing him the connection to other Whare wānanga. However, Papa Hōhepa would never have described himself as this, nor would he call himself a tohunga or any other descriptive of this class. Nevertheless, Papa Hōhepa was preordained to receive elite mātauranga and was revered as such, a tohunga. At this echelon of exposure there is an intrinsic connection with Te Ao Mārama, being the place where our spiritual elders or ancient ones and deities reside.

Papa Hōhepa defined wānanga as: *Waa* being time, space and place, *Wana* is learning stimulus, *Nanga* is active deoxyribonucleic acid (DNA) and *Ngana* is persistent. So, while in wānanga one is immersed within the mātauranga of that time, space, and place where learning is intensified and one’s intrinsic, innate being is activated. The environment determines the learning and the learning or transfer of ancient knowledge, is continual. In its simplest understanding, the purpose of wānanga is the sharing of mātauranga. However, the level to which the learning takes place is highly dependent upon the participants. The objective is to develop enlightenment or, as Barlow (1991) described, engage in esoteric learning.

Te Whare-Wānanga

To be chosen to enter any Whare-wānanga, a meticulous selection process would occur. Prerequisites of acceptance for most were near impossible to achieve and highly dependent upon one’s whakapapa. Often tauira were successful due to their lineage. Being of rangatira or tohunga descent meant exposure to an environment of innate learning and almost always guaranteed success. Children were also chosen because they displayed an extraordinary skill of knowledge retention and ability to narrate that information, pure determination, and resolute dedication. Māori knowledge was explicitly learned and with purpose, and often those learnings began to be instilled into the individual before they were born (Melbourne, 2009).

One of the first wānanga that has been recorded involved the grandfather of prominent tipuna Maui-tikitiki-a-Taranga. Maui was a great navigator and scholar. His grandfather Tama-nui-ki-te-rangi raised Maui and taught him much of the mātauranga that is held by his people of Ngati Maui. Melbourne (2009) suggested Maui and his brothers could be considered the earliest tohunga class. Ngati Maui claim the wānanga of Maui, Te Aho-o-Matariki as the first Whare-wānanga to be established. However, each hapū throughout the motu had its specific Whare-wānanga, and some of these environments have prevailed. The mātauranga Papa Hōhepa shared in his lifetime is an example of the continuance of this knowledge pathway.

Whare-wānanga were not necessarily a physical construction replicating what we commonly call a whare (house) with four walls, floor, and ceiling. They could be in the taiao (environment) or amongst expert tohunga. Every Whare-wānanga is specific to their construct of design. Every whare has a kaupapa and it is the kaupapa that determines the style and design of learning. The contemporary interpretation of whare can tend to limit the learning environment. In Melbourne (2009) an ancient translation is offered by Paraone Tai Tin as 'longevity of vision'; *wha* meaning distance of time and *re* meaning to watch or observe. Therefore, when used in Whare-wānanga it is interpreted to mean, "those chosen for this education must be prepared to commit 'time' and 'focus' to the realm of waananga and curriculum therein, and hence your worldview is guided by the philosophy therein" (p. 12).

Te Whare-Tangata

An example of a whare that is not specific to a physical structure is Te Whare-tangata, the womb of wāhine or the uterus, and its symbolic orientation to the human body. Te Whare-tangata, the home of reproduction is the place where the most integral wānanga of the human being take place pre-birth. Simultaneously, the wairua, mauri, and tākuira are in development, one unable to progress without the other. These non-physical, intangible structures intimately intertwine to energise the physical being.

The taakuira is the eternal component of humankind that allows a connection with divinity, while the semi-eternal capacitor is the wairua... the taakuira has been compared to the eternal soul that infuses itself at conception within the heart. The taakuira's function is as a conduit between the physical body and the spiritual self in order to source the Whatumanawa. In this symbiosis the wairua is the link, while the mauri functions as the advocate. (p. 103)

Te Whare-tangata transmits the vibrations of te reo, oriori¹⁶, takutaku¹⁷, and waiata¹⁸, exposing pēpē to the energy of these knowledge suppositories. Pre-natal knowledge exchange such as this has been termed pumaumaharatanga or cellular memory (Melbourne, 2009, p. 70). These bio-rhythms enhance the full potential in life for the pēpi and enables them to accomplish their destiny.

Wairua

Wairua is commonly defined as spirit or the human spiritual dimension, which is not incorrect. However, wai-rua relates to the two waters of tāne and hine coming together to create life (Pere, 1982). Wa-i-rua also refers to *wa*, time, space, and matter; *i*, DNA of what the pēpē is meant to be; and *rua* connects the human to the deities of cognitive, physical, spiritual, and emotional attributes. Therefore, the wairua explains how we are created and connect to the environment, the whenua (land), and the rangi (sky or heavens) (wānanga, Paraone Tai Tin, July 2024).

Pere (1982) also iterated spirituality as a dimension that was internalised from conception, “emanated from Io, the supreme supernatural influence” (p. 14). Pere (1982) and Barlow (1991) highlight the importance of wairua not only as a spiritual dimension but as also encapsulating the physical realm. Barlow (1991) added before humans were imbued in the physical, they dwelt in the realm of Atua. He continued to say that the joining of these two entities, the physical and spiritual, is achieved by the mauri. Pere (1982) reminds us that traditional Māori practices and values ensured spiritual and physical wairua elements were sustained and nurtured as one entity.

Mauri

Mauri is the life essence; it encapsulates the four elements of earth, water, air, and fire. Hence, mauri has whakapapa to Papatūānuku. It is because of mauri that the human being connects to all living things (wānanga, Paraone Tai Tin, July 2024). Barlow (1991) further described mauri as;

a special power possessed by Io which makes it possible for everything to move and live in accordance with the conditions and limits of its existence. Everything has a mauri, including people, fish, animals, birds, forests, land, seas, and rivers; the mauri is that power that permits these living things to exist within their own realm and sphere. (p.83)

¹⁶ Oriori – to chant a lullaby, song composed on the birth of a chiefly child about their ancestry and tribal history.

¹⁷ Takutaku – to recite karakia, incantation.

¹⁸ Waiata – song or chant.

Mauri joins the spiritual and physical to give life; when death occurs the mauri is no longer able to bind these elements. Pere (1982) also outlined elements of mauri outside of the human being, such as, “mauri o te whare (mauri of the house), mauri o te marae-atea (mauri of the marae-atea), mauri o te karanga (mauri of the calling) and mauri o te kumara (mauri of the sweet potatoes)” (p. 32). Although the human being cannot control their own mauri, through appropriate ceremony or covenant, a mauri may be established to a place, subject, or moment.

Tākuira

Tākuira is the soul, the infinite connection to the past and future, enveloping the DNA cells of the human being. As Melbourne (2020) indicated, the tākuira embeds within the manawa (heart) to become the whare of the tākuira. The body is the physical vessel for the tākuira. However, while the connection between the physical and spiritual entity ends upon death, the tākuira continues toward enlightenment. The tākuira provides the stability for the wairua, while the mauri is the stimulus or aspiration for the wairua. Hence, with these structures in sync, human spirituality is awakened.

E Hine!

The definition of wahine strengthens the understanding to te Whare-tangata. Like the definition of wa in wānanga, ‘*Wa*’ connects time, space, and matter; ‘*hi*’ are the stimuli unique to the female being; and ‘*ne*’ is the connection of DNA. In balance, tāne can be defined as ‘*tā*’ being colour, the male contributes colour to the physical being such as eyes, hair, and skin; ‘*ne*’ again connects DNA.

Further, the name ‘Hine’ derives from Papatūānuku, as the first Hine. Consequently, it was passed to most of her uri. Papatūānuku and Ranginui were begat by Io; they conceived Tāne. Tāne led the making of the first human being called Hine Ahuone, also known as Hine-i-ahumai-i-te-one. Hine Ahuone was fashioned at Kurawaka (Melbourne, 2020; Reed, 2021) the sacred place of fertility provided by Papatūānuku (Reed, 2021). Melbourne (2020) discussed the relevance of Hine within Te Ao Māori:

Hine are vital components of taxonomies, understanding spirituality and how it is manifest in all existence form a Māori worldview, much of which has been ignored due to their exclusion from recorded histories. As Papa is to Rangi so the Atua wāhine are to the Atua tāne as they are an essential spiritual/physical binary that defines all existence. (p. 139)

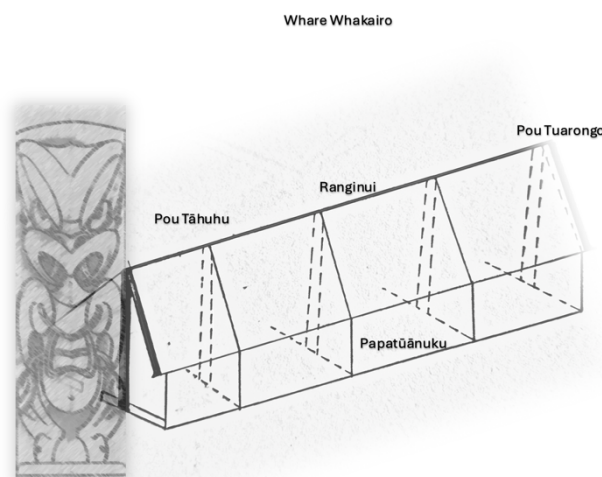
Hence, ‘*Hi*’ refers to the first breath inhaled, providing oxygen and spiritual, physical, mental, and emotional stimulus. ‘*Ne*’ again refers to the genetic construct of the female anatomy and the ability to procreate a future blueprint for their own generations. This uniqueness highlights the constant connection to *tīpuna*, *ariki*, and *atua* (*wānanga*, Paraone Tai Tin, July 2024).

Whare Whakairo

The Whare whakairo or wharenui¹⁹, the ancestral house in its original format, depicted the bodily form of our originators, Ranginui and Papatūānuku. In recent times the whakairo of the wharenui expresses the connection to tribal ancestors. Barlow (1991) outlined the structure of the Whare whakairo and how it relates to the deities. The main ridge poll is *tāhuhu*; the backbone, the *heke* or rafters, are the ribcage; and the *maihi* or barge boards in the front of the whare are the outstretched arms. The *papa* or floor of the whare is Papatūānuku, and the *Pou* or posts of the whare represent Ranginui and Papatūānuku’s children suspended in the action of parting their parents. Barlow (1991) described *Pou Tāhuhu* and *Pou Tuarongo* as reflective of the living and those that have passed. *Pou Tāhuhu* symbolises the initial thrust of Tāne, pushing his parents apart to create light and *Pou Tuarongo* at the end of the whare represents the verge between life and death. At the front of the whare is the *kōruru*²⁰, which depicts an ancestor of that whare. Upon entering the whare, Māori are, in essence, returning to their place of origin and, in this action, cutting themselves off from the outside world. Upon exiting, they have a revitalised sense of being in the outside world.

Figure 4.2.

Whare Whakairo



¹⁹ Figure 4.2 Whare Whakairo – Whakairo image by Roi Toia. Outline of Whare by Paraone Tai Tin.

²⁰ *Kōruru* carving usually depicting the face of an ancestor to that Wharenui.

The wharenui structure reflect the wāhine and tāne elements. The manuhiri side of the whare is the taranui, it biologically aligns with the make-up of a tāne. The tangata whenua side, taraiti echoes the biological side of the wāhine. Nui, meaning big or large, highlights the learning that males need to do to understand who they are as a person. Iti, meaning small or little, highlights the learning of females. Females are naturally more advanced than males, therefore, the degree of learning is typically less. As one enters the whare, taranui is on the right, usually larger in size than the left side, which is taraiti. This is visible in older wharenui but sometimes not as obvious in more contemporary whare (wānanga, Paraone Tai Tin, July 2024).

Significantly, the doorway of the whare is the threshold of the two sites; ko te wheiao, ko te ao mārama, the world of darkness and the world of enlightenment. Wheiao being the place just before the world of light. The whakairo (carvings) of the doorway often depicts that of the vagina. Reflective of the connection between exiting the whare and moving into a state of enlightenment of the outside world, to that of giving birth. It is the divide between celestial and terrestrial space. In childbirth this is the act of giving birth, from the time that labour starts until the baby is born and breaths. Hence, the saying “tihei mauriora ki te wheiao, ki te ao mārama” (Barlow, 1991, p. 184).

This kōrero shows the intimate connection between Io, Papatūānuku, Ranginui, our Atua, and human beings, especially wāhine Māori. The whare is a constant reflection of who, how, and where Māori have been created, and the significance of the thresholds between the two realms of the tangible and intangible. Hence, the whare emulates the framework required to acknowledge multiple layers of mātauranga. In particular, as a conceptual model, it allows the experiences of Kahu Pōkai to be comprehensively explored.

Te Whare-Mauokoroa

Te Whare-mauokoroa is the wānanga in which children learn their skill or offerings to their hapū. It is the whare that reminds us of the genesis of life. Within Whare-mauokoroa are five pou, which align knowledge with the life cycle. When life is conceived, there are specific stages of development that are represented in each pou: protection, identification, knowing the value of what your responsibility is to be, and the role in sharing that responsibility. The five pou are as follows:

Pou Tuarongo: Encapsulates the procreation of life, it is here that connection to those in Te Ao Marama, Atua, and tīpuna takes place. This is where all things in life are designed. The essence of the being is felt in life.

Pou Roua: Here is the place of protection. This pou acknowledges that everything in life or kaupapa needs protecting. It is here that te whare ahuru mōwai²¹ dwells, protecting the developing pēpē. Layers of the being are connected and protected.

Pou Poutokomanawa: This is where alignment to oneself occurs, when pēpē is registering his or her own and connecting to its environment. The being identifies its rhythmic sounds and vibration.

Pou Tāhuhu: This is where confidence and connectivity in kaupapa is absolute. Pēpē has innate connection to itself and is fully developed. The being knows who it is.

Pou Koukouaro: Koukouaro sits outside of the whare, at this point is where the being is active and ready to share kaupapa. The being is born. (wānanga, P Tai Tin, July 01, 2021)

This pedagogy of learning involved dedication from hapū members and the understanding that learning was from an intangible realm to most. More importantly, the learning was already set in motion from conception to completion, meaning an individual pathway had already been ordained. The essence and yielding of each pou could also occur within te Whare-tangata, such as previously indicated as pumaumaharatanga; or outside of it. Pregnant mama exposing their unborn pēpē to the phonological vibrations of tohunga instilled genealogies, waiata, and other forms of mātauranga.

A unique feature of te Whare-mauokoroa was that if a child showed a tendency toward another whare, they could simultaneously attend both. There was also no pre-determined graduation timeframe, if one graduated at all. The first phase protected the life coming into being. The next confirmed roles, members became aware of their purpose, whether that be as simple as I am female, or I am male, or more complex to being tohunga. Once the individual intent was identified, such as the attachments to being female or male, these attributes were instructed during the wānanga of te Whare-mauokoroa. As a contributor to your whānau, hapū, and iwi, once the wānanga was completed, you then practised what you were innately meant to do. Papa Hōhepa shared this takutaku with his taurira that expresses the esoteric environment of Whare-wānanga;

Takiuru takiuru takiuru
Hou hou te toki māreana
Ko te nuku māreana
Ko te rei tawhito ana te ururei
Makowai ko te tūnga te hou
Pipiwaiana ko te morehu
He korowhiti
He korowhata

²¹ Te whare ahuru mōwai is the amniotic sac and fluid.

Ka tu ki runga ko te manurei e
Taiparatia

The intensive internal inherit challenges of the being that is human
Sacred adzes forms my haven of learning
Purity of thought connected through terrestrial natures
Purity of sense align to celestial natures
Sourced are the heavens of the ancient ones, the winds of change called to be
answered
The sacred fountain of sustenance exists for one purpose
Seek for validation, seek for affirmation,
There you will find confirmation
The sacred bird exists within you
Hold fast to your kaupapa. (Papa Hōhepa)

Te Whare-Kōrero

Te Whare-kōrero is a general term for exponents of wānanga to join and contribute to kaupapa, whatever that maybe. As indicated previously, collective participation in kōrero physically manifests the construct of the whare. The whare then creates the space to honour each other's thought, each other's physical presence, and acknowledge the sacredness of the beginning of growth. Te Whare-kōrero is where tikanga Māori, whakaaro Māori, and te reo Māori direct the learning. It is the place of your knowledge coming together with the knowledge of other practitioners to identify connections to move forward in the kaupapa (wānanga, P Tai Tin, January 22, 2024).

The Whare-kōrero enacts the importance of whakawhānaungatanga²² to learning and sharing mātauranga whilst restoring a traditional way of thinking to learning. Each of us have our own Whare-kōrero, our whakapapa of mātauranga that has evolved from a life time of collation. As Rhonda Tibble expressed in her kōrero:

We are the matriarchs of a 1000, we bring from what is above us and we transfer that to
tuku heke, to the seven generations beneath us. And each and every one of us is the
kōruru²³ of a whare kōrero. (wānanga, May 2024)

Over the years, the thinking and understanding of traditional Whare-wānanga has, for many, been lost. Therefore, the structure of marae and the whare within these dwellings provide a link to whakapapa and are a feasible medium to connect the context of sharing mātauranga. Durie (2017) emphasised mātauranga Māori to be an evolving body of knowledge that can be

²² Whakawhānaungatanga - establishing relationships.

²³ Kōruru is used here to indicate the relevance and importance of each participant in the whare-kōrero.

contextualised for contemporary praxis that is experienced rather than just learned. Hence, the whare provides a point of association to the practice of Whare-wānanga and brings forth a relatable Māori way of being and thinking in the world.

Conclusion

Each whare like te Whare-mauokoroa, are guided by the mātauranga to which they exert and have their intricate design. Pou can outline the key elements of the whare but, as discussed earlier, pou (like the whare) might be any structure or edifice that fits the kaupapa or narration of the specific wānanga. Therefore, in this sense, there may not be a definitive descriptive of either pou or whare. The importance is being in the process of kaupapa allows the time and space to strengthen Māori thinking, Māori speaking; hence expands one's Māori lens. Te Whare-kōrero provides the environment to identify and articulate this practice (wānanga, P Tai Tin, January, 2024). Pihama (2019a) supported practices that remind us to draw upon the mātauranga of our ancestors and the knowledge that is bound within our language and our cultural templates.

This chapter has expressed the theoretical foundation of the research. The purpose of this in-depth explanation was twofold. First, it shows the study is immersed in the knowledge systems of te ao Māori. Secondly, it informs the philosophical underpinnings that guided the theoretical process and, therefore, implication of the research. At the same time, the discussion highlighted the value of te Whare-tangata as the house of humankind and an integral Whare-wānanga to future generations. Importantly, by exploring traditional learning environments it allowed time to describe crucial elements such as mauri, tākuira, and wairua. It gave space to outline the wharenui as an expression of the innate connection between Atua, Papatūānuku, wāhine, and tāne. Therefore, the Whare-kōrero exposes the metaphorical and metaphysical influences that direct this research and provides the structural edifice to connect to mātauranga and guide the learning outcomes.



CHAPTER FIVE

Taku Whatu o Taku Rangahau (Methodology)

Prelude

This chapter explains the methodology, methods, and analysis used for the research. To provide deeper understanding the worldview, the epistemological, ontological, and methodological lens is discussed. The methods used are described, pointing out concepts integral to Māori research. Identification of participant inclusion is outlined, with an explanation of the consultation undertaken. Following this, data collection and analysis are explained. The Māori framework used for analysis will be discussed. Finally, this chapter identifies specific issues relating to ethics when doing Māori research including the research limitations. It concludes by pointing out distinguishable aspects relating to research rigour.

The purpose of this research was to explore what it is to be a Māori midwife or Kahu Pōkai. The key question was ‘What are the experiences of being a Māori midwife?’. The question intended to uncover the attributes that bring wāhine to the space of being a Kahu Pōkai and, in particular, what (if any) difference Kahu Pōkai make for birthing whānau. This study provides the opportunity to present Māori maternity knowledge that specifically focuses on the experiences of Kahu Pōkai. It was obvious that for Kahu Pōkai to feel safe to share their pūrākau the methodology required should be synonymous with their worldview. Hence, Kaupapa Māori and Mana Wahine theory guides the research, demanding an agenda that legitimised a Māori way of knowing and doing, while ensuring the understanding of wāhine Māori was at the forefront.

The study overtly considered the meaning of being Māori and being female, positioning the worldview distinctly with wāhine Māori. In line with this positioning, processes of decolonisation were observed to liberate marginalised philosophies and values, particularly where wāhine are concerned. As a fundamental aspect of whānau ora, this research provides insights into Māori midwifery and offers an alternative understanding to better support the needs of Kahu Pōkai and birthing whānau. This thesis will contribute to the Indigenous literature of childbirth.

Epistemology and Ontology

Epistemology refers to ways of knowing, including the nature of thinking; while ontology aligns with what is considered real, the nature of reality or the philosophy of being. Methodology refers to how knowledge is acquired and provides an approach to systematic inquiry. Axiology refers to the values, ethics, and morals that guide the research. Interconnected notions of Indigenous

ontology, epistemology, methodology, and axiology will influence how this research takes place (Chilisa, 2012; Curtis, 2016).

The previous chapter has clearly shown this research is positioned within an Indigenous Māori worldview that takes a Māori way of knowing and doing for granted. The thesis title, 'He Matatauihi i Ngā Ururei Whēako Hei Kahu Pōkai', further exemplifies this stance by expressing the tangible and intangible realms that form the research foundation. It describes the ontology and epistemological lens. Matatauihi refers to the calling of spiritual and physical energies, ururei connects ancient tikanga to the physicality of being in the world, whēako relates to the experiences that are both physically and spiritually embodied, and Kahu Pōkai encompasses the uniqueness of what it means to be Kahu Pōkai. By definition, it connects and guides the research to dwell within Indigenous knowledge systems.

Chilisa (2012) described ontology as the "body of knowledge that deals with the essential characteristics of what it means to exist" (p. 20). For Māori, this will include how they relate to the land and connect to the environment (Chilisa, 2014), and non-academic knowledge systems such as pakiwaitara (fictional stories) and pūrākau (true events). Much of this information has been passed orally without literary reference, although it is evident within living tikanga. For example, the naming of Māori services often links to the exploits and reputation of our tīpuna or a particular tikanga to that service. The new term Kahu Pōkai given for Māori midwives encapsulates the knowledge systems, dedication, and passion Māori midwives display toward the kaupapa of being a Māori midwife. Pōkai describes the term of pregnancy from pre-conception through to post-birth. Kahu refers to the expertise Kahu Pōkai display while incorporating the tangible and intangible realms, which this research will show is evident in Māori midwifery practice.

Warbrick et al. (2023) examined the connection between Indigenous peoples and the broader ecosystem of health and well-being. They highlighted the value of knowledge systems, such as this kōrero, to understand and organise the relationships between all things, including land, ocean, and astrology. For example, their use of the whakatauki²⁴, "Whatu ngarongaro te tangata, Toitu te whenua – As people disappear from sight, the land remains" (p.1), while indicating the enduring nature of the land, provides an insight into the relationship between Māori and the natural environment. Ratima (2003) and Jahnke and Taiapa (1999) suggested that exemplars

²⁴ Whakatauki – proverb or saying.

like these depict the ontological, epistemological, and theoretical framework for Māori research. Additionally, Warbrick et al. (2023) emphasised that knowledge is conveyed in ways relatable to Indigenous peoples through the personification of characters and events.

Māori regard knowledge to be culturally endorsed and based upon time-honoured values, hence the epistemological stance of Māori research is value-mediated. As Ratima (2003) explained the values the researcher holds will influence the research. The reciprocal notion of respect directs Indigenous peoples, particularly when establishing relationships. Respect is a shared concept that maintains collective equilibrium and harmony between the each other and the environment (Smith, 2012a). The relationality in undertaking the research can be understood using whakapapa which provides a genealogical link between humankind and connects the environment to Indigenous peoples. Whakapapa offers an organisational framework to appreciate the connection between all things, mountains, rivers, forests, and each other (Warbrick et al., 2023). Kōrero and practices such as these provide insight into Māori perceptions of knowledge. They are an easily understandable medium for transmitting Māori worldviews.

Whakapapa can also validate the interactive relationship between the research, researcher, and the researched (Ratima, 2003). Importantly, Indigenous ontology and epistemology will be different from non-Indigenous perspectives. These distinctive features legitimise Māori knowledge and support the multifaceted Indigenous worldview.

Methodological Lens

As a Māori researcher, my methodological lens is influenced by the context in which I have been born, grown, and learned. It embodies my Ngāti Poroutanga, being a mother, nan, mokopuna, teina, kōka, hoa, hoa rangatira, and Kahu Pōkai. The mātauranga shared by Kahu Pōkai that took part in this research does not need research to confirm its legitimacy or validity. The research is merely another context in which to experience this mātauranga.

An assumed trait of native peoples by the colonial settlers was that Indigenous peoples could not use their intellect and were incapable of invention, imagination, or even the ability to utilise their natural resources and environment (Smith, 2012a). This misrepresentation and misunderstanding could not be further from the truth. Prior to the colonial invasion, the Indigenous peoples of Aotearoa had their knowledge systems and a complex society in which survival meant tangata whenua had a deep understanding of the context of their environment and knew how to thrive within it. Devastatingly, colonisers rejected Indigenous systems of order

and dismissed Indigenous languages and modes of thought as inadequate. This rejection ultimately led to the fragmentation of Indigenous society and disconnection from Indigenous histories, knowledge, language, and land. Over time, histories were re-written to favour the imperialist view of the world, re-shaping and re-ordering Indigenous ideologies.

The renaissance of *te ao Māori* and *te reo Māori* over the last few decades has brought with it an expectation of access to Indigenous approaches. This has gained momentum with the dedication of Māori to recover, reclaim, re-create, and re-imagine our knowledge systems and how our history is presented to inform our future. Hence, Māori research is inherently connected to the revival of *te reo Māori me ōna tikanga*²⁵ and the fundamental organizations of where these practices exist (Smith, 2012a). From there, *tangata whenua* will demand autonomy over knowledge transmission and institutional systems that cultivate monocultural assimilation will be rejected (Durie, 2004). In response, Māori require methodological frameworks that promote an Indigenous worldview and embrace the complexity of Indigenous knowledge systems. Therefore, it is essential to utilise a research framework that embraces a Māori way of knowing and doing, locating this study within *te ao Māori*. *Kaupapa Māori* and *Mana Wahine* theories offer the platform for research that promotes these principles prioritising Māori.

Smith (2012a) and Bishop (1996) emphasised the importance of reconciliation of the past to the present and reprioritising accordingly. Decolonisation is part of this process, it involves centring the worldview of the colonised to illuminate their perspective, liberating the voice of the marginalised. It uses processes to enhance a restorative approach in the development of practices and ways of being to uphold the integrity of Indigenous culture. Bishop stressed Māori researchers are then able to consider and express knowledge from a platform that embraces Māori cultural practices, philosophies and preferences.

Māori research is part of recovering our own stories of the past and, in this case, a particular focus will be given to the reclamation of traditional birthing knowledge. This will be an important part of rediscovering Māori maternity practices in the modern world. August (2005) acknowledged *Kaupapa Māori* as a safe space for research involving Māori women's bodies, the knowledges surrounding bodies, and the locations they may dwell, providing a platform to remove the silencing of female Indigenous ideologies. Chilisa (2012, 2014), along with many others, such as Ritenburg et al. (2014), Simmonds (2014), and Walker et al. (2013), stimulated

²⁵ *Te reo me ōna tikanga* – Māori language and protocols or practices.

ongoing discussions about Indigenous research frameworks, including the idea of decolonisation to advance these ideas further.

Smith (2003) reminded us that Kaupapa Māori was initiated to shift tangata whenua from the mindset of, “waiting for things to be done to them, too doing things for themselves” (p. 2). During these early periods there was an emphasis on becoming more proactive, turning the attention to focus upon conscientisation or consciousness-raising rather than decolonisation. This shifted the attention from the coloniser to place Māori at the centre. However, with this in mind, processes of decolonisation are important. Decolonisation continually places the research within a Māori world acknowledging processes of colonisation and, importantly, the time before whereby Māori were intact as an Indigenous peoples. It engages analysis of the impact to our past, present, and future. Indigenous discourse critiques such positions and poses solutions that encapsulate these ideas (Smith, 2012a).

At the same time, examination of the white feminist movement in Aotearoa by academics such as Linda Smith (Smith, 2019), Leonie Pihama (Pihama, 2001, 2019b, 2020) and Jessica Hutchings (Hutchings, 2002) questioned if this platform truly appreciated and valued the need to work with wāhine Māori. Linda Smith challenged wāhine Māori to take control over the interpretation of their own stories. By examining the experiences of wāhine Māori and orientating these within a Māori worldview, insight to the complexities endured by wāhine Māori will be revealed. In turn, this may provide a framework to assist in the emancipation of oppressive practice. So, while Kaupapa Māori prioritises tangata whenua, Mana Wahine explicitly theorises the experiences of wāhine Māori; and, in this case, allows the space to critically analyse the position of wāhine Māori and Kahu Pōkai, particularly regarding maternity practices.

The key elements of Kaupapa Māori theory include “the principle of self-determination or autonomy, the principle of validating and legitimising cultural aspirations and identity, and the principle of incorporating cultural pedagogy” (Smith, 2003, p. 6-7). This allows Māori researchers to operate from Māori terms of reference including whakawhānaungatanga, manaakitanga (hospitality, kindness, generosity), whakapapa, and tikanga, realities that resonate throughout this research. Rather than being stagnant and undynamic ideologies, it may necessitate an innovative approach amalgamating traditional knowledge to align with contemporary ways of being Māori (Durie, 1998b; Ellis, 2005). Mana Wahine provides the space

to take these elements further, focusing on the reclamation of mātauranga wāhine Māori and recognises the unique place of Indigenous wāhine within a colonised land (Hutchings, 2004).

Kaupapa Māori theory immerses the research within te ao Māori, allowing for richer meaning to be revealed. Expanding on this idea, Māori academics such as Simmonds (2014) and Pihama (2001) consider Mana Wāhine as an epistemological framework giving voice to wāhine Māori and impressing the need to examine the interplay of being Māori and being a woman. As a framework, Mana Wāhine provides explicit consideration of the complexities faced by wāhine Māori by confronting hegemonic discourses and challenging ideas that position them as 'Other'. These theoretical positions provide a robust foundation for the research to evolve and enhance the value of this research, allowing Kahu Pōkai the opportunity to share their unique kōrero and revealing what influences Māori birthing experiences. It is envisaged that the knowledge gained from Māori midwives will reinforce the operational value of these methodological concepts in practice.

Positioning the Methods

Kaupapa Māori research acknowledges certain assumptions, which include the legitimacy and validity of a Māori worldview as taken for granted, and that views expressed do not seek to justify Māori knowledge and tino rangatiratanga (autonomy) (Cunningham, 1998; Smith, 1999). This study also implicitly understands "Māori childbirth as a normal physiological event" (Leatham, 2014, p. 39) and the idea that Māori interconnectedness acknowledges the tangible and intangible (Pitama et al., 2002); and that "wāhine will define the period they recognise to be 'the childbirth experience', the duration of which may span from pre-conception to the postnatal period" (Leatham, 2014, p.39).

The Kaupapa Māori position supports what Lincoln and Denzin term an "epistemological version of validity" (p. 211)(as cited in Bishop, 1998). This is articulated as an authority of text that is "established through recourse to a set of rules concerning knowledge, its production and representation" (Lincoln & Denzin as cited in Bishop, 1998, p. 211). Bishop (1998) acknowledged hegemonic discourses can be problematic for Māori researchers regarding validity and processes of "objectivity, subjectivity and replicability" (p. 210). These methods of validity are defined from within a Western worldview which when utilised continues to discredit Māori realities. For example, initially, hermeneutics was being used but became problematic as Kahu Pōkai questioned the need for a non-Indigenous methodology. I found the answer to this question difficult to justify, particularly given the availability of robust Māori theoretical frameworks.

Hence the decision to not continue with the use of hermeneutics came about during the later stages of the interview process. It was a decision that was reinforced by both my confidence in presenting the Māori theoretical platforms and the positive reactions of kaikōrero. The research process felt safer. Kaupapa Māori proactively promotes a Māori worldview as legitimate, authoritative, and valid (Bishop, 1996).

Traditionally, Māori were pragmatic in assessing whether practices were acceptable and held validity. This is termed, “taonga tuku iho, which are literally the treasures from the ancestors. These taonga (treasures) are the collected wisdom of ages” (Bishop, 1998, p. 211). Taonga tuku iho guide and encapsulate the way in which Māori live in contemporary society. Kawa, or the principles that direct practices such as relationship building or whakawhanaungatanga are emersed within taonga tuku iho. Each iwi or hapū will have their own processes however it is universally understood by Māori that if kawa is not adhered to the result is worthless (Bishop, 1998). Approaching Māori research in this way acknowledges the significance of participant experiences, concerns and empowers their ‘voice’. Therefore, control resides with the researched and illuminates the intricacies of Indigenous realities.

Time-honoured processes of whakawhanaungatanga are essential in establishing relationships. Whakawhanaungatanga allows researchers to identify physical connections to each other, as well as the embedded connection to the land and environment. For example, the space between the researcher and researched is multi-dynamic, inclusive of physical and spiritual distance. Customary processes involved in whakawhanaungatanga enables the elimination of distance to allow for deeper, trusting relationships to flourish (Cram, 2001). The practice of whakawhanaungatanga engages a greater depth of inquiry and allows powerful kōrero to emerge.

Consultation and collaboration with key stakeholders is essential to ensure practices within Māori research is tika (correct) throughout the research process. This occurred within the Māori midwifery sector at hui, with Māori midwives, whānau, hapū and iwi stakeholders, including kaumātua and kuia. Whakawhanaungatanga and meeting kanohi ki te kanohi (face to face) facilitated the process of consultation. Principles of kawa within these elements were applied maintaining the integrity of the research process to enhance the application for Māori. Māori leadership and autonomy over the research process ensures rangatiratanga. Inherently this will promote Māori engagement at each point including identifying the goals, objectives and way in which the research will take place (Health Research Council, 1998).

As part of the consultation process, it was integral for me to have support from a cultural advisor and te reo me ōna tikanga expert. Their input was essential to all stages of the research process. Aside from ensuring adherence to tikanga, invaluable knowledge of history and other understandings broadened my concepts, challenging thinking and offering new pathways that may not have been considered. This was particularly important once analysis commenced. Again, this role was undertaken by Paraone Tai Tin utilising mātauranga learned from Papa Hōhepa. Papa Hōhepa and the repositories of mātauranga he has shared will be dedicated to further discussion in subsequent chapters.

Methods

Participants

During the early stages of this process, I presented the background, plan, and intention of the research at Māori midwifery hui. These presentations provided the foundation for this research and contextualised my personal journey in academia, which included a presentation of my Master's research (Leatham, 2014). The findings and recommendations of my Master's thesis also gave rationale for continuing with the chosen topic of exploring the experiences of Kahu Pōkai. It was important for me, as their Kahu Pōkai colleague, to give them the opportunity to experience me as the researcher. The presentation introduced the Ngāti Porou kuia who took part in that research, offering my audience the opportunity to get a sense of my way of researching and, in turn, gain some trust in the process.

Recruitment

The plan was to have 12 Kahu Pōkai take part in the research. Consultation with significant members of Māori maternities helped determine whom I should approach as kaikōrero and what the inclusion criteria would be. Kaikōrero were eligible if they had been or were currently a practising Māori midwife. Participants were recruited by purposive sampling; snowballing was also utilised allowing respondents to recommend other people who would be relevant to the research (Heinlein, 1999). Ratima (2003) and more recent academics, such as Simmonds (2014), suggested Māori research embraces Western methods, like having an emergent design that allows some freedom but maintains strategies that are consistent with an Indigenous worldview.

Once kaikōrero were identified I approached Kahu Pōkai to gauge their interest in taking part in the research. Most Kahu Pōkai that were asked agreed to be interviewed. They were only asked once, as it was evident if they did not want to take part. The ones that did not want to take part gave reasons such as not feeling like they had the knowledge to take part in research

or not having the capacity in their workload. Some suggested others who they felt would be better suited to the research. For some, although they were comfortable with me as the researcher, there was a definite sense of mistrust in any research. Historically research has been done 'on' Indigenous peoples, perpetuating systemic inequities and dominance by mainstream institutions. This extended legacy of health research has exploited Indigenous peoples, failing to have any impact upon the unyielding health disparities and is no longer tolerable for tangata whenua (Huria et al., 2019).

For those Kahu Pōkai who showed interest in taking part in the research, I sent them an information pack via email. This consisted of two forms. One was the University generated Information Sheet²⁶; the other a more personalised and extended initial information form, Extended Research Brief²⁷. Additional detail included my pēpēha and context to the research. Ngā ringa hapai showed appreciation for the supplementary information and voiced it gave them a clearer understanding of the research.

Nine interviews were conducted. At the time of the interview, most Kahu Pōkai signed written consent²⁸, some gave verbal consent. However, during the process of review and consultation, on-going verbal consent was given by all Kahu Pōkai for continued inclusion of their pūrākau. After the nine interviews had concluded there was a sense that the data gathered had reached saturation; therefore, at that point no further Kahu Pōkai were recruited. Kahu Pōkai who took part ranged from being employed to self-employed, relatively new to retired, non-practicing Kahu Pōkai. Most had several years of experience in midwifery and would be considered senior midwives.

Data Collection

The role of the participants was predominantly to share their stories, contributing rich data to the research. However, due to the nature of Māori research, they were also key stakeholders. Therefore, consultation with participants throughout the research shaped many aspects including approval of data interpretation and the way in which knowledge will be disseminated. It is envisaged that new understandings will influence local, national, and international understandings of Indigenous maternity care; therefore, their contribution is essential to the integrity of the research.

²⁶ Appendix B – Information Sheet.

²⁷ Appendix C – Extended Research Brief.

²⁸ Appendix D – Consent Form.

The objective was to enable Kahu Pōkai time to express their experiences as the key informants to this research. The timeframe of collecting the data spanned over a period of 2-years, starting in 2018; but the majority of interviews were undertaken in the later part of 2020. In 2019, the world was thrust into the COVID-19 pandemic, which led to imposed lockdowns in Aotearoa. These restrictions put a hold on face-to-face data collection until the second half of 2020. There was some consideration to continuing data collection via online forums. However, it was decided interviews would need to wait until they could be conducted ā tinana (in person).

Interviews occurred within environments that most suited the kaikōrero, they were ā tinana in the place of their choosing with whomever they wanted to be present. Most Kahu Pōkai chose to share their story at their home and on their whenua. Tikanga appropriate to the moment was adhered to, although Kahu Pōkai guided the depth of this process. For example, some Kahu Pōkai led their own karakia to commence the interview and some chose not to. Processes of whakawhānaungatanga were naturally immersed within the kōrero. These rituals facilitate the removal of (multi-dimensional) distance and allow a trusting relationship to be enhanced, permitting deeper levels of enquiry (Cram, 2001).

Initially, Kahu Pōkai were asked to introduce themselves in whatever way they deemed appropriate. Some shared their pepeha²⁹, others articulated their iwi, hapū, and rohe connection within the body of their pūrākau. Following introductions, open-ended questions such as; Tell me about yourself and your journey to becoming a midwife, engaged the notion of collating the background or history of each pūrākau. In most kōrero this initial query led to unintentionally answering subsequent questions such as: did your birth experience impact you wanting to be a midwife, and if so, how? and, what sustains you in midwifery practice, what keeps you going? We also explored what being a Māori midwife meant to each Kahu Pōkai. A rich collection of mātauranga was revealed, and although many of these concepts have had relevance in other Māori health research (Murphy, 2011b; Simmonds, 2016; Wikaire, 2020), particularly that of whakapapa, kaitiakitanga, and whanaungatanga these fundamental components will be discussed in relation to understanding being a Kahu Pōkai.

²⁹ Pepeha – *Pē* is an ancient word for mana. *Hā* is a common word for breathe. In this analytical lens it means life cycle. The first *Pē* refers to the mana of our deities. The second *Pē* refers to the mana of our ancestors. The word *Hā* refers to the life cycle that of our deities dating back to Hineahuone, it also refers to the provisions made by our ancestors to maintain future life cycles (wānanga, Paraone Tai Tin, May 2023). Also known as a traditional introduction, a way to identify your ancestors, connection to the land and people.

The process of whakawhanaungatanga acknowledged any existing relationship between the researcher and the kaikōrero. Given that we were all Kahu Pōkai, it was recognised that there would be similar connections, both professionally and personally. The relationship between the research, the one doing the research, and those being researched can have a considerable influence upon the authenticity of the research (Smith, 1999). Potentially complex dynamics such as these could have created power imbalances; however, these issues were discussed and made explicit prior to engaging in the interview. Also, kaikōrero had agreed to taking part in the research knowing the researcher. Overall, the established relationships created a level of comfort, trust, and ongoing connection to the research. Smith (2012b) reiterated, increased input from tangata whenua will not only meet Tiriti commitments but gives the research increased validity and enhance Māori participation. An essential criterion to the uptake of results by the community, Māori must play a significant part in identifying all aspects of research, in this case Māori midwives.

As previously mentioned, the research question that guided this study was: What underpins the experience of being a Māori midwife? It was supported by guiding questions³⁰ and prompts, such as:

- How do you practice in a way that integrates your Māori heritage?
- Tell me about a recent experience of caring for a whānau.
- Tell me about a midwifery experience that stands out in your mind.
- Tell me about a time when the 'maternity context' got in the way of *being* Māori.

Within the conversations these questions encouraged dialogue that further explored the idea of Māori midwifery. Kōrero were audio recorded, and later transcribed for analysis. With permission, I held the audio recordings in a secure place.

The Pūrākau

For time management reasons, the recorded interviews were transcribed verbatim by a professional transcriber. Once transcriptions were received, I checked them against the audio recording and edited them. This process included listening to the recordings against the transcripts, ensuring accuracy, and allowing the opportunity to mark any significant moments in the recording that may not have been identifiable in the transcript. During this process, I also removed any identifying features and space-filling words. I then created the story-flow by

³⁰ Appendix E– Research Questions.

placing events in the chronological order of the Kahu Pōkai's pūrākau. In other words, I made the story make sense.

Physical data (i.e., consent forms and transcripts) are stored in a locked cabinet (at my house) until the project is completed. At the time of completion, I will offer all physical data back to the participants. Otherwise, they will be transferred to the archive storage facility in Taupua Waioira Centre for Māori Health Research. The de-identified data will be stored for up to 6-years, then hard copies shredded and electronic copies deleted. Consent forms have been stored separately from the data.

Each Kahu Pōkai, aside from one, gave consent to be named. The Kahu Pōkai, who has remained anonymous, has been given the pseudonym 'Hine'. Hine was chosen in acknowledgement of the connection of kaupapa to the Atua of Hine. Extenuating birth details or information that could identify whānau or the naming of other health professionals was removed from each story. Confidentiality and anonymity were considered throughout the interview and transcribing process. Particularly, as mentioned, the profession of Māori midwives and midwifery overall is small. Additionally, whānau birthing can, at times, be easily identified by way of the story. After every edit of the pūrākau, it was sent back to the Kahu Pōkai for approval.

The decision was made to present the pūrākau as a whole story. Like Diamond (2003), I was mindful that intonations, emotional expression, the pauses and inflections heard in oral accounts are lost in transcription. As an insider researcher, it was integral to the validity of the research to maintain the kōrero as close as possible to the way in which it was given. Therefore, creating the pūrākau as complete as possible paid tribute to the voice of each Kahu Pōkai. The aim was to maintain a strong sense of personality and feature the power of the story itself (Diamond, 2003). In doing this, it provided an initial process of interpretation to take place. The writing of the pūrākau involved using the words within the transcripts to tell the story in the third person. Key statements were merged to emphasise the idea being expressed. Pūrākau is acknowledged here as: "a traditional form of Māori narrative, contains philosophical thought, epistemological constructs, cultural codes, and worldviews that are fundamental to our identity as Māori" (Lee, 2009, p. 1). They also allow Indigenous ontological and epistemological paradigms to evolve. These aspects were overtly exposed as the data analysis unfolded. Once I had created the 'pūrākau' I returned this version to ngā ringa hāpai for their review. With their consent, their stories are presented.

Along with the interviews of Kahu Pōkai, other sources of information such mythical literature, waiata and takutaku were gathered to contextualise the emerging kōrero. Kōrero with kuia, kaumātua, mātanga tikanga (expert in tikanga), and mātanga hauora (health expert) built upon the knowledge of the study. Bishop (1996) advised oral dissemination of knowledge was traditional practice therefore as a form of inquiry, pūrākau naturally align for Māori. Mātauranga was also gathered by oral commentary passed from tohunga and experts of Te Ao Māori.

Data Analysis

This research presented the opportunity to utilise a traditional approach to mātauranga Māori as an appropriate way in which to consider the data. The framework chosen embodied mātauranga particular to the tikanga of pōkaitanga and will be explained from the construct of its Whare-kōrero, Te Whare-kōrero ā Kahu Pōkai (see Chapter Four - Whare-kōrero). With the guidance of Paraone Tai Tin, the elements that make up the Whare-kōrero and Te Whare-Mauokoroa have been adapted to examine the kōrero shared in this research. They provide the grounding to express mātauranga Māori. Mātauranga expressed within the pūrākau were examined in the context of the research question, contemporary midwifery practice, and, importantly, traditional te ao Māori knowledge. These platforms gave me multiple avenues to explore the perspective of Kahu Pōkai extracting deeper levels of understanding in a way that has not been done before.

Analysis included reading, re-reading, writing, re-writing to extract key themes or mātauranga within each pūrākau. During this process, and by being in wānanga with Paraone Tai Tin, it became obvious that the mātauranga held within the title of this thesis provided the analytical tool. This line of thinking was reiterated by scholars such as Chilisa (2012); Lee (2009), and Ruakere (2016) who highlight the importance of philosophical underpinnings embodied within Indigenous language and experiences to research. Researchers can draw on these knowledge systems to theorise Indigenous research, reclaiming cultural heritage. Including the connection between the living and non-living, the land and all things within it to Indigenous peoples and, therefore, to Indigenous research. Murphy (2011b) and Simmonds (2014) emphasised the values and processes within te ao Māori that have the potential to broaden and redefine existing methodologies and ways of doing research. Importantly, as outlined by Smith (2012b) the chosen methods need to be appropriate to the kaupapa of the research.

The Whare-kōrero ā Kahu Pōkai is the whare in which the wānanga of this research took place. The Whare-kōrero ā Kahu Pōkai is not a physical whare, rather a conceptual structure. Within the whare are the five pou, which provided the level or phase to which the kōrero belonged. From there, the kōrero was considered using the mātauranga held within “He Matatauhi i Ngā Ururei Whēako hei Kahu Pōkai”. To do this analytical process, the philosophy of the Rauru was adopted (Leatham, 2014). The following section explains the foundational platforms from which this mātauranga dwells and the intricate concepts upon which the analysis took place.

Te Whare-Kōrero ā Kahu Pōkai

Kahu Pōkai took part in this research with the purpose of building upon Indigenous birthing knowledge. Their stories were collated, prioritising their Māori worldview. Therefore, it made sense to take the opportunity to express this research and the findings within a framework that potentially revitalises traditional learning platforms in a way that has not yet been done within maternity research. During wānanga, uniquely Māori midwifery knowledge was shared that identified an inherent connection to being a Māori midwife. It was, therefore, essential to explore the pūrākau in an environment that acknowledged and exposed distinctive mātauranga. This environment was Te Whare-kōrero ā Kahu Pōkai.

Paraone Tai Tin (wānanga, June 22, 2024) explained the Whare-kōrero as an extension to the understanding of any Whare-wānanga; it is a whare that specifically involves those within the wānanga, in this case, Kahu Pōkai. The pou of te Whare-mauokoroa, outlined in Chapter Four, can align to the learnings and mātauranga of Te Whare-kōrero ā Kahu Pōkai. The intentional value of each pou identified, protected, and explained the purpose of the kōrero. I have termed this whare, Te Whare-kōrero ā Kahu Pōkai, to give focus to the thinking of being a Kahu Pōkai, Māori midwife. This research and the knowledge sourced within Te Whare-kōrero of Kahu Pōkai is not intended to be finite, as Durie (2017) indicated mātauranga is progressive. Therefore, ‘ā’ of Te Whare-kōrero ā Kahu Pōkai indicates this is an ongoing platform and acknowledges the principle of evolutionary practice. This research created an avenue to explore the kōrero in a way that re-energises traditional mātauranga.

The Whare-kōrero ā Kahu Pōkai is a conceptual model where the wānanga or thinking took place. The whare, pou and rauru are the analytical structures that will be explained in this section. Māori systems of knowledge and ancient mātauranga were privileged in the data analysis. The outside of the whare reflects the rauru. The inside of the whare is where the pou are situated. The whole structure stimulated exploration, examination, and mindful consideration of the data.

The mātauranga of Matatauihi, Ngā Ururei, Whēako, and Kahu Pōkai were revealed as the kōrero unfolded. The pou provided the strategy to unravel the knowing within these pūrākau. Matatauihi, encapsulates the intangible and tangible energies activated by the kaupapa. It involves the innate feelings stimulated by one's whatumanawa³¹. Comprehension in this dimension extends from the spiritual realm rather than the mental intellect. Ngā Ururei, offered the next level of analysis. This is where pūrākau showed the presence of Atua within the practice of being a Kahu Pōkai and encompassed unique cultural knowledge sources. Whēako, involves the experiences that are gained by the human being. This is where Kahu Pōkai conveyed direct or indirect learning from life encounters. Kahu Pōkai as a source of mātauranga or theme acknowledges all that has contributed to being a Māori midwife. This is where the commitment to the kaupapa of the mama and pēpe is acknowledged.

Ngā Pou

The use of pou as dimensional structures is not uncommon in Māori research. Elder (2018) utilised pou in the area of mental health to exemplify principles of practice. The components represented by these pou included wairua, whānau experience, and mātauranga Māori. The notion of using a construct such as pou allows for the elements to operate harmoniously, interweaving in and around each other. This is reflected with the use of pou in Te Whare-kōrero ā Kahu Pōkai. The pou are the same as those in Te Whare-mauokoroa; however, the dynamics of each pou have been adapted to include the mātauranga of Te Whare-kōrero ā Kahu Pōkai. Figure 5.1 Ngā Pou o Whare Kahu Pōkai shows the placement of these pou.

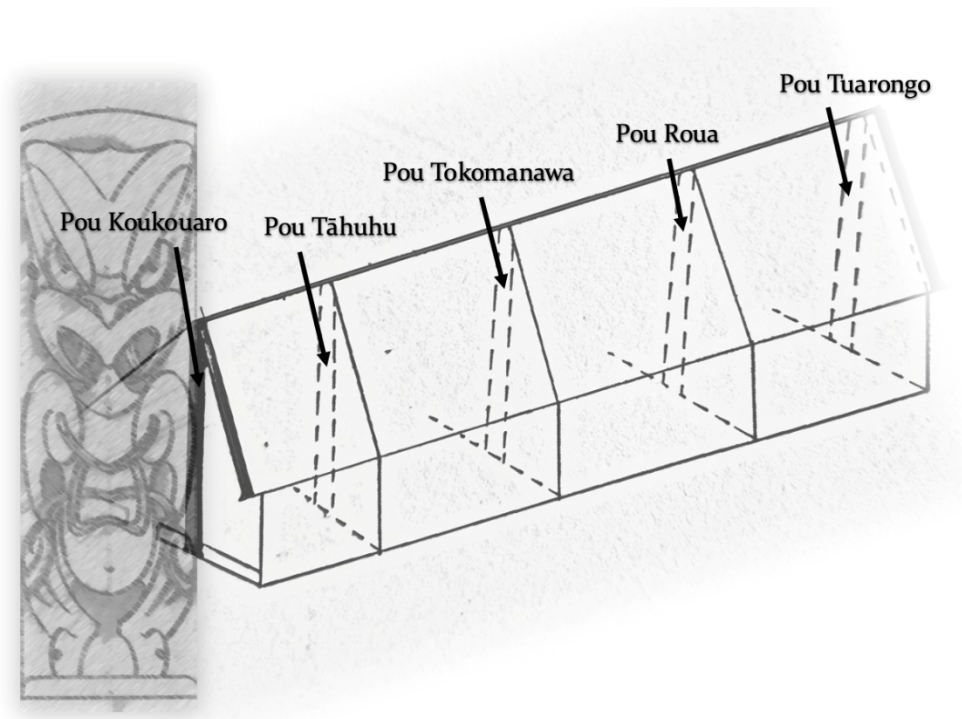
Pihama (2019a) expressed the importance of acknowledging and being guided by the reo, tikanga, and mātauranga of our tīpuna. Importantly, it is acknowledged throughout this thesis, in particular with reference to Papa Hōhepa. Pihama (2019a) goes on to say:

We need to draw upon te reo (the language), tikanga and mātauranga (the knowledge), of our tupuna as both learnings and guidance to restore the mauri and mana of our people. It is through the intersection of these understandings that we stand as a resurgent force to colonisation. Te reo, both as language and as voice, tikanga and mātauranga work hand in hand in the recovery of the wellbeing of the mauri (sacred life force) of our people. (p. 192)

³¹ Whatumanawa – having a sense for doing without questioning, that which one intuitively knows needs to be done. When you are in sync with their whatumanawa, your action is instinctive (Melbourne, T. (2020). *Ngā māramatanga tō te wairua Māori hai akoranga mātauranga; Epistemologies of Māori spirituality to inform education pedagogy*. [Te Whare Wānanga o Awanuiārangi].

Figure 5.1.

Ngā Pou o Whare Kahu Pōkai

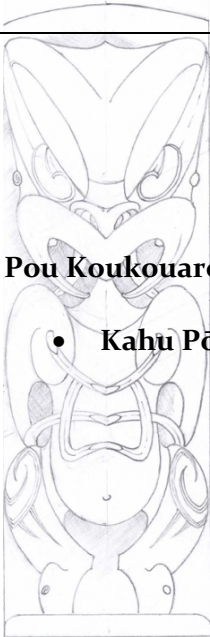


“He Matatauihi i Ngā Ururei Whēako hei Kahu Pōkai” created the avenue to explore deeper meaning within the pūrākau of ngā ringa hapai. The elements that provided the mātauranga of analysis or themes are: Matatauihi, Ngā Ururei, Whēako and Kahu Pōkai. The pou provide the level or phase of the mātauranga. The relationship of the Pou to Matatauihi, Ngā Ururei, Whēako and Kahu Pōkai are outlined below in Table 1.

Table 5.1.

Ngā Pou O Te Whare Kahu Pōkai

	Pou	Mātauranga
Pou Tuarongo • Matatauihi	All energies are conceived from the absolute realm of sacredness provided by deities. The life cycle is derived from IO. Pou Tuarongo endorses the connection of life in the spiritual, to life in the physical.	Matatauihi refers to the spiritual and physical connection of energy that is provided by the Whatumanawa. This feeling is automatically recognised by intuitive and instinctive senses. These experiences can happen in a moment. Without question, you follow through with your first thought or sense.
Pou Roua	This Pou refers to the protection and guidance we receive from our deities while developing our understanding of identity and natural purpose. This protection element emanates across all the pou; hence, each phase of development in life is protected. Pou Roua does not have a specific theme attached; rather, its source of mātauranga expands across all dynamics of the Whare-kōrero ā Kahu Pōkai.	
Pou Tokomanawa • Ngā Ururei	Refers to self-awareness and primary source of sustenance; that is, your hākui or mother. The wānanga that occurs within Te Whare-tangata. Innate potential and purpose come into alignment. This is the place where the association between who you are and who you will be in life is being made.	Ngā Ururei indicates the connectivity to deities, ariki, and tīpuna is continuous. This reminds us we serve a higher purpose. In caring for the iwi, hapū, whānau, and mokopuna, succession planning is inherent.
Pou Tāhuhu • Whēako	Refers to the innate confirmation and affirmation of identity and purpose. This is developed and endorsed in direct support of	Whēako refers to the life experiences both personal and professional Kahu Pōkai have had.

	Pou	Mātauranga
	deities, ariki, tīpuna, hākui, whānau. This is where the confidence in the kaupapa is absolute.	These experiences sustain and support identity in passion, purpose and potential.
	Refers to the timing being appropriate to connect with the physical energies of life.	Kahu Pōkai , the elements that highlight this realm of thinking, includes 'Kahu' and 'Pōkai'.
	It is the connection in spiritual essence to manifest an everlasting bond and enlightenment.	It encompasses an absolute point of knowing your passion and drive to provide for mama and pēpē as a descendant of Atua, Ariki, and Tīpuna.

Rauru

The Rauru has a unique style of intertwining spirals that move upward and downward forming an oval shape. The downward spiral is called Iho and the upward spiral is Aho. As the Iho and Aho move toward each other they meet in the centre to form the Whatu or 'eye of the Rauru.

Iho is a means by which celestial energy is directed downward

Aho is a means by which terrestrial energy is directed upward

Whatu is the culmination of potential in life provided by our sacred deities. (Leatham, 2014, p. 117)

In my Master's thesis (Leatham, 2014) the traditional depiction of the rauru³² was used. This research further illustrates the philosophy of the rauru by transferring the ideology to the Whare-kōrero, depicted in Figure 5.3 Rauru ki Whare³³. Whare Whakairo³⁴ have specific structures that each have their own kaupapa. Every element serves a physical purpose to the building, such as structural support, but also imbues a spiritual function. Together, they achieve the absolute synergy of the whare, structurally, functionally, and spiritually. The front of the whare is supported by two amo, the external side support beams of the whare. The amo connects to the maihi and the raparapa. The maihi and raparapa form the A-line of the roof structure. The maihi are the arms and shoulders, the raparapa are the hands of the whare (Barlow, 1991).

³² Figure 5.2 Rauru (Iho, Aho and Whatu)

³³ Figure 5.3 Rauru ki Whare

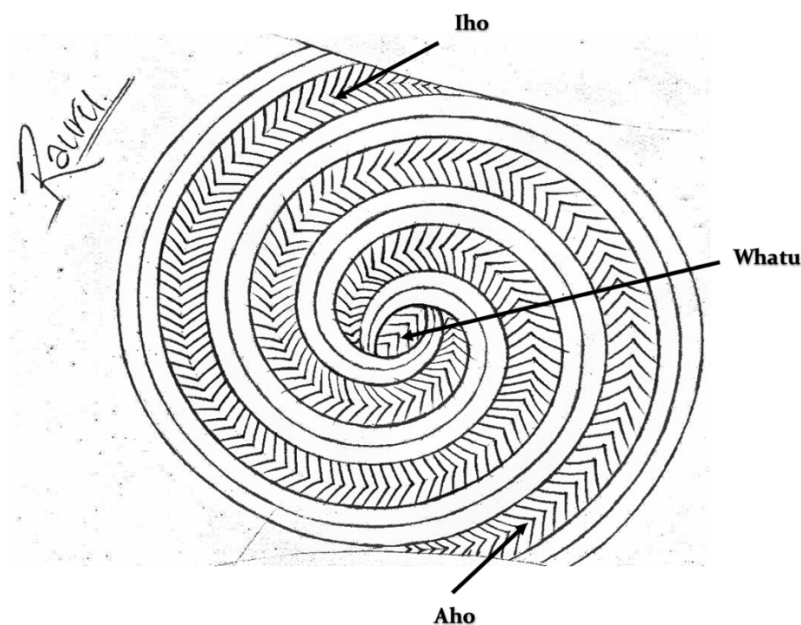
³⁴ Figure 5.5 Whare Whakairo

The amo are the legs. These structures directly join the Kōruru and the Tekoteko sits above the Kōruru. The Tekoteko is in direct connection with Atua and, therefore, enlightenment. The two amo replicate the role of the Iho and Aho. The Tekoteko represents the Whatu, this can be seen in Figure 5.4 Whare ki Rauru³⁵ (wānanga, Paraone Tai Tin, July 2024).

During the analytic process, the energy of the Iho and Aho flow toward the Whatu to consider positive potential and negative potential. The Iho and the Aho are constantly working simultaneously to feed the Whatu. The Iho engages knowledge that is instinctive, intrinsically within the subconscious and blends prior learnt experiences. The Aho is the energy that comes from the thinking, the application of that knowledge and where logic-Māori is formulated. The Iho is where the question promotes the thinking. The Aho is the space where the response is stimulated. The Whatu determines your way forward, blending the Iho and the Aho to achieve enlightenment. When these energies meet at the Whatu, change or transformation may be realised to create new energy or understanding.

Figure 5.2.

Rauru



³⁵ © Figure 5.4 Whare ki Rauru.

The Whatu

The tenets held within “He Matatauihi i Ngā Ururei Whēako hei Kahu Pōkai” guided the analysis of each pūrākau. Māori knowledge was exposed utilising ancient understandings held within kupu. The outcome of this analysis is placed within the Whatu. By doing this, elements of the pūrākau have been extracted to example the ongoing relationship between innate knowledge and the way in which this is expressed in contemporary Māori midwifery practice. This way of working enhanced the ability to engage with ancient mātauranga as it aligned to the kōrero of Kahu Pōkai (wānanga, Paraone Tai Tin, July 2024).

Figure 3.3.

Rauru ki Whare

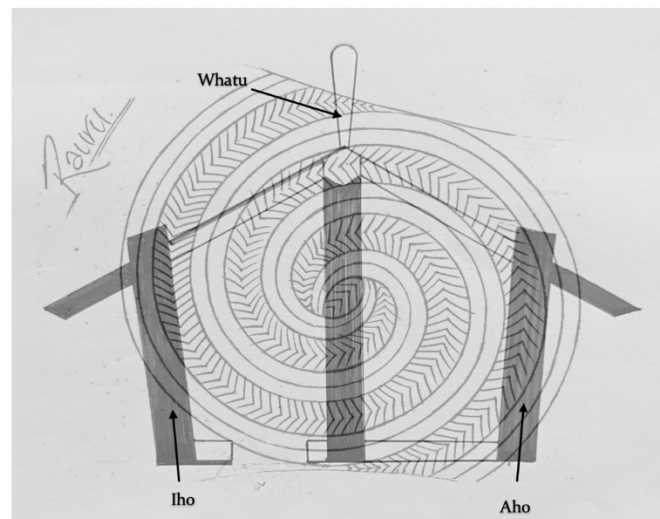


Figure 5.4.

Whare ki Rauru

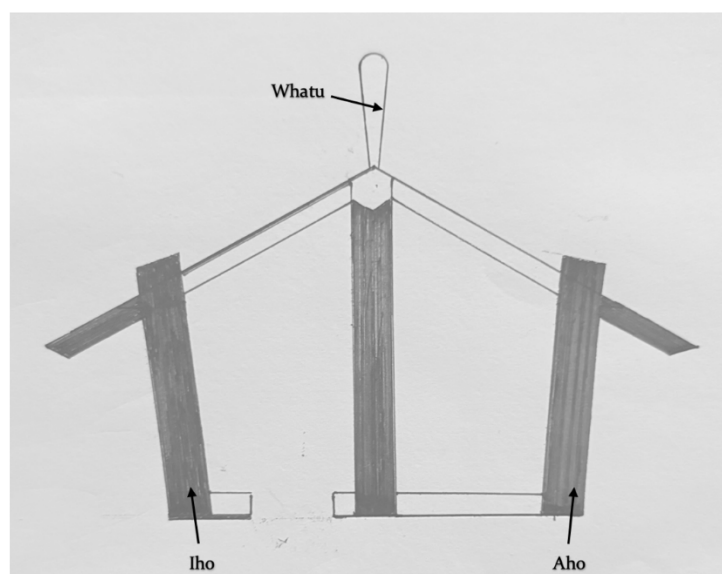
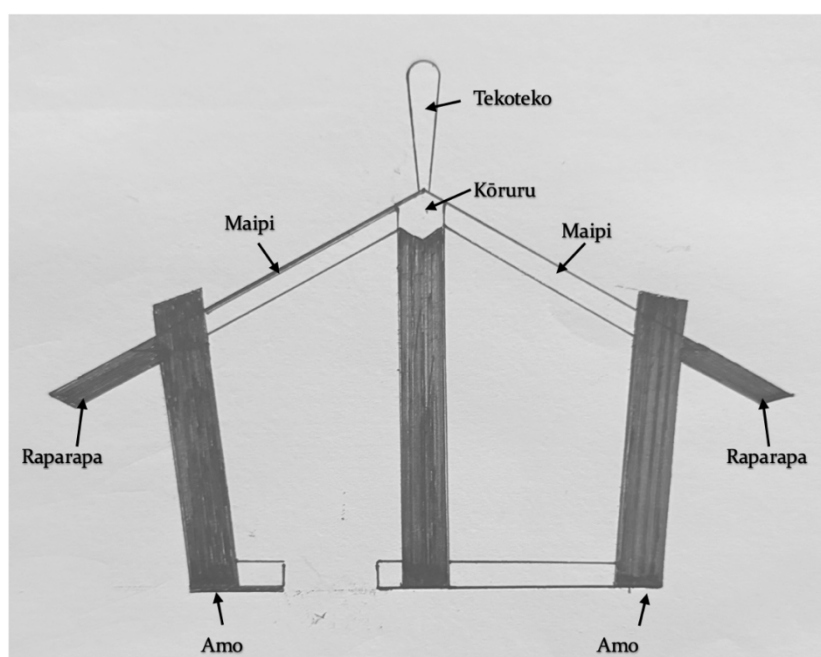


Figure 5.5.

Whare Whakairo



It is important to note, and as a reminder, that this mātauranga is not new. It has been in place mai rānō³⁶. This thesis does not justify the knowing held within terms, it is merely an opportunity to share and relate mātauranga to what has been shown to be living in practice. Connecting back to the whare supports our knowing of who we are and that we are a part of life provided by Atua.

Ethical Considerations

Ethical issues have become increasingly significant. Essentially ethics is what guides behaviour and conduct. For research this means ensuring the researched are protected from any harm including physical, mental, or psychological (Chilisa, 2012). Ethical principles of beneficence, non-maleficence, justice and autonomy has been broadly accepted both internationally and nationally, they are central to conducting research here in Aotearoa. Ratima and Ratima (2004) discussed the justification to applying these principles as they relate to Māori. Beneficence is about attaining the greatest benefits for tangata whenua; non-maleficence commits the researcher to do no harm intentionally; justice involves being fair and considering equity; and autonomy creates opportunity for Māori control. Grbich (1999) highlighted researchers need to

³⁶ mai rānō – since long ago or forever.

consider their accountability, ethical design and execution. However, Hudson (2004) found universal ethical principles that are founded upon Western notions is insufficient when considering tikanga Māori.

Cram (2001) offered ethical guidelines for Māori research that, when put into effect, improves the legitimacy and application of the research for Māori. The seven guidelines Cram (2001) offered provided the foundation for this study, encapsulated within these are the universal principles outlined above. These ethical guides are; ‘aroha ki te tangata’ (respect for people their space and terms), ‘he kanohi kitea’ (meeting face to face), ‘titiro, whakarongo... kōrero’ (look, listen... then speak), ‘manaaki ki te tangata’ (sharing, hosting, and generosity), ‘kia tūpato’ (be cautious), ‘kaua e takahia te mana o te tangata’ (do not trample the dignity of a person), and ‘kia māhaki’ (be humble). Smith (2012a) and Chilisa (2012) supported these concepts by saying that ethical principles that have evolved based upon the accountability to the researched will also then be informed by them. This will include every phase of the process, from research question to data gathering, analysis and dissemination.

Consultation occurred with Kahu Pōkai and key stakeholders throughout the research process, from the way in which recruitment occurred (outlined earlier in the chapter) to data analysis and dissemination. Early in the process my position as an insider researcher was made explicit, and allowed time for ngā ringa hāpai to consider potential conflicts such as, power imbalances, shared whānau and professional connections. Although I took for granted the option to have whānau support, it was expressively offered. At the same time, issues of confidentiality were discussed. Due to the nature of the research, it was made clear that Kahu Pōkai could choose to remain anonymous, only one chose this option. However, as highlighted earlier, any identifiable information in the pūrākau was removed. Data storage and destruction has been outlined earlier in the chapter. Ethical approval was granted by Auckland University of Technology Ethics Committee (AUTEC)³⁷. Table 5.2 outlines some of the ways Cram’s (2001) guidelines were considered in the research.

³⁷ Appendix G – AUTEC Ethics Application and Approval Memo

Table 5.2.

Rangahau Tikanga Māori (Code Of Conduct)

Guideline	Example
Aroha ki te tangata	The aim and motivation of the research is to enhance childbirth for tangata whenua, along with promoting mātauranga Kahu Pōkai. Participant recruitment was guided by Kahu Pōkai. Ngā ringa hapai lead their interviews, their tikanga was facilitated and respected. Review processes of their pūrākau were done to allow the time each Kahu Pōkai required.
He kanohi kitea	Consultation happened prior to commencing research in hui ā tinana with Kahu Pōkai. Interviews were only ā tinana Follow-up hui ā-tinana were offered; however, these only occurred informally.
Titiro, whakarongo...kōrero	Consultation with key stakeholders, such as Kahu Pōkai, guided ‘the way’ and ‘the why’ of this research. As such, hermeneutics methodology was released as Kahu Pōkai did not display affiliation to this worldview.
Manaaki ki te tangata	Kahu Pōkai have been informed of each phase of the research. They have had the opportunity to share in the mātauranga as it develops by way of Māori midwifery hui ā tinana.
Kia tūpato	My role as an insider researcher was constantly considered and reflected in the process. It has been important to be motivated by tikanga and mātauranga Māori such as these ethical guidelines. Sharing the pūrākau of others obliges the researcher to be mindful of the way in which it is presented therefore appropriate support and consultation is integral. Those key people have been Kahu Pōkai, primary supervisor Denise Wilson, secondary supervisor Liz Smythe, and cultural, tikanga advisor Paraone Tai Tin. Including ensuring the academic sources of mātauranga are evidence based and demonstrate Māori advancement.

Guideline	Example
Kaua e takahia te mana o te tangata	Their pūrākau was treated with respect. The write-up of their pūrākau considered their safety (e.g. exclusion of names and situations that could impact anonymity of others). The story-teller reviewed each edit of their pūrākau. Upholding the dignity of ngā ringa hapai of this research and the whānau that were included in their pūrākau was at the forefront of this research. Therefore, the inclusion of their pūrākau as a whole story was integral. First and foremost, it acknowledges the entirety of the journey they have shared. They also provide a level of interpretation that could not be offered by departmentalising them.
Kia māhaki	My place is enhanced by the presence of their story in the research. Hence, the pūrākau that was shared, in themselves, are humbling. Kahu Pōkai trusted the process and have given without question. They allowed me to guide the research but gave critical feedback as needed. As the researcher I do not take for granted the way in which their story is told. Dissemination of findings will occur with the Kahu Pōkai and their whānau first. Following that, kōrero with ngā ringa hapai will guide further dissemination.

Limitations

As a Māori researcher, my greatest limitation is my lack of fluency in te reo Māori. It is not my first language; and although I have spent many hours in classes to learn my native language and live with fluent te reo speakers, I have yet to gain confidence in te reo Māori. Melbourne (2009) speaks about te reo as a critical factor to providing a culturally safe space for his participants, particularly when participants have reservations about the research or the cultural knowledge the researcher holds. He also found that being fluent in te reo Māori allowed for more significant and deeper information to be shared that may not have been divulged if te reo was not used. Although I am not a fluent speaker of te reo Māori, I am comfortable in environments where te reo Māori is being used. Therefore, Kahu Pōkai used te reo Māori freely. The opportunity for clarification was reciprocal in all aspects of the research process including the use of te reo Māori.

One of the principal limitations to the completion of this research has been the time allowance I have been able to give while working (mostly full-time) throughout the entire research process.

Continuing to practice as a Kahu Pōkai has been important for varying reasons, including financial. It also provided constant context and motivation toward the current relevance of the research. This information was important for the ongoing support of the academic institution. Some would say it is impossible to complete a research project of this nature and work full-time. It was the main reason that I was unsuccessful in a funding application. Ironically, if I had been successful, I could have reduced my midwifery hours significantly and dedicated more time to the research. Hence, like many Māori researchers, I have traversed the pressures of producing an academic piece of work within academic timeframes while continuing to contribute to the workforce. I am grateful the university has continued to support my enrolment, albeit advantageous for them, that this research is completed. Although most of the Kahu Pōkai who took part have moved forward in their careers (including myself) and are now in different arenas of the maternity sector, their shared knowledge continues to be critically relevant.

Research Integrity

There is an intimate link between the research, the researcher, and how the research is conducted (Smith, 2012a). As an 'insider researcher', being Māori and a midwife, I was familiar with the Kahu Pōkai who shared their stories. This allowed for a level of trust from the start of the interviews and enhanced a comfortable environment, encouraging the kōrero to flow. However, as Melbourne (2009) highlighted, being an insider researcher can put into question the objectivity of the researcher. He goes on to say that there is no gauge to test the researcher's bias. I tend to agree with these notions but add that in the context of Māori research, the consultation process allows for interpretations to be checked by those who have shared the information, guarding against misrepresentation. Smith (2012a) also added that an insider researcher has added responsibility to ensure the research is tika³⁸ and pono³⁹, as it is not only their reputation at stake but the reputation of their community. This goes along with the idea that the attributes the researcher holds influence the research as much as the methodology that has been employed. These were notions that required constant consideration and discussion to ensure the integrity of the research was upheld.

Although this is a relatively small research project it was still important to ensure strategies and practices were critically measured to ensure the research was a tool for advancing Māori well-being and health outcomes. The CONSIDER statement (CONSolidated criteria for strengthening the reporting of health research involving Indigenous Peoples, CONSIDER) was

³⁸ Tika – Appropriate, correct.

³⁹ Pono – Integrity, honest.

designed by Indigenous health researchers, practitioners, epidemiologists, and methodologists of Australia and Aotearoa. They were all experts in their field of Indigenous health and equity (Huria et al., 2019).

The scope of the CONSIDER statement is all forms of original health research, regardless of methodologies, that includes a substantial Indigenous component including research: conducted on Indigenous lands; in which Indigenous identity is a criterion for participation; that seeks Indigenous knowledge; in which identity or membership of an Indigenous community is used as a variable for data analysis in which interpretation of data refers directly to Indigenous Peoples; or research that is likely to affect the health of Indigenous Peoples. CONSIDER is designed to enhance research practices with and involving Indigenous Peoples. (Huria et al., 2019, p. 2)

The CONSIDER statements include a checklist⁴⁰ of eight research domains including research governance, relationships, prioritisation, methodologies, participation, capacity, analysis and findings, and dissemination. Research governance, the way in which this research was undertaken, meant that with the guidance of research and cultural supervisors control resided with me. It was important to protect the intellectual property of the Kahu Pōkai in this research. This was done in consultation with them, and only what they agreed to have published was included. It was integral to protect the mana⁴¹ of their kōrero to not underestimate their contribution to this research. This element overlapped with the relationships that were well established, enhancing my ability to adhere to Indigenous ethical guidelines. Again, consultation with Māori supervisors and Kahu Pōkai strengthened this process.

From the start, it was clear that the prioritisation of this research aimed to improve maternity outcomes for whānau Māori. Repetitive evidence is compelling (PMMRC, 2017; 2018, 2022) and undisputedly shows the importance of research that connects to improving maternity health outcomes for tangata whenua. Further, the significance of Māori health practitioners' influence on these outcomes cannot be underestimated. The methodologies used in this research clearly prioritises Indigenous well-being and Indigenous health advancement. As discussed previously, Kaupapa Māori and Mana Wāhine provided the best foundation to ensure a safe, robust, and rigorous process for the research and all those involved. Participation in this research is not

⁴⁰ Appendix H – CONSIDER Checklist.

⁴¹ Mana – prestige, authority, control, power, influence, status, spiritual power, charisma - *mana* is a supernatural force in a person, place or object... “Mana is the enduring, indestructible power of the *atua*” and is inherited at birth, the more senior the descent, the greater the mana (Barlow, 1991, p. 61).

ongoing, Kahu Pōkai understood that their contribution to this research was only for this format, any future use of their knowledge or opportunity for their stories to be shared will only be done with their consent. This research did not provide any funding development for other Indigenous researchers. It may, however, provide further evidence for such things as future research or policy development or educational pathways for future Kahu Pōkai. It may also provide evidence toward sustainable Māori midwifery practice.

One of the most critical drivers for this research was to contribute to improving Māori maternity outcomes, particularly for our mokopuna. Therefore, dissemination of research findings will first and foremost be shared with the participants and their whānau. With their approval, dissemination will occur in relevant Indigenous and non-Indigenous midwifery forums. This will likely happen informally and formally, and it may include smaller publications of key findings to inform broader maternity understandings of Indigenous praxis and birth knowledge.

Conclusion

This chapter has explained how this research was conducted. Kaupapa Māori and Mana Wahine are methodologies that allow Māori researchers and those taking part to feel safe, their voices heard, and their experiences viewed in a way that appreciates their worldview. It was integral that the methods used endorsed a Māori way of thinking, doing, and knowing. This allowed Kahu Pōkai to share their stories in a manner that felt comfortable. As an insider researcher, I found that trust was easily developed and pivotal in endorsing the research process. Cram's (2001) seven guidelines for Māori research ethics were employed, along with the CONSIDER statement (Huria et al., 2019), to enhance the validity of the research.

The way in which the information was examined needed to expose Māori knowledge, so it made sense to use a traditional concept of knowledge transmission, the Whare-kōrero. The conceptuality of the Whare-kōrero along with the philosophy of the rauru (Leatham, 2014) provides the foundation for this Māori research. These guiding models clearly reside within an Indigenous worldview, expressing Indigenous value systems, tikanga, and mātauranga. Using methods such as these confirm the validity of Māori research outcomes. Importantly, research such as this challenges the Eurocentric norms of the maternity sector and provides an alternative resource to consider Māori maternities. Creating this space implores academia to validate mātauranga Māori which is crucial for the advancement of tangata whenua.

PART TWO

Te Whare-Kōrero ā Kahu Pōkai



42

Rua Pōkai i Te Rauroha introduces Part Two of the thesis. Rua are the sacred beings or Ariki who nurture the uniqueness of ira tangata (human beings); Pōkai encapsulates the pregnancy cycle; and Rauroha entwines the aroha that enhances the energy of the future generations. Therefore, Rua Pōkai i Te Rauroha presents the precious pūrākau of Kahu Pōkai. These purākau have been gifted to this research. Therefore the stories as told here, are subject to copyright (including images) and are not to be reproduced in any form without written permission from myself Beatrice Leatham or from the kahu pōkai whom the purākau belong.

⁴² © This is a photo of my taonga hei tiki named “Rua Pōkai i te Rauroha”.



Ngā mihi maioha ki a koe
 Ko Whetūmatarau me Pukeamaru ngā maunga ki Hikurangi
 Ko Awatere me Karakatuwhero ngā awa e rere atu ana ki te Waiapu
 Ko Nukutaememeha me Nukutere ngā waka
 Ko Hinerupe rāua ko Tamakoro ngā whare tīpuna o te whānau
 Ko Rongomaitāpui me Tamateaupoko ngā wharekai
 Ko Te Whānau-a-Hinerupe me Te Whānau-a-Te Aopare ōku hapū
 Ko Ngāti Porou te iwi
 Ko Beatrice-Ann Materoa Leatham-Tai Tin ahau



Ko tōku matāmua me ōku mokopuna
 kei mua i tō mātou whare tipuna, ko Tamakoro.

My journey as a midwife commenced relatively similarly to the nine Kahu Pōkai to follow. The birth of my daughter, pictured above, ignited the vision of what I was going to do in my life—to become a midwife so I could be there to welcome Māori babies. In reality, this research process commenced with my Master's degree, so it was not only logical but there was a sense of responsibility to continue to the next phase, the Doctorate.

Research by definition and in practice is an intense process. It is not something done lightly or I imagine on something that does not count as important to the researcher. Therefore, the researcher's philosophical worldview, professional stance, and, to some degree, personality, is completely exposed. There is a constant play on saying enough but not too much, and always the pressure to get it right! In saying that, my pūrākau is as much this research as all the birth stories I could share. Most importantly, it is intertwined in the pages of this thesis as an extension of my commitment to Māori babies. The reason I do this research is for mokopuna. The same reason I am a Kahu Pōkai, so mokopuna enter this world to hands that appreciate their whakapapa.

It was 1992, I was 21-years-old having my first pēpē. At that time, most wāhine received pregnancy care from their GP. My pregnancy care had gone by without any concerns and I went into labour naive as to what was going to happen. I often wonder how I managed to escape the anxiety of hearing repetitive horror stories of giving birth. How did I have such a normalised attitude toward birth? Now, my only answer is that my innate confidence was guided by our Atua.

I had a lovely Scottish midwife caring for me in labour who I met for the first time when I arrived at maternity unit. I had no pre-conceived expectations of labour, having only given it one thought during the pregnancy. Around 36 weeks, I looked down at my puku and thought, somehow this lump has to come out of me! My labour progressed as well as any first mama could hope for. Pēpē was crowning and as I pushed I recognised the absolute privilege this Scottish midwife was about to have. She would be the first person to lay her hands on my pēpē. It was a profound moment. I thought, what an honour she was about to behold and I wished those hands were Māori. Until that point I had not really considered working with my people; but in that moment I knew I would do her job so I could be there for that very reason.

In 1997 I started the 3-year midwifery degree. Twenty-seven years later I am the midwife I envisaged. Along the way I have had opportunity to work with some amazingly strong,

dedicated wāhine. Nine of those wāhine are about to tell you their story. Before they do, let me introduce them.

I first met Heather at a Ngā Maia hui when I was a student midwife; she was formidable. Her long hair and strong presence was an image that captured the very essence of wāhine Māori and Māori midwife. Joanne was another one of these Māori midwives. It was an early era of Ngā Maia, I was young and in absolute awe of the outspoken, dynamic, and creative personalities that surrounded me. I was in awe of their Māori-ness. Joanne was always passionately engaged in kōrero and, like Heather, never let anyone get away with treating whānau badly—they were fierce.

Nerissa and I went to high school together. When I began my doctoral journey, I knew I wanted to include some home-midwives, so it was only natural and respectful that I approach her. She and her husband Jody were my second interview. The synergy between them and their story revealed a pūrākau that was rich in the history of their children and their life. Kendra is another home midwife. She cares for whānau with passionate loyalty and love. Her story reminds me of the power of our rangatahi, to know who they are and what they want to achieve.

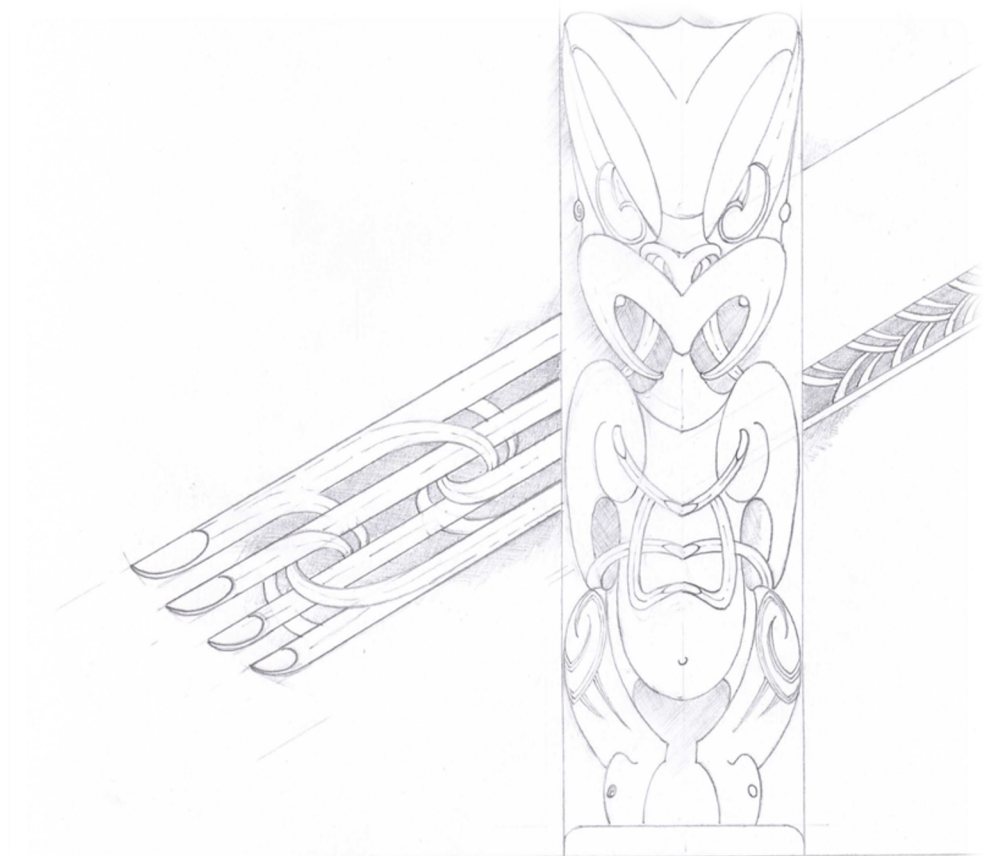
Nicole's reputation exceeded her. I felt like I had known her my entire career. She was renown as the first tangata whenua president for NZCOM and, at the time of her interview, she was working at the then Auckland DHB in a senior leadership role. Her heart belongs in Te Tai Tokerau and, like the many leaders in her whakapapa, she leads with humility and insightful expertise.

I first met Aroha as a student midwife, she was as impressive then as she is now. It has been an honour to be part of her journey as a midwife and watch her move from being a student to a confident Kahu Pōkai, influencing Māori maternities. Shar was another student midwife I had the privilege to work with. Her wairua encapsulates all those around her. She has an unrelenting commitment to serve whānau as much as the whenua that sustains her.

I met Hine the day of our kōrero. She was as humble as she was insightful. Her story is rich in mātauranga and her fluidity to share is inspiring. Kiley was my last interview. She was simply impressive. Kiley's cultural intelligence and integrity to kaupapa is admirable. It was a beautiful kōrero to complete this part of the research.

A very experienced, wise (and retired) midwife, who is also one of my supervisors said, after reading your stories; “You have captured something very sacred. If I had read these years ago, I would have been a very different midwife” (personal communication, Liz Smythe).

Testament to the richness, honesty, and aroha of your pūrākau. I am incredibly grateful to all my Kahu Pokai sisters for opening their hearts and trusting me in this process. I am grateful to every whānau that have allowed me to be part of their births. We descend from greatness, we directly connect to Atua and, as Charlotte Mildon (2018) says, Māori whakapapa to taniwha and tipua. We are descendants of Papatūānuku and the Atua of Hine. I do not take these connections lightly for myself or for the mokopuna I am privileged to help into this world.



Ko Aotea te waka
Ko Taranaki te maunga
Ko Waingongoro te awa
Ko Tangahoe raua ko Ngāti Ruanui ngā iwi
Ko Ngāti Tupaia raua ko Ngāti Tanewai ngā hapū
Ko W'arepuni te marae
Ko Titokowaru te rangatira
Ko Roi Rangi raua ko Margaret Craigie ōku matua
Ko Heather Kimirongo Rangi Muriwai toko ingoa.



Heather is staunchly, unapologetically tūturu Māori, tūturu wāhine, and tūturu homebirthing midwife. She exudes the wisdom of someone who has played this role before. Her passion for the job is evident in the tears that flow when she speaks of her experiences and the anger that can be heard in her tone when she talks about whānau that suffer the inequities of health, especially in the birthing arena.

In my younger days as a midwife, I admired Heather from afar. Unbeknown to me, our length of time as midwives are very similar but I recall feeling intimidated by Heather, unsure that someone with her presence could be bothered with a young inexperienced midwife. Of course, she would be surprised to hear this; however, the reasons I felt that way are the same reasons I am humbled that she would be part of this research, my first interview. As we settle into our kōrero I am reminded of the presence Heather emanates, her manner that 'says it like it is'.

Heather is married with two children and multiple mokopuna. She is the baby of five, she has four older sisters. When she was 4-years, her whānau moved to the Matamata region. She never really felt a strong connection to this area, not like her own whenua, Taranaki. Heather's husband got a job teaching in Matamata, so when their children were 5 and 3-years-old they moved back there from Auckland. Heather started her career pathway as a dental nurse until she had her babies. When she had her first baby she had a year of maternity leave, but after returning to mahi she realised she did not love being a working mother or leaving her boy, so she left. From that point, she did whatever was needed to support her whānau, waitressing at night, teaching special needs, and making crafts to sell at local markets. Then, came wanting to be a midwife. One night Heather dreamt she was going to be midwife.

I became a midwife because it was my turn, but I didn't know that at the time. I just knew, one day, I needed to be a midwife. It hadn't been in my head before that day, at all. Honestly. I woke up, I can remember it vividly. And it was there. It was not something that I'd ever thought about ever before. If anything I was looking at teaching. When I say it, it sounds almost like it called me. But I woke up and that's what I had to do. I didn't know how to or where to, but I knew I had to find a way. My kuia had been a lay midwife but I didn't know that at that time, I didn't know that until after she died. She was a lay midwife for our hapū and wider. So, it was just my turn.

Heather started her studies in 1996 with having completed the science and research paper for year one. That was a huge advantage. She was travelling every day to Wintec from Matamata which was about 45-minute drive. She liked the drive as it gave her space to switch on and then switch off, ready to be home with the whānau. But she really felt that all she did when she got home was sleep. Her tāne had taken on all the school activities, sick children at home, and being there after school for the children. It was Heather's turn to follow her aspiration. She was accepted into the first year of direct entry midwifery at Wintec. There were 10 Māori and 12 tauiwi students in her class.

It was a pretty powerful group. Becky Fox was our tutor and you didn't get in unless you had a whānau interview. She wanted to know, who was going to look after this girl when she wasn't at school, who was going to be there to get her through and what were the whānau going to do to commit to get her through. By doing this, it put responsibility not just on the student, but also on her whānau. Becky used to always say, as far as the road to midwifery goes they're your best support and worst enemies all in the same day. She had real contact with our families throughout the course. That was the difference.

Over that whole period of training, it was Heather's moment of 'ko wai au?'. This was a time of really looking at where she fitted, how she fitted, and with who? She was 37 at the time. As whānau they had strong links with their marae and they'd always go back to Taranaki. So, it wasn't a question of was she Māori; she knew she was Māori. It was, how does this Māori woman fit into this mahi of being a midwife?

In her first year she did a clinical placement at the hospital with her closest mate, who still, today, is one of Heather's best friends. They spent most of the whole 3 or 4-weeks of the placement hiding in the tearoom because they both couldn't cope with what was going on there, for Māori women. Heather felt the experience at the hospital was like watching her own birth experiences; it was the same for every Māori woman that walked in the door. She knew then that the hospital and the 'systems' were never going to be a place that she could feel comfortable enough to work within.

She had done placements with Māori midwives but she didn't feel as philosophically aligned to them as she did with the tauwi homebirth collective. She felt some of the Māori midwives she had worked with were midwifery 'by the book', they did hospital or birthing unit births but no homebirths and there was minimal cultural aspect to their practice. The homebirth collective practiced in a way that was women and whānau centred. There were also many whānau Māori coming to them for care.

When Heather had her babies, they were living in Auckland. She birthed at National Women's Hospital. Her first baby, Ben, was born in 1984, not that long ago. Heather felt she was a good at giving birth but described the experience as 'not that flash at all'. Typically, as a first time mother, she did not know how things went, so did as the doctor said. She remembers that around 30 to 35 weeks, at two visits the GP actually did a vaginal examination (VE) on her. She didn't know why and didn't realise that she should question it either. It was just what happened but there was no clinical or medical reason to do that.

She went into labour feeling she knew nothing. She recalls having had a normal first baby labour but remembers minutes before her son was born being shot with pethidine. It took them 6 and a half minutes to resuscitate him. She knows she didn't ask for pain relief. She also had her legs in stirrups. The births were all like that. She had a full episiotomy; again, they all were like that, her baby went to NICU and she went to the ward. She recalls wandering through wards looking for NICU to get to her baby.

Heather was induced with Kimi her second baby, again at National Women's, and to this day she does not know why. She remembers shaking with fear about going into that induction, but she had a lovely midwife who cared for her with kindness. Heather still remembers her face because she was so kind. She remembers squatting on the bed, she knew instinctively that if she got into that position with her husband there to support her, then no one could get to her. She birthed her baby 3-hours after the induction started, with no other interventions.

I don't know why I birthed at National Women's and not at Middlemore, because we lived about 200 metres from Middlemore. My babies were given Hep B vaccine, it was compulsory because we were Māori and we lived in South Auckland. Experiences like this are building up for me, enforcing a feeling of 'anti-establishment'.

Injustice is what drives my big sisters and me, probably because we were born into it. In whatever shape or form. I can't sit back, I do not want to perpetuate what happened to me, for my girl and my mokos and the women that I really love and care about and I don't care if it gets me in trouble.

While Heather was doing placements with the home birth midwives, she also had the privilege of spending time with Ngāti Haua kuia in Waharoa and Matamata. The kuia knew her because of her mother and father, and now to become a midwife was considered highly. It gave them a feeling of safety. So, after she graduated, she gradually became the “whānau midwife”. The nannies were at all the births of their mokos. They would tell Heather and show her their different traditional practices. She would also go back home to learn from her whānau about Taranaki knowledge and tikanga. She could see how iwi were all so different in their ways. All that she learned became her practice, her style. Heather believes every midwife has their style. Heather recognised early that it is not so much te ao Māori driven, it is iwi driven.

I was doing a lot of work in Te Arawa, but it would not be for me to go there and say, I have this practice and we can do it like this, or in Hamilton or Tauranga and around the Hauraki Plains. Often it was just opening the door of possibility for whānau. To look at what they might do and what their nannies and aunties might know about. And it is still like that for me. Otherwise I'm being arrogant. What is 'traditional home birth'? That will be different for different whānau hapū and iwi, really different.

In many ways, I wished I'd lived in the era of my kuia. I couldn't practice like the book said. I knew what the book said, and whānau and I talked about what the book said, and I could do that stuff, but that was not what these wāhine and whānau wanted.

When Heather went to Turuki Health Care in South Auckland to practice, she had negotiated that she would do births in primary units or at home but not Middlemore, and for about the first 7 to 8-months they stuck to that rule. Then it became apparent that they couldn't continue. Middlemore was 200 metres up the road for the women in their community, and to fit their needs they were forcing the women to drive to Papakura or Botany when they didn't have the means to do that. Heather realised they couldn't continue. The battle began to normalise birth in a tertiary hospital for women who were going there for geographical reasons not medical. However, in her previous self-employed practice she had cared for women who were committed to their health, home birthing, predominantly healthy women and who worked for what they wanted. Now, she was caring for many women who did not have the means to prioritise their health, which subsequently put them at risk for things like bleeding. No matter how gentle their births were, they would often tear, then they would bleed. Heather went from not doing any active third stage to actively treating haemorrhages. That was a steep learning curve about the realisation of 'whose birth is this?' It was an ego awakening for her, about meeting the need of her wāhine, not herself, identifying where each woman was, not where she wanted them to be.

I was compromising them by my belief system, that I assumed was their belief system because that's what I'd known. They were beautiful Māori women but if they were choosing to birth in a hospital, not at home.

Heather shared a hard story about responsibility. She looked after a whānau member who birthed really well but then, 2-hours after birthing, proceeded to bleed profusely and required life-saving surgery. The mama was in a critical life-threatening situation, and as one of the surgeons who had saved her life said, it was a 1-in-20,000 scenario. She was on life support for 3-days but survived. Afterwards, she talked to Heather about her experience while she was under anaesthetic. She could name everyone that was in the theatre working on her and tell Heather what they were talking about—an out-of-body experience.

The whānau that had been there on the day were okay with Heather but some of the extended whānau were not. Because it was such a small community, everyone knew about the birth, which was a normal waterbirth in the local primary birthing unit. Heather had to maintain her integrity in this situation and simply, as she said “ride it out”. For Heather, the connection made within whānau is what is important. It isn’t so much about what can happen to the midwife, but how the midwife is in that space. Three weeks after the event she returned to the hospital with the nanny to collect the wharetangata of her woman. She saw this as being part of her role as the whānau’s midwife. They met the histology clinician in the chapel, the pre-arranged place for collecting the wharetangata, then took it home to the whānau for burial in their urupa. That was her job in that whānau.

They don’t say that is the job description, in your midwife training. But that is what it is, all of these things that are not one-offs. You might have midwife title but you’re way more than that to whānau. Otherwise you wouldn’t be there. That actually is part of your role.

Heather had a baby pass away from ‘sudden unexplained death of an infant’ (SUDI) at 5-weeks old. The police were at the home interviewing the whānau when Heather arrived at the house after being called by the devastated mama. The mother had asked Heather not to leave her baby alone.

So that was my job to go to the mortuary and sit down in the bowels of the hospital with baby. The pathologist found me a chair to sit outside his room while he did the autopsy, the mama had asked me to be as close as possible to baby. So I sat out here to be by baby. Then took baby to the funeral directors where I met the whānau and we dressed baby, singing to him throughout. We put him in his cocoon on the seat next to me in the car, and drove back to her house.”

And I’m sure not just Māori midwives do that stuff, but they (others) get a choice, we as Māori midwives are expected to. And those moments are desperately sad highlights, of the places that I’ve had the privilege to be in.

Heather looked after a staunch Māori wahine who had laboured at home for 25 hours but could not get her baby out of her odd-shaped pelvis. They transferred hospital, but she refused to let

the obstetric team do a caesarean on her unless her tohunga was in the theatre too. The tohunga was dressed in hippie pants and had dreadlocks. He was tohunga status to Heather and the mama but perceived as a huge risk to the obstetric team. In the end, Heather was relegated to look after him in the far corner of the theatre because the mama wouldn't be touched unless he was in the room. However, on day two, post caesarean section, the mama ended up with an infection; of course, the blame goes to the tohunga and Heather, the ones who were the furthest away (5 or more metres) from the operating table.

For me, those are highlights because it was another piece of the jigsaw of, what do I do about institutional racism? Why do I fight so hard about that? Stories like this have fuelled my fight against institutional racism. Being accused and blamed because you chose that Māori stuff.

Heather acknowledged that for the first 5 or 6 years of her LMC practice, in the rare times she would need to transfer Mama into the tertiary units, she allowed their way to dominate conversations and intimidate her.

I let them make me feel so dumb, so inadequate and so unskilful. Until it dawned on me no, in the rare transfer situations I've kept babies alive until we got here. That actually takes skill, so give me some credit.

I've done my job. Now it's time for you to do yours. I brought her here because you have that skill, I have these skills, so now how do we do this together? I don't let them intimidate me anymore. I stand up to that because otherwise that's disempowering. That is being fearful and I don't do that well, but you learn. It's like growing up and I've grown a little bit in midwifery. Don't give your power over, stand in it.

Heather doesn't believe being a midwife interrupted being Māori for her, like attending tangi; except there was one significant time when she felt she had to compromise being Māori. In the beginning of her second year of training her dad passed away. It was a dark place for her to remember but expressed its importance to her story. He died over their holiday break and they were going back to kura the following week. She remembers needing to go back and although she felt pretty shaky and unstable at the time, she didn't have time to fail. Becky her tutor knew but she didn't say anything about it, she didn't acknowledge it at all, it was 'school as normal'. From that point on, Heather's relationship with her was not the same. Heather continued to work hard and pass with high marks. Her tutor didn't acknowledge the loss she had experienced and that hurt Heather to her core. Not long after Heather graduated Becky got terminally ill, Heather went to see her. They had a whole conversation that didn't involve any words, it was had just with their eyes.

My interpretation of that from her was, this is how it needed to be for you. Otherwise you would have let yourself wallow. And I would have. When she died I went to her tangi but I

was still a bit cross. Later, I was at Te Puia springs doing a locum stint there with another Māori midwife, she said to me, come on we'll go up and see Becky, her urupā was along the river. So we went up there, I must have spent a couple of hours there with my mate. I finally came to a point where I got it. Only one dropped out during our training, 9 out of 10 passed. She was so hard on us, but it wasn't about that we all passed, for her, there was no room for us to fail. She was a formidable woman and absolutely had a presence. But she is the reason that all of us have become who we've become.

For the first time, Heather has stepped out of full time practice. Before this, she didn't really understand what that would really mean for her children and her mokopuna. She was too busy doing the mahi, loving it, being it, and breathing it. She knows her children weren't neglected but there were times that she definitely missed out on being their mother, simply because she wasn't there. She was at someone else's birthday, not theirs. Heather decided she would not do that with her mokopuna, which is why she doesn't find it hard to say that she is done now. Because now it's about her and her whānau. At the time of Heather's kōrero she was working within the DHB and NZCOM as an educator.

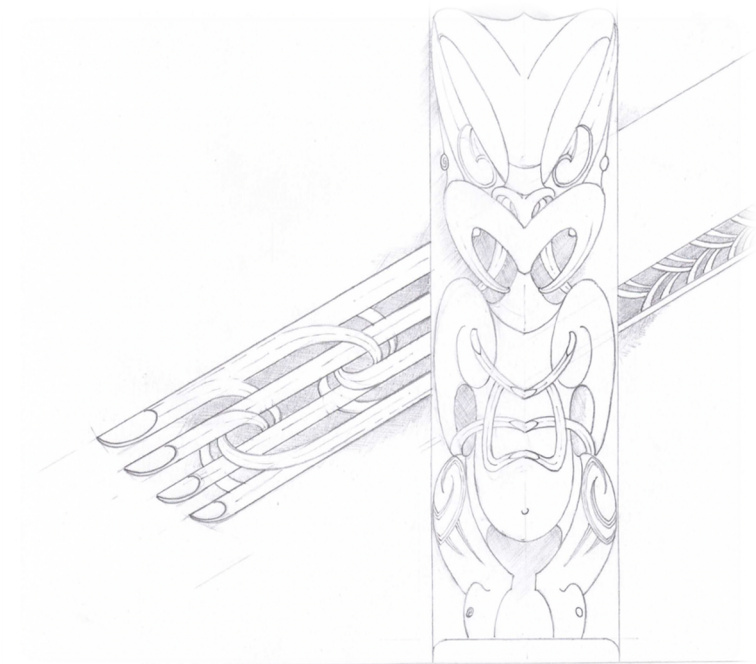
I've avoided the inside forever but I didn't realise until I came to the DHB and saw you can actually make a difference from within, you just have to do it strategically. And it's not to takahia on anyone's mana because we don't have the power to do that, but you have to do it in a way, and it has taken me almost 60 years to work this out, that makes 'them' unable to not listen. The battlefield is just in a different place now, same battle. And I've learned that you only do the battles not the skirmishes. Skirmishes are not worth the time, pick the big ones. The big ones because they are the long term and they will benefit my moko girls and all whānau.

She is now the Chief Clinical Officer Maternity for Manatū Hauora, MOH. Heather is directly responsible to the Minister of Health and influential to the broader maternity context. Although her hours are somewhat regulated, the role is challenging, time-intensive, and comes with a huge amount of accountability. Heather has an immense wealth of knowledge and experience to the practice of midwifery. She is a huge asset to the leadership of the maternity sector.

Heather is very mindful that the stories she has shared are not stories that she shares often. But she believes this research is really important for her, as well as for the voice of Māori midwifery. Heather strongly expresses that the learning institutions right around the motu, the councils, the colleges and the Ministry need to hear what being a Māori midwife is like, and what that means not just for Māori midwives but for the whānau that Māori midwives are trying to protect.

We are there to protect their wairua, their mauri, and their birth. That's why I have little patience for those of us who do not acknowledge their role as a Māori midwife within this

Western medical model. Every birth that I do or have done helps the healing of my births. If that mama gets what she needed and in the way she needed it to be, then she is me, for that little bit and I am pretty happy about being a part of that. Especially for my own mokopuna. Because honestly, I can say this, I am not doing this mahi for me. Every time it's for my girl or my moko girls. My time's too late. I can't get that sexual assault stuff out of my head, but I will for them. So, before anything I'm Māori and then I'm a woman who's a midwife. That's just, everything.



Tērā ia e mā mai rā
 E pakia mai rā e ngā ngaru o te moana
 Ko Te Kurī a Paoa
 Kei ngā repo o Te Wherowhero
 Ta matau waka o Horouta
 Ko Matiti te taumata tiroiro o Tāmanuhiri
 Ko Rangiwhaho,
 Ko Rangitauwhiwhia, ko kahutia, ko Tāwehi,
 Ko Rangiwhaho Matua hoki ngā hapū
 Ko Ngai Tāmanuhiri te iwi.



Nerissa is a midwife of over 10 years. She grew up in the Tairāwhiti region, trained as a midwife there, and is now the Director of Midwifery for TWO, Tairāwhiti. She has always been dedicated to her whānau and her mahi as a Māori midwife. She has a reputation that precedes her, one of being humble in her achievements, integral in her manner, and devoted to the betterment of her people.

Nerissa comes from Muriwai a settlement just outside of Gisborne, and for most of her life lived in Gisborne. She is the second daughter of 6 children. Her father is from a small island called Rotuma and spent many years overseas working on peacekeeping missions. Her mum has sadly passed away. Nerissa married Jody Walters. They have 6 children, 2 grandchildren, and multiple other children who have lived with them throughout their lives. Her midwifery journey would not be what it is without the presence of her husband Jody, and their birth experiences. They have had good births and not-so-good births. Nerissa's story cannot be told without the telling of these.

During Nerissa's high school years she went to boarding school in Hamilton. While there her mother became unwell. Nerissa's dad was away working, so Nerissa returned home. Nerissa and her husband Jody met when they were 16-years-old. Nerissa's mum was still unwell, and she asked Nerissa if she could go away to get herself better. So, at 16, Nerissa and Jody looked after her siblings and ran the household. They continued to go to school but worked in the weekends and holidays to earn money.

When I was 16, I went to my Aunt's birth and I watched the hospital midwife and I thought man I would like to be like her. I remember looking up how to be a midwife and it meant that I would have to move away and at the time, I had my siblings, and so my priority was to keep them in a stable home so it was a fleeting idea that I thought would be great, one day.

At 17-years-old Nerissa and Jody were having their first baby. Nerissa had a good pregnancy and towards the end of the pregnancy Nerissa's mum came home to help her with the labour and birth. When they arrived at the hospital in labour, they did not get a very nice welcome and were treated like teenagers that didn't know what they were doing. They felt judged and discriminated against.

I remember a midwife saying to me, while I was labouring. 'Did you not want to grow up first?' Then, saying to my husband (my boyfriend at the time but now husband). "Did you not want to let her grow up? You guys have got your whole lives ahead of you".

We put up with a lot in those early years. I remember, we were really looking forward to the birth of our oldest daughter, but that whole time in the maternity room was really about power. The prejudice around us being teen parents, Māori in a system that really wasn't supportive.

When it came time for their daughter to be born, they were taken into the birthing suite. While Nerissa is pushing, she was told;

There are about 12 doctors on the other side of the room (a one-way mirror wall) observing the birth! New doctors who just needed to experience a birth. There was no asking, no consent, no nothing.

Baby was born just on shift change over and instead of the midwives giving baby to Nerissa or Jody, she was left in a tub at the sink. Nerissa's mum had gone to pick up her younger siblings from school, so she wasn't there to advocate for them. Baby stayed there for quite some time before another midwife came in.

No one said we could get her. We thought, we're still young and we hadn't had a great experience so far so we sat there and waited, it felt like half an hour. It was strange. I sat on a bed and we waited. We waited for someone to come and tend to us. I wasn't holding her. It was weird for me to see my baby over there on the sink and just have to wait for somebody to come.

This experience has made Nerissa very protective about that time after birth for women; she is very aware that it's a special time, their time to be with their baby.

Nerissa had a lovely midwife for her second pregnancy. When she had her first baby, she was told she had inverted nipples so would not be able to breastfeed. Nerissa literally took that on and truly believed she would not be able to breastfeed. However, with this baby, her midwife worked with her antenatally to prepare her to be successful with breastfeeding, and she was. Initially, baby was very colicky, but she was a good breast-feeder. However, because of the colic, baby would not sleep. In hindsight, Nerissa recognised that she also had postnatal depression.

Baby would just be consistently crying. I often remember waking and Jody would be holding baby to the breast, to feed her. I would just let her feed. During this time, I would do puzzles, 1000-piece puzzles, I remember the Plunket nurse came over and she said, "you do lots of puzzles". I said to her, "because I don't feel like my mind is right and it makes my mind feel right". She never asked anything more about that and to be fair to her, I don't think she had the skill to identify that stuff. So there was no clinical support and nobody said to us maybe you have postnatal depression, nobody said that, and nobody asked.

Baby number three was on her way, Nerissa's mum had just had surgery and even though she was in a lot of pain, came to support Nerissa in labour,. Nerissa believes this baby was probably a shoulder dystocia. As she was birthing she instinctively got into McRoberts position and her mother helped hold her legs. The midwife was doing what Nerissa now recognises as supra-pubic pressure and then their 10lb 8oz baby girl was born.

That was probably, my best birth I felt supported, I felt like I had some control, I felt like, I had the right people there, and my midwife was really, really supportive. We had so many other children at home, but I don't feel like I had postnatal depression after her because I had some control over her birth. I don't think there was anything wrong after that one. She was a beautiful baby.

They had a beautiful Māori midwife with their son. During the labour Nerissa had some bleeding, so she was being closely monitored. The baby then started to have some significant bradycardia (low heartrate). Nerissa remembers hearing her midwife yelling at the obstetrician that they needed come immediately, but the obstetrician did not come. Five hours later their son was born via caesarean section and although he was fine, Nerissa needed to go to ICU and have six units of blood. She spent 3-days in and out of consciousness in ICU.

Nerissa's clinical notes do not give her a clear outline of what happened and there is no record of the blood loss. The obstetrician did say to her that they nearly had to take her uterus. Nerissa's response was if that was necessary, they should have. A midwife later told Nerissa that the blood loss increased to 3-litres. In this same pregnancy, at about 34-weeks pregnant, Nerissa was told that her baby's brain and the chambers of his heart had not formed properly and he was probably not compatible with life. At 35-weeks, a midwife said to her that she should terminate because he was not going to survive.

So I thought, if my child was going to die, he would die in my arms, knowing we were all with him and that he was with us and loved. And so, I wasn't going to terminate.

So it wasn't the easiest birth and not long after he was born, we were told that he was going to be retarded, global development delay. Not to expect great things from him, that he probably wouldn't be able to do the things boys might want to do like play rugby. Well,

he's done that and more. Looking back at that birth some of the things that happened were real rubbish.

After this birth Nerissa was also told not to expect to have any more children, that it was not a good idea to have anymore. Nerissa had two subsequent pregnancies, the first one she miscarried, the next one she was 'advised' to terminate, first by the GP and then by the obstetrician. It was 2009, Nerissa had already seen her baby's heartbeat so there was no way she or Jody could terminate their baby.

While pregnant, her friend told her that the midwifery degree was coming and they would be able to study in Gisborne. Nerissa applied. At the interview she was asked why she wanted to be a midwife. Nerissa shared her birth experiences and said she did not want young Māori women to experience what she had. Nerissa started her midwifery training in 2010. One week into the midwifery degree Nerissa had a caesarean section for their baby girl. Although she haemorrhaged, this time she only needed two units of blood and didn't need to go to ICU.

At the beginning of the midwifery training there were 13 students from Gisborne, 6 of whom were Māori. By the end of the first year, four students dropped out, and by the end of the degree, Nerissa was the only Māori student left.

By my second year there was only myself and another Māori student left. We told the institution, we are losing our Māori students, it's not working and Gisborne needs Māori midwives. I was asked what did I think should change, I suggested if we're going to teach science, teach it in a relatable way for Māori women. I'm not an academic, I scraped through, most days it made sense to me, but I had a passion for this. My colleagues were wondering if this was for them or not, or were they going to make it; they didn't. It was enough to tip them out. And my feedback wasn't followed up.

Throughout her studies Nerissa struggled with what she was told was asthma; at times it was difficult for her to breath. She was consistently treated for asthma; however, on one occasion she had a new doctor review her. He listened to her breath and instantly knew it was not asthma at all, she had an obstruction. She had two goitres crushing her windpipe and required immediate surgery, a 14-hour operation. Disappointingly, while Nerissa was in ICU she was told by the institution she should leave the course. Nerissa had consistently passed all papers with A's and A+'s. She was astounded that the midwifery school did not ask her how they could support her or show any compassion. There was no empathetic consideration from the learning institution at all.

So because they told me, we think that you should consider studying at a later time, that just made me more determined, I thought, I'm going to show you what I'm made of.

Much of Nerissa's second year placement was spent with the Māori midwife who had looked after her for her last baby. They would do home visits in the most humble of homes but be treated like queens. Being served water in yoghurt pots, because that was all the whānau had and make-shift couches of a mattress covered with what was obviously their best sheets. This midwife never batted an eyelid, never spoke down to them, and always treated them with the utmost respect. She taught Nerissa really important and lasting lessons of how to really be with women.

So those were the study years. We thought it was going to be pretty plain sailing; but a hideous birth at the start and a life-saving operation in the middle! Then to graduate at the marae with all of the whānau there. That was pretty neat.

For the first 18 months of Nerissa's career she was a core midwife in the hospital. Her Māori colleagues encouraged her to learn as much as she could. Their experiences weren't great so they were very protective of Nerissa and confident she was going to be as good, if not better than their counterparts. Nerissa was mentored by a wonderful midwife who told her, "people don't care how much you know or what you say but they will remember how you made them feel, so always be true to who you are". Nerissa felt spoiled with the support she received during this time and it has set a precedent for her future practice as a mentor to new-graduate midwives.

Nerissa thrived as a core midwife. She was able to put the theory she'd learnt to clinical situations and appreciated all the knowledge she was gaining. Like any new-graduate she found aspects challenging, especially when staff constantly asked her what should be done in situations like baby loss or what should happen for certain whānau. This made her feel like she was the 'token' Māori. There was an expectation that she was the resident expert in all things cultural.

During her second year, she was approached by whānau wanting her to be their midwife, so she started to set herself up in preparation to go out as an LMC midwife in the community. She eventually went into practice with other Māori midwives. The number of women wanting her was phenomenal. She tried to keep her caseload to four a month, but found it really hard to say no. The other Māori midwives in her community advised to keep her caseload manageable and Nerissa learned very quickly what her limits were. She noticed a theme with the women that were seeking her care, they were mostly young Māori mama with minimal or no support.

When her daughter got pregnant, Nerissa chose her midwife. Her labour was induced, which ended up being a week-long process. On the fourth day, the obstetrician wanted to take her

daughter to theatre to have a caesarean section. Her daughter's midwife challenged the obstetrician by asking what was the rationale for that decision? Nerissa admired the way in which this midwife stood up for her daughter, it was a pivotal moment in that she witnessed how she would need to be for the whānau in her care.

As an LMC, Nerissa gained a reputation as the midwife who gave the extra care; so in the early years she was the one staff would call upon for the young women with no midwife. Almost always they were Māori or Pasifika, women with complications, emotional issues, or whānau in distress. Nerissa felt she was supposed to go in and 'save the day', and typically she would, but she didn't do it for the staff or the hospital, she did it for the women and her whānau.

In my LMC practice, I felt, especially with the first-time mummies, that I needed to give them a bit more time, which was to the detriment of my family life. So, half hour appointments turned into hour appointments. I didn't have antenatal education so it was a priority for me to give this to these women. They needed to go into labour feeling confident that they could do this, their bodies were designed to do this, and they could do it. So I'd spend lots of hours away from home, serving these women.

Most of the time I looked after first-time mums, always the ones who were young. I remember, one of my first young primips that I looked after saying to me on day two, "no one helped me during the night and I'm really sore now". This should be our priority, caring for our young mums. But I felt because she was young and Māori she was a statistic. She was just put to the side. So I started being a bit more verbal about things like that, especially for those women. Because, I was that woman.

One night, she was called for a 14-year-old girl who had presented at the emergency department with her mother with abdominal pain; she was actually in labour. The maternity staff felt Nerissa would be the best person to care for her.

I learned a lot from that girl. She was a beautiful girl and she's a beautiful mother. She still makes her son call me nanny and she calls me mummy!! I saw in her, me. But she didn't have support like I had. So, I became that person for her. I remember walking in the room and looking at her and wondering how can you conceal a pregnancy? Then I realised she'd already had the baby, that's how you conceal a pregnancy! Anyway, because she was unbooked and I hadn't expected that income, when I got paid for her care I went over to her home and asked her what do you need? So anything that baby needed, her and I went and got it because they had nothing.

Along with young mama Nerissa was often the midwife for gang whānau or those closely connected; they would seek her out. At times this has meant Nerissa has been in some unsafe spaces.

I birthed the grandson of one of the gang leaders here. Although it sounds ridiculous, I'm very well protected, he has a lot to do with where I go safely. I was looking after a woman

who was the partner of a gang member, beautiful woman. He had a very heavy presence when I went into that home, it was not a very nice situation for her. I would drive up their road, and there would be three gang cars parked on the side, I'd think what am I getting into? But those cars were there just for me, and I know the gang leader put those things in place, because I birthed his grandson. That mum eventually went to prison. But still messaged me on her phone, that she was not allowed to have.

Along with her strong community connections, Nerissa also nurtured rich relationships with maternity colleagues and specialists. These relationships have been built upon mutual respect, integrity, and a reputation of being reasonable and knowledgeable. She is open to robust conversations that often lead to the best outcomes for the mama and her baby. Nerissa is very considerate and mindful of when and how to have difficult conversations. This has not been easily achieved and has taken a lot of navigation to enhance her practice as a midwife.

Much of Nerissa's way as a midwife has been learned from other Māori midwives, like guiding fathers to birth their babies. She cared for a couple having their second baby. Their first experience had left them feeling neglected and out of control. In particular, the father was very anxious. Nerissa was mindful of this and when it came time to birth baby Nerissa made sure he was ready to birth his baby.

When they arrived his ahua was hurting, he was really anxious about how it was going to be. He was now a new man. He told me, he needed that. We got feedback from him, he had written about how healing the whole birth was for him. And because it was healing for him, his partner had a great birth even though she haemorrhaged and there were other things that happened, but they didn't see that.

Those are the opportunities we need to take to make birth better. I think Māori midwives do this well, I think we do those things better...

Nerissa cared for a whānau whose kuia was at the birth of her moko. She questioned Nerissa's qualifications to be there. Nerissa told the kuia that te reo Māori was not her strongest language but her heart would be what she would want in the room for her moko. Nerissa said to the kuia, it was her responsibility to birth her moko, and it was Nerissa's job to do the clinical things to make sure baby and mum stayed well. So the kuia birthed her moko with a beautiful karanga. She turned to Nerissa and told her she was alright, she could stay. It was a very emotional moment for Nerissa. Not long after that the kuia passed away. Nerissa attended the tangi and was treated like a queen. The kuia had written a diary for her moko about educated women that she admired and wāhine she wanted her moko to be guided by. Nerissa was listed in the diary. They read a snippet of this at her tangi.

There have been times that although Nerissa has a strong Māori identity she has questioned her Māori-ness, particularly when challenged about not being fluent in te reo Māori. Experiences of being revered by kuia, along with Jody's reminders of her whakapapa, the knowledge of her gracious tīpuna who were all native speakers, give her the foundation to turn to. In doing that, she does not have to validate herself in front of any other iwi or any other whānau.

Although Nerissa finds it hard to say, she is very respected by the community of midwives and doctors that she works with. She highlights this as a point to say that as Māori midwives we do not allow ourselves to celebrate our achievements. One week she birthed 12 babies so suggested to her practice that they go and celebrate the achievement of their hard work. But they were too busy to stop and allow themselves that moment.

We need to take the moments to recognise what we do. Acknowledge the importance of our whānau and their contribution to us as Māori midwives, allowing them the time and space to show their appreciation of us, this is important.

She commenced her Master's with the aim to move into some part of midwifery that allows her to pull back on the intensity and velocity of practice. However, Nerissa is now in the most senior midwifery role in Tairāwhiti and represents her community at a national level. She continues to support her midwifery colleagues filling in when there are staff shortages, which happens weekly. Nerissa has come to the place where she feels she has reached her autonomy, her tino rangatiratanga in the way she wants to practice. She still finds it hard to say no, but has learned for her own well-being and, importantly, the well-being of her whānau, she has to recognise her limits and be unrelenting in those boundaries.

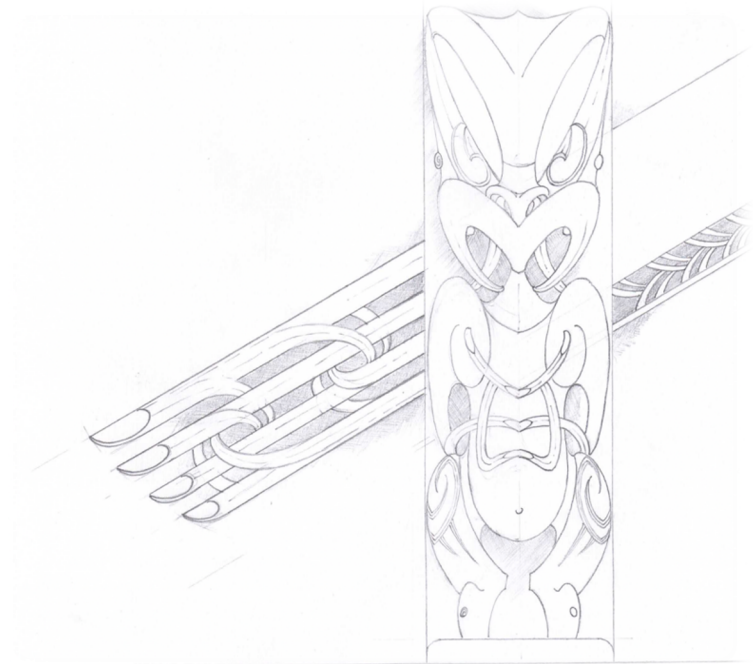
I think in general, because of the way we're raised, as Māori, we are better equipped to look after our own. We just have to put ourselves in a good space to do that. It's innate in us.

Nerissa continues to advocate for whānau Māori, particularly whānau Tairāwhiti. She remains steadfast in her belief in the power of wāhine and our power we have as Māori midwives. She and Jody continue to turn up for whānau when they are in distress or have lost their baby, when whānau need karakia, a kai, or just their company. She is reminded of the deep impression left with her when she was 16-years-old, the midwife who showed her gentleness and a way of creating a calm, supportive environment. These experiences, along with her own births, have influenced her art of being a Māori midwife.

She would whisper to her now and then you've got this, you can do this. I watched her massage her back and tell her, breathe, she was just beautiful. It wasn't one particular thing, but her whole manner the way she spoke, the scene, the mood she set in the room and she made herself invisible; it wasn't her show. She was just an observer on the side and she would step in whenever she felt she needed to. And I thought as I watched her, I can be

her, I want to be her. I can do that for women. I knew it couldn't be then, and I now know I needed all the experiences I've had to be the midwife I am today.

My birth experiences began to create the conditions eventually for me to see midwifery as an expression of, and I guess an extension of how we are as a whānau. It's not that I'm a midwife; it's that I'm whānau, and I can do this for our whānau. And other whānau like our nephews and nieces who have come along. Because of our previous, whānau get a sense that actually they're not just getting a health professional, they're getting somebody who has a way of being that acknowledges me and my family and all the things we've been through.



Ko Maungataniwha te maunga
Ko Tapapa te Awa
Ko Hokianga Whakapau Karakia te moana
Ko Mamari me Ngatokimatawhaorua ōku waka
Kohatutaka, Te Ihutai me te Kapotai ōku hapū
Ngāpuhi me Te Rarawa ōku iwi



Nicole is a strong advocate for whānau. She is motivated to contribute to improving health outcomes for Māori. At the time of hearing her story, she was the NZCOM president and affected significant change within that organisation. At the same time, she was in a leadership role within a tertiary DHB. While in these positions Nicole continued to care for birthing whānau, although her current role as the interim Chief Māori Midwifery Advisor for TWO is her focus. She is very pragmatic in her approach to midwifery, particularly in these leadership roles. Her ability to encourage whakawhanaungatanga is immeasurable, and she is highly respected throughout the Māori midwifery community. This is her story.

Nicole was a teenage mother and it changed her world. Observing the midwife during her pregnancy made her think, being a midwife was something she could do. She was told that she needed to do nursing first; she didn't want to do that. For her, nurses were always around people who die. It wasn't so much the death but the grief of those left behind that she did not think she could cope with; and at that time, she saw a lot of death.

When Nicole was growing up, she loved to listen to her grandmother tell her stories about her mum and her great-grandmother. She was always curious about birth and would ask her grandmother to tell her about her dad's birth. She would tell Nicole how she had to go to the hospital to have him because, in the 1950's they did not have a choice.

Her first pēpē and her last pēpē were both born in the hospital but all her middle children were born at home. She told me that she had proved to them, the doctors, that she could have the rest of her babies at home. Her cousin would help her and her father was around for the first few (not all of them) but for the first few.

She would tell Nicole about giving birth at the whānau home, under the Totara tree at the end of the back paddock by the lemon tree. Then her grandfather got angry with her so he chopped the tree down. Hearing stories like that as a child, reminded Nicole of how much her grandmother meant to her; and for Nicole, midwifery was the way in which she could be with whānau in all that it encompassed.

Nicole's journey to becoming a midwife related to her journey of becoming a mother. It wasn't a difficult decision, it just took longer than she anticipated. Nicole had never considered babies came out of anywhere else than where they should come out, and did not know what a caesarean section was. She just assumed the normal happened. In retrospect, and knowing what she now knows as a midwife, her labour and birth was relatively easy and straight forward, 5 and a half hours from when she opened her eyes to her son being born.

After Nicole had baby she continued to go to school, and because she was breastfeeding her whānau would bring baby to kura. She would go and feed baby at the marae, or once he started kohanga reo she would run across to the kohanga and breastfeed him. She breastfed him for about 2-years, for her that was all part and parcel of being his mum. These were good times. But as a young mother she felt the prejudices projected toward her and these experiences have impacted the way she is as a midwife.

While Nicole's son was still young they moved to Australia. Her mum has Australian whakapapa and her grandmother's father was Indigenous to Australia. They had direct entry midwifery in Australia. At that time, the programme had only recently been approved in New South Wales, so Nicole applied but was declined; she was so annoyed.

I applied again and got in. I remember the very first day doing whānaungatanga, I told the class they made a mistake, they should have let me in the year before because now I am a whole year behind where I should have been! I remember because they all thought it was funny but I was being very serious. Anyway, I did my midwifery.

It was 2007 and doing midwifery in Australia was just a means to an end for Nicole. Her focus was to achieve the tohu and be a midwife. There were other Indigenous women (of Australia) in her class. They called her their Indigenous sister. Out of a total of 52 students, six were Indigenous to Australia, only one got through to the end. The Australian Government had allocated six places out of 50 to go to Indigenous applicants and the institution only accepted the minimum six Indigenous students.

Just that in itself is racist. Being exposed to this, I decided that I was going to put my head down and get the work done and get out of there. Which I did.

Nicole's aboriginal whakapapa was always kept quiet within her whānau. During her grandmother's time there were many mis-truths told. Mothers did not want the authorities to know that their child was a 'mixed-race', otherwise they would be put under the Flora and Fauna Act which was eventually overturned in 1967 only a few short months after her grandmother passed. Consequently, birth certificates were very inaccurate to keep children safe. Nicole spent

a lot of her time with the Aboriginal women in her class and because of this she was exposed to the racism they were subjected to.

Racism is alive and well in Australia, its palpable, you can measure it. I spent a lot of time with these women, so was exposed to the racism they experienced. One day we were getting on a bus to go to the beach, the bus driver turned to my mate and said, "you control those", referring to her children like they were dogs. Seeing Indigenous people being kicked on the trains, being denied petrol at petrol stations because they are aboriginal. It was pretty bad, very real.

Nicole was desperate to be home; when she came home for holidays she felt like Aotearoa was calling her. Even though she has Australian whakapapa returning to Australia became harder and harder.

When you fly out of Auckland and see the edge, flying out over Mangere, you look back and it just feels like the whenua was trying to pull me home. So every time I flew away, to come back to Australia, it got harder and harder and the rope got pulled tighter and tighter. You can feel a physical 'pull', it's for real.

Nicole still has this feeling, when she travels away from the North, she can still feel the pull to be back on her whenua. When she sees her maunga she has the feeling she's home. She finds it such a settling feeling, like her tūpuna saying, 'you're back, we got you'.

Although Nicole was determined to come home, she completed her graduate year in Australia. The maternity system is quite different to Aotearoa. Australian midwives are not autonomous and do not have the same authority to do things such as prescribe. So, although Nicole was able to transfer the majority of her qualification to New Zealand she had to do another five papers to be able to practice in Aotearoa. The papers included cultural competence and the Treaty of Waitangi. Nicole requested to get accredited with the Treaty paper but was told no.

I thought, well I have to do it because I want to come home. The Treaty paper was a 14-week course, it took me 4-hours. I scanned the websites about Te Tiriti and after 4-hours of looking at the reading material, what was meant to be a 14 week course, I sat the exam.

Four hours, even though I did have a bit of an advantage there's no way that anyone would need 14-weeks, it was just reading websites and documents. But you can read all you want and find the right answers, it doesn't make you Māori and doesn't make you safer.

Coming home was the best decision I ever made.

After completing this paper Nicole complained to the NZMC. Even though she was born and raised in Te Tai Tokerau, with Waitangi right at her doorstep, she still should not have been able to achieve a 14-week course in 4-hours. She identified that as a big problem.

Becoming a midwife for Nicole was a selfish decision and all about being around whānau. First and foremost, being around her own whānau but also being immersed in other people's whānau. It keeps her humble and is what she loves. Making this her profession and getting paid simultaneously was an easy decision. She thrives in finding the links between herself and another whānau.

How often are you in a labour and the aunty that you've not met turns up, they look at you and go hi, are you blah, blah's moko? The next thing you know, you're related, it's so common. And that, is whanaungatanga, I love that about birth. It's not just about this pēpē, once that connection is made the whānau say, you were meant to be our midwife, you were meant to be here because we're whānau. But, we didn't know we were whānau until the aunty or nanny turned up.

Nicole feels strongly that no matter what you do as a midwife you always reflect on what you could have done better. This is forefront in her thoughts when she shares a story of caring for her cousin's wife.

It's really humbling to have emotional attachments to the wahine that you care for, whānau, its special. I was my cousin's midwife, that was really special but the outcome wasn't a good one. It's really hard because although the outcome wasn't good, I felt, in hindsight that I was the right person to be there. We, she, we experienced a stillbirth at term.

Nicole believes that because they were whānau and they had a close connection it made her cousin's journey and her grief a little easier. It meant her cousin did not have to explain things to a stranger, even though if it was a different midwife they would not be strangers, but being whānau they had a relationship that went before they were physically on earth. As Nicole says;

we had a relationship from childhood, well, before childhood with our tūpuna. We've got the same tūpuna so technically that's intrinsic DNA stuff that has been handed to us through our tūpuna so that bond was already pre-existing, before our own births.

Even though her cousin had been raised away from the whānau, she wanted her pēpē to go by their grandfather. Because they were whānau, Nicole was able to be her voice within the whānau and her cousin did not have to repeat her wishes to anyone else.

As midwives we advocate for women but in this case it was more than the midwifery, it was whānau and it was special for me because I knew that I could support her in a way that nobody else could have. I was her midwife but also I was her whānau.

Other health professionals, non-Māori, may perceive looking after whānau as a conflict but Nicole has never had this experience. The communication with her cousin was very open, right through the pregnancy. Nicole's cousin asked her to let the whānau know that pēpē had passed. Nicole then became the main organiser of the practical jobs and facilitated tikanga processes

that needed to be upheld. Nicole organised the undertaker, the gravediggers, the kai, and the kaikōrero until the sister arrived. Nicole made sure that the things to keep her cousin safe were done. Nicole had attended tangi with whānau before who had lost a baby but this situation was different, this was whānau, and it was very special for Nicole to be able to be there in that role for them.

Nicole calls on a kuia in her region who is also a midwife to keep herself safe from the perspective of being both midwife and Māori. Nicole is able to speak with her about anything, and in confidence, she knows that she always reminds her to remain rational and remember what is important. Sometimes she tells Nicole to slow down, or just suck it up. Whatever it is, she has a way of telling Nicole what she needs to hear in a kind but direct manner.

Initially Nicole worked in a primary birthing unit while she explored how to go into LMC practice. Eventually, Nicole felt ready to go out as an LMC and practised as an LMC for about 3-years before becoming the chairperson for her region's NZCOM. Her first meeting as a NZCOM regional chairperson was the meeting where the College had decided to take the Governor General to court on gender discrimination of equal pay, human rights for pay equity. She felt that was a sharp learning curve. The following year she was asked to be on the mediation group for the NZCOM to negotiate with the MOH. Soon after she was voted in as the President of NZCOM.

Following this, Nicole was encouraged to apply for a position at a tertiary unit in Auckland. The role was about improving equitable outcomes for Māori within women's health. Many rural whānau would need to get care at this facility either because of their medical condition or a condition to do with their baby, Nicole had cared for whānau that had needed to transfer to this tertiary hospital. Many experienced quite racist treatment, so Nicole saw it as an opportunity to be there and influence the care that whānau would receive. However, Nicole was aware that most of her experience had been remote rural and there were other Māori midwives that had committed a lot to the rohe, so she did not want to be perceived as coming in to 'save the world'. That was definitely not her intention.

I believe that if I get something it's because my tūpuna want me to do it. So, if I didn't get this role in Auckland it meant that this wasn't the place I was supposed to be. But if I get it, this is where I'm supposed to be and what I'm supposed to be doing at this point in my life, I'm here for a reason and once that reason has been fulfilled then I no longer need to be there. I almost feel like I'm led by another force, like I'm not led by my own desires, I'm led by something else that is leading me.

While Nicole was an LMC she was in an emergency situation that was happening in the carpark of the hospital. A non-Māori clinician, who was also new to the area, made a complaint against Nicole because she had apparently not afforded this woman privacy. The clinician thought Nicole was an aunty or a sister. Nicole was very well known to other staff. Nicole was performing an emergency procedure which was a life or death situation. The other clinician wanted to get a bed, which at the time was not high on Nicole's priority list, so a complaint was laid. Nicole really felt like it was because she was Māori. They had a face-to-face meeting with Nicole the Directory of Midwifery, the clinician, and her manager.

She said, I thought you were an aunty and I said, that's a good thing isn't it? Wouldn't it be good thing that I'm looking after my own whānau? How would that be a disadvantage that I was their aunty?

Nicole explained to her that in their community the majority of the population is Māori, so she questioned her as to why Nicole being an aunty would be seen as a disadvantage. The clinician unfortunately did not understand that concept. However, the whānau were very grateful that Nicole had chosen to save the life of the baby over providing mum with privacy.

I apologised to the mother for showing her butt to the world and she said, "what? Aren't you all clinicians?" I said, "yes". And she said, "so have you never seen a woman's arse before?" That's how she said it, haven't you seen a woman's arse before? I said, "ka pai, I'm just letting you know, just making sure". She said, "nah man, I'm sweet, I've got a baby in my arms that's all I care about".

Nicole has experienced, and believes Māori midwives are more likely than others to get complaints against them, sometimes just because they are Māori. She has had other non-Māori colleagues say to her, I did that but never got a complaint. She has had many irrational complaints with clinicians addressing her via a computer screen rather than rational conversations face-to-face. One of those involved a baby that needed to be transferred into hospital. It was the middle of winter and the car had no heating. To avoid a hypothermic, hypoglycaemic baby, Nicole got the mother to do skin to skin to keep baby warm and well. Another situation that Nicole recalls was a complaint made against her because she had not given a baby vitamin K during a transfer. She had not given it because the mother was haemorrhaging and requiring urgent attention. Nicole's approach in these situations is to contact clinicians to have a conversation about her decision-making process, to allow others the opportunity to understand the situation from her perspective. She feels strongly that unless these conversations happen then there is no opportunity to affect change and understanding.

In a Pākehā way you respond in writing, but our tūpuna didn't do that, they sat in front of one another and they would kōrero. They would put it all out there on the floor. I guess that's another practice that I do that our tūpuna did, I don't sit back and on technology to

do the talking for me. You're much better to have those conversations and get a resolution face to face. It is in this process that education and understanding can happen for both parties, including me.

Nicole encourages whānau to do whatever traditional practices they want to at the birth of their baby, like waiata, karanga, or karakia. She was once asked if she could do that, which she did, but she prefers for the whānau to take up those roles. Nicole is also proactive about promoting practices like the use of muka⁴³. There is fear around the use of muka. Nicole has had paediatricians insist on having full blood counts done on a baby when it has had a slight ooze from the use of muka. To justify the use of muka, Nicole has measured the amount of blood that is lost if the cord is clamped and cut early, there is about 20mls. If muka is tied too loose or the muka comes off and there is some leakage of blood at maximum blood loss may be 2mls; this will get all sorts of complaints but cutting the cord early is considered normal and okay. These attitudes are barriers to traditional practices.

It is also very important to Nicole that whānau are the first to touch their baby, so she gets them to help with the birth.

It wasn't actually a choice, it was more like, whānau this is your pēpē you're going to be touching them first. Then, it got to a point, when you're looking after the same whānau they just do it. I step back and I'm only needed if they want help or whatever, but there are the whānau that have done it several times, so you're just the onlooker in the room really, those are special times.

Nicole has always worked in environments and with colleagues that understand what is important to Māori, like tangihanga, so she has never found a conflict between being Māori and being a midwife. For her, she is Māori, that is who she is and she is also a midwife. She knows she can't get away from being Māori. If she chose, she could leave the midwife life behind, but she could never leave the Māori life behind. However, as a Māori midwife, she believes you can't just be okay, you have to be on top of your game. Some regions have a good cohort of Māori midwives but most regions do not; therefore, there are not enough of Māori midwives to advocate for each other.

You might be the first one to blaze that trail or you might have been the only one to blaze that trail for years. It's almost like you stand alone in the dark.

Nicole has dedicated herself to her profession and over the years has made many personal sacrifices, but she could not imagine doing any other job. She loves her work. She loves the

⁴³ Muka – used to tie the umbilical cord or pito. Muka is harakeke (flax) fibre that is twisted into a cord to secure the umbilical cord before it is cut.

challenge of the work, she loves to challenge others, not just in midwifery but in the broader maternity sector. She loves to challenge thinking and explore how different people process topics or issues. For her, success is whatever each individual deems it to be and it may not have anything to do with being at the top. So, although she appreciates the significance in the roles she has been in, she has never accepted any of them for the accolades or for status recognition. Nicole's brother takes great pride in telling everyone what she has achieved, but she sees that his achievements are far greater. He is a good father, a loving partner, and has six beautiful children; that to her is success.

He sings my accolades, 'my sister is the president of the College of Midwives' but I say, I would much rather have been in your footsteps with a beautiful whānau and loving partner because the sacrifices I've made personally means, I have one son. I would have loved to have had a larger whānau, my relationship fell down when I was a student, as it does when you're studying right? Especially in health, midwives have pretty high rates of relationship breakdowns.

Nicole loves working in her region, in summer and winter she has togs in the car; summer there are stop offs at the beach or river and in winter the natural hot springs are close. Along with whānau these are the things that maintain her work life balance and sustains her in this job. Although the fight for better outcomes motivates her, she definitely feels there is a force beyond her control that is keeping her in the profession. She has literally felt tūpuna at births describing it as a 'swirling of energy around the legs'. These experiences have been very empowering, an energy that keeps her going. So when Nicole gets to be at home, in Te Tai Tokerau she always feels like it is her time to 'reset', before she has to go again into whatever situation she is needed or to wherever her tūpuna direct her.

I guess, there is a bit of my tūpuna in me about the fight. But, the way in which I do that is a strategic way. I'm not like turning up to the battle with my musket or anything, my strategy is to speak from the side or try to help in other ways. It's like motherhood, it never ends. Just because they've left the nest, you don't stop being a mother, you don't stop being a nanny or sister, it never ends. It's always a part of me.

So, at the end of my life, when I'm an old nanny, hopefully I've got mokopuna that are bringing me kaimoana every day ah! I can look back and think that I was successful because my mokopuna have a Māori midwife and my mokopuna aren't being treated differently because they're Māori. They're getting the same care, that is rightfully theirs and the care that they are receiving is because they are consenting to it. That is for me, success because I know that then, my children or my nieces and nephews their mokopuna, are receiving the care that's appropriate for them.

Ko Pirongia me Taupiri aku maunga,
Ko Waipa me Waikato aku awa,
Ko Tainui taku waka,
Ko Ngati Apakura me Ngati Maniapoto aku iwi,
Ko Ngati Hinetu taku hapu,
Ko Kahotea taku marae,
Ko Ngamihi Taratu kaa me Hiamoe Tapuikore aku kuia,
Ko Sagan Rama taku papa,
Ko Irene Rama taku mama
Ko Joanne Rama ahau



Joanne is strong wahine Māori who has overcome many personal and professional challenges to advocate for birthing whānau. The endurance of her wairua, her innate knowing, and passionate personality have created opportunities for her to enhance the well-being of those around her. Her story is entwined with the direct implications of colonisation and the political environment in which she trained. Joanne will always be a birthing activist; she was taught by the best. She has spent most of her midwifery career as a self-employed LMC. She has never been employed by a DHB as a midwife. Her story of being a Māori midwife is compelling and brings clarity to her self-definition of now being a ‘recovering midwife’.

Joanne grew up in Pakuranga, Auckland. Her Dad, Sagan, married her mum, Irene, and because they were a ‘mixed marriage’ they could buy a home for \$15,000. Although the housing incentive was part of an integration process, Māori in this community connected strongly. Early in Joanne’s life, she recognised the importance of her Māori culture. Although the opportunities to do so were limited, she had an innate desire to learn as much and as often as possible. Joanne did all she could to surround herself with te ao Māori and te reo Māori. She was always the one in her whānau that would attend tangi with her dad, just to be exposed to things Māori.

Joanne’s whānau, like many, were living the stresses that evolved from racial discrimination and loss of cultural connection. She is very cognisant that witnessing alcohol and family abuse made her an angry young person and, hence, she grew up fast. In 1980, at the age of 14-years, Joanne’s mum got her a job as a nurse aide in an aged care facility. At 16-years she applied on Joanne’s behalf to do nursing training. Joanne loved her training but knew that becoming a nurse was her mum’s dream, not hers. It was, however, the start of a relatively long career in nursing and she celebrated the fact that she was doing something that was having a positive impact on her.

There is something about washing human bodies, holding people’s hands, simple stuff like taking temperatures and blood pressures, that’s nice. Hugging whānau when they’ve just

received bad news or a mum who has to go home to her other kids and letting her know that her little one is safe with me tonight. I'm staying tonight and I'll look after her like she's my own. Making sure that whānau were there when their whānau were dying or if they didn't have whānau I'd stay with them, just like we'd stay for a birth, we'd stay for a death. I'm really, really grateful for all of those experiences on my journey, all of them.

But at the same time, racism was normalised, inequity was normalised. All of a sudden I had to make a stand, and I had to learn to use my voice, believe it or not, but I used to be really shy. I used to say nothing. Awakening to the realisation that I live in a racist world and it is normalised bought out the activist in me. It was never easy making a stand.

At 18-years-old, Joanne was diagnosed with ovarian cancer. Best practice at that time was a bilateral oophorectomy, removal of both ovaries. Joanne knew this would mean no babies and she had planned on having heaps of babies. “*I know I'm having babies. I've dreamt about my babies*”.

The surgeon was her close friend and did everything in his power to ensure there was some possibility of pregnancy, but he was not confident. He fast-tracked her onto IVF, but they still had to wait for a year before they could start the process. While they waited, Joanne and her partner were doing the natural, rhythm method to try and get pregnant. Although she had physically recovered from surgery she was still grieving from the overall impact of the cancer.

Her first year of nurse training was nearly completed and Joanne discovered she was miraculously pregnant; she was overjoyed. During that pregnancy, Joanne had been suffering from severe perinatal depression, which had been misdiagnosed as depression associated with the cancer. It wasn't until her fourth pregnancy that she was formally diagnosed with perinatal depression. Joanne described the birth of her first baby as horrific. She gave birth in the maternity hospital and had a retained placenta of which the removal left Joanne feeling as if she had been sexually assaulted.

The most horrific birth experience ever. I remember looking at these two Pākehā midwives, especially the one that pulled the cord off and I knew that wasn't the way to birth a placenta. Even though, all I'd ever seen was active management this was a retained placenta. The obstetrician came in, assumes that I've had an epidural, assumes that I've had some pain relief because I'm a primip and I've just had a baby. He literally put his hand right up there to try and peel the placenta off. It didn't work.

Joanne was young when she started going to self-help courses that were mostly about finding purpose but were perceived as unconventional at the time. Joanne practiced her first ever karanga at one of these courses. She did the karanga to a room full of Pākehā women (and one Māori woman). It was at this class that she realised;

I just want to be of service to Māori women and create opportunities for them, and I want to be the best human that I can be. I had no idea what that looked like, I'm at the end of my nursing and now I don't want to be a nurse. I can't see within nursing how I can achieve that. There were no Māori providers and even though we had cultural safety it was still the same. A nurse is a nurse, is a nurse. But at the same time we're trying to say, well no, actually Māori nursing is distinctly different.

Joanne started her midwifery training in 1991. She didn't enjoy her midwifery training. There were no Māori tutors, not even for the cultural component of the course, and only one other Māori student. Joanne was continually challenged by the systems that created barriers to her getting the birth experiences she needed. When she finally did get to attend births, they felt amazing;

I just had the most amazing night, it was just amazing. Then I just sort of got it, this is what I should be doing, this is what I should have been doing. This is my happy place, this is so cool!

However, she also started to recognise how horrendously medicalised the care was. Third week into the course, Joanne realised she was pregnant. Her class had been told that if anyone got pregnant, they would have to leave the programme. She was able to conceal the pregnancy right up until her State exam.

Joanne decided she was going to have a home birth. Her father was not happy about a home birth, and on the day he locked himself in a room and stayed there the entire labour. When it went quiet, he popped his head out to see his moko being born. He had never seen any of his 7 children being born. This brought up many emotions and memories. He reminisced about babies being born back in his hapū. He remembered how the baby would be born, the whenua would get buried, and then the mama would carry on working in the gardens or how the Aunties would go to work then come home with a pēpē, or disappear out the back then come back in with a pēpē. Witnessing his moko being born had been such a healing moment for her Dad. Joanne reflects upon this birth as having tūpuna intervention, the right people were in the right place at the right time.

I felt that there was a tūpuna intervention at this birth. They showed me where Ray should be, where I should be, the men being there, the balance. Crystal created that, she created what she wanted when she arrived, she is so good at creating the world that she wants. Because it wasn't within me to create that for me. That was an amazing year.

During 1991-1992 the Nurses Amendment Act was being passed in parliament. Joanne was excited by what this would mean for midwifery but recalls the midwives around her in the

maternity units were not excited or supportive. These were tauiwi midwives who had never done any continuity of care and were also making racial comments to Joanne

...if I have to look after one more large family or Joanne you're white enough that you could get away with being one of us, you could make your life a whole lot easier.

Joanne had learned about the Treaty and was starting to become more culturally aware about activism and tino rangatiratanga. During 1992 Joanne attended the International Homebirth Conference and Birth in the 21st Century Conference; she was excited to have the opportunity to hear speakers like Sheila Kitzinger, Janet Balaskas, and Michel Odent. This was also the first informal gathering of Māori midwives. At the time Sheila Kitzinger was being hosted by Māori kuia to document traditional birthing practices in a book she was writing. During the conference, Māori midwife Becky Fox stood and challenged why non-Māori were learning about traditional birthing knowledge before Māori midwives. Becky had a significant impact on Joanne, igniting her desire to learn the history of midwifery and giving insight to how political birthing was.

Joanne qualified as a midwife and was pregnant with her third 'miracle' baby. This time she went into labour 5-weeks early, so needed to birth in the hospital. The night this baby was born Joanne reconnected with her previous midwife. Later, she took Joanne to a meeting about a collective that was forming called 'Putea o Pua'. There she met Janet, who became her first midwifery partner. This was Joanne's third birth, and it played a part in her life direction, particularly her direction in midwifery. However, because Joanne had not done an episiotomy during her training she was blocked from getting an access agreement by the DHB, which meant she could not care for whānau in the hospital.

I meet Janet and we just clicked. She's my soul sister. Chaz coming early, was like him telling me, if you don't get this, you're going to get this. My births had drawn me into this Māori midwifery world. Chaz had to be born at hospital for me to reconnect to Charlotte, to then find Janet.

Wāhine were now seeking Joanne out to be their midwife. Many of these wāhine had previously had non-Māori midwives and were telling Joanne about their experiences that weren't all good. The midwives they'd had were people who Joanne respected and believed were supportive of her. However, once whānau started choosing her over them, they started showing Joanne how they really felt. They would tell her whom she could and couldn't look after, that Māori deserved better care than she could provide, and that she was not experienced enough. Even other Māori midwives did not treat her well, some of that was because she was the youngest of the group. These experiences made Joanne become quite insular. She felt the only person she could trust

was her partner, Janet. However, she also had support from a very influential non-Māori midwife, Joan Donely. Joan became quite protective over Joanne and had a strong influence on her. Joanne respected her as another strong mentor in her practice journey.

It was so conflicting. I have Māori woman who didn't want anything, they just wanted to birth, so that's fine, then when it doesn't go that way, they (midwives) use it to criticise me. Janet always had my back, we were always solid but I still couldn't get the access agreement and, I had all these women booked.

Joanne eventually got an access agreement at the DHB but she had a caseload of whānau who were booked wanting to birth at home. She was not going to tell these wāhine to now birth at the hospital to suffice the requirements of an access agreement, so that someone could watch her do an episiotomy. To date in her career as a midwife, Joanne has only ever done one episiotomy. She also always did home visits, both antenatally and postnatally.

In 1994 Nga Maia formed and had its first hui. At that time the general thought was that traditional birthing was by Māori for Māori. Janet interviewed her Uncle who was a 'midwife', to gain more knowledge and understanding. He taught them about muka and birth positions, like being upright to birth. They also learned that for many iwi it was a male's role to assist wāhine to birth. To restore this practice Joanne started getting the Dads actively involved in their births, "we were like imposters. But, we're here so what do we do? We get the dads involved".

Joanne's first birth was a homebirth, the day labour started she progressed well to second stage but had been pushing for some time and the progress was slowed. The baby had passed meconium, and the heart rate started to have decelerations; Joanne started to think about transferring to the hospital. The mama's mother arrived, and she asked the midwives to leave the room so she and her daughter could have some time together. Her mum did karakia, then the midwives were invited back into the room; her presence calmed the environment. Joanne let the whānau know they were thinking they needed to move to the hospital. But with the next contraction and push, they saw a peep of baby's head. Up to that point they had not seen baby. Her mum did another karanga. While her daughter pushed, baby was born. Mum then did another karanga for the whenua. While Joanne was cleaning up she heard another karanga, this time it was for them, the midwives. The husband did a beautiful mihi to his baby and to the midwives. Joanne cried the purest tears she had cried since the birth of her own baby. She felt a longing in her she did not even know was there. She felt she had just been part of something that was more than just a birth.

I didn't even know what it was, I'd just been a part of. It just happened. The Māori midwife looking after a Māori woman... That's why I love my journey, I didn't know any of that, but

what I know is, sitting in it, and being a part of it, I could not deny any of it. The power of those taonga that not all whānau have. So when you experience it, you don't ever want to be anything but Māori.

Tragically, in 1996 Joanne experienced her first baby pass away. The baby had undiagnosed infantile polycystic kidneys, which had not been picked up on scan. It meant baby would not survive. This was not known until after the autopsy. Baby was born at home and needed immediate resuscitation at birth. Joanne's resus skills were excellent and she managed to keep baby alive until they arrived at the tertiary hospital. Once at the hospital the neonatal staff took over, baby was put on life support. When Joanne went in to see baby, she remembers a staff member saying to her, are you happy you've killed one now. Joanne's immediate response was; "well by the looks of him he's still alive so no I haven't, I haven't killed anybody". And she left.

The parents of the baby treated Joanne with love and respect. Some of Joanne's non-Māori and Māori colleagues were all telling her that she should not attend the tangi, that it was not her place to go. They were telling her that it was time for the whānau and that she needed to back away, another midwife in the practice could take over the postnatal care. Joanne had a different perspective on the experience.

The whānau sent me home that night, I'd been up all night and they sent me home. I didn't go home. I went to the house, and I cleaned up so that they didn't come home to all the birth mess. Then, I went home. I hop into bed, then the phone rung and it was the baby's dad. Baby had passed away. So I went straight back to the hospital, actually no I didn't. I howled like I have never howled before, and then I went up to the hospital. I get to the whānau room and the whānau were all in there with their baby. We had karakia, and then baby's dad got up and he did a mihi to us. He called us specialists, at the time I was thinking, I didn't know you had an obstetrician! And then I realised he was talking about us. Anyway he was amazing, it was just amazing. The parents love is deeper than any ocean, and it still is 23 years later. That is how they treated me at the time. We stayed with them and we went up to the tangi. That's Māori midwifery.

Baby was born in his membranes and I remember thinking why is there no water? The heartrate through the labour was perfect. Then I'm thinking, wow, he's glowing. It was like I caught a star. It wasn't like any other baby I've caught before. I can still feel that, feeling in my hands when I think about it. It's still there. Then breaking the, why did I cut his cord? I hadn't started using pounamu then. He was floppy so I did have to cut. I cut his cord, I cut his lifeline and in that moment I felt his wairua go...

This was my journey too, I went to the tangi, we were on this journey together. No, my pain is a different pain to yours, actually my pain is different in that there is some joy because I caught a God. I was chosen to catch a God. Who do you tell that to?

Joanne was feeling distraught and not wanting to be a midwife anymore. Criminal proceedings had started; she had been ‘interrogated’ by the police and the professional midwifery bodies. She went to the marae and spent the day with her kuia. After listening to Joanne, the kuia told her, if she is meant to continue this work, ask for a tohu. She also told Joanne she was hoha with her because she was not seeing the gift she had been given in the last week. Joanne definitely did not feel like she had been given a gift instead she believed she had killed the baby. The kuia calmly told her, no Joanne you did not go there to kill a baby. Joanne left the marae on a mission to be shown a sign, a tohu that would indicate to her to remain a midwife.

The tohu revealed themselves all in one night. The first arrived by way of the midwifery lawyer with the autopsy result of infantile polycystic kidneys, meaning baby could not have survived outside of his mama. The second tohu was a birthday present from her parents, a black pounamu taonga that Joanne ended up wearing all the time. The third tohu, was attending a birth in the same night. Joanne described it as the most amazing birth. She arrived at the home and baby just fell into her hands. If she had not received the autopsy report and the taonga from her parents, Joanne would never have gone to the homebirth. After that birth, Joanne felt settled to continue being a midwife; however, she now understood how hard the journey of Māori midwifery and being a Māori midwife was.

In 1997 Joanne took the year off to learn te reo Māori. She also began working with tohunga Papa Hohepa and his healers network. It was perfect timing and Joanne was hapu again. This baby was born on the day the baby died the year before, and Joanne’s 9-year-old daughter got to catch her little sister.

The reward for actually practising Māori midwifery which to me is not muka, it’s not karanga, it’s not karakia, it’s not any of that, it’s whānau ki te whānau, whenua ki te whenua. As much as it was about putting whānau hands in my hands, the more you let whānau own their experience, the better they will be. You just make sure that they bury that whenua. That is the starting point of decolonisation for many of our whānau. And that is my thing I’m most proud of in my whole 18 years that I survived being a midwife, was every whenua went back to the whenua.

Joanne’s last pregnancy in 2000 was with her twins. She birthed in the hospital after going into labour at 32 weeks. Joanne birthed her first twin standing up on the hospital bed, the second baby was breech but she refused to get into the lithotomy polls. For most of the labour and birth Joanne felt great and in control but after the first baby was born the obstetrician came in and, without Joanne’s knowledge or consent, started the syntocinon drip to keep the contractions

going. Joanne felt like poison was entering her body, she was not happy. That moment of losing control ended with Joanne experiencing post-traumatic stress.

I know what they stole from me, it wasn't just a little bit of synt[ocinon], you took away my power. So, pretty much from 2000 to 2003, I was completely powerless in my life. Post-traumatic stress disorder is a terrible thing to battle. Having flashbacks and that feeling of disempowerment... but that birth, the way I birthed my twins, made me such an urban legend.

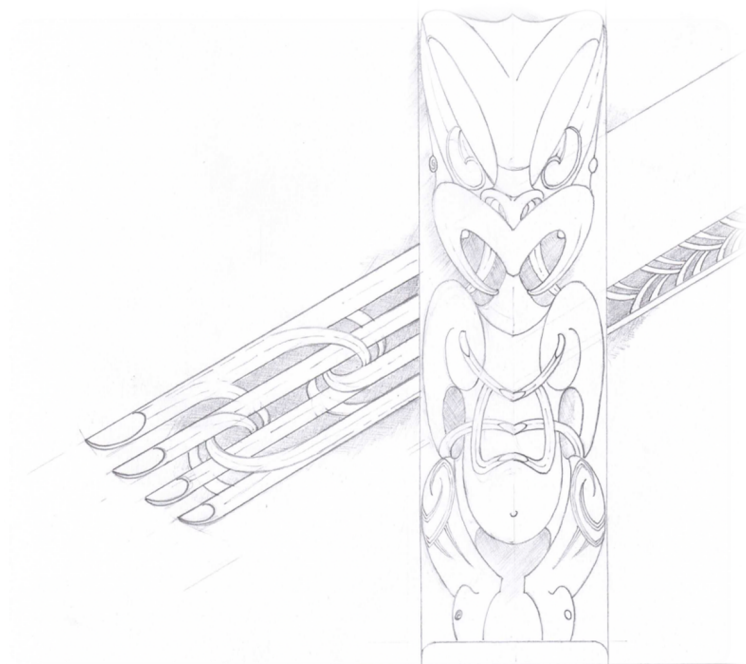
Joanne celebrates the positive outcomes of Kaupapa Māori models and recognises the need for more research to challenge the dominant culture that denies Māori the opportunities to be Māori. One of the first things Joanne was taught by her nan on the marae, was “to milk the cord to make sure the baby got everything”. Those knowledge systems were already there, such as the power of muka which is far superior to the plastic cord clamp. But she is also not so belligerent as to believe that everything that happened 200 years ago is applicable today and will happen. She is very clear that isn't the case. She is very philosophical and although her midwifery pathway was not easy, she remained steadfast in her commitment to birthing whānau and grateful to those that imparted their time, knowledge, and wisdom to her. She is mindful of a lesson from a tohunga who said to her;

It's in our DNA, it's just waiting.' So, it all makes sense now, the things that have unfolded, Putea o Pua, Ngā Maia and not getting an access agreement. Being a Māori midwife to me has been about going to those Oranga Tamariki⁴⁴ meetings and walking out with good outcomes because I have committed to visiting that mama every morning. Or, it's taking mothers that have a little bit of PND [post-natal depression] up to spend time getting some healing. Listening to them. It's all of that. It's being a nanny, it's being a good nanny to my mokopuna. I actually think that my time in midwifery, what I did in Nga Maia and what I did disturbing all those people, has actually make it a little bit easier for others that have come. I think every generation of us has made it just that little bit better. I'm not sure why we don't acknowledge our wins but we don't do that well. But, we do have to be real and have the conversations about the racism that lives within midwifery. It will not go away unless we actually say it's there. There is no place for racist men or women to practice in this profession. They don't even try and hide their conscious bias, so as a profession we need to weed them out.

So, I know I don't quite fit the definition of a midwife anymore. But I definitely know that I will always be a Māori midwife. Towards the end of the journey of midwifery I knew that I had arrived because I never got to do anything anymore, all I did was write notes. Whānau did their own births. That's what I wanted. And now, there's wonderful new

⁴⁴ Oranga Tamariki, also known as the Ministry for Children, is a government department in Aotearoa responsible for the well-being of children, specifically children at risk of harm, youth offenders and children of the State. Definition obtained from Oranga Tamariki website (<https://www.orangatamariki.govt.nz>).

midwives out there that let us do that. That is why we chose our whānau midwife, because she let us do our own thing. If you let us do our own thing, then I'm happy with you. I have had the most incredible journey – hey I met you! I met Janet. I met Rose Pere. I learned how to love myself and I'll be forever grateful for my children and their birth journeys to the evolvment into this Māori midwifery space.



Ko Hikurangi te maunga
Ko Waiapu te awa
Ko Horouta te waka
Ko Rahui te marae
Ko Te Whānau a Hunaara te hapu
Ko Ngāti Porou te iwi
Ko Makere raua ko Wallace Mackey oku matua



Kendra is Ngāti Porou; she was born and grew up in Gisborne, most of her whānau live there. She hails from the tiny East Coast settlement of Tikitiki. Her whānau have a strong connection to Tikitiki, both her mum and dad grew up in there and have either lived there or in Gisborne their whole life. She is the youngest in her whānau and has two brothers. Kendra moved away after she finished school to Palmerston North to study and lived there for about 10 years. Then she felt a huge pull to come home. Her parents were also getting older and she wanted to be closer to them.

Kendra's skill and passion for her mahi as a midwife is expressed in her kōrero. She is confident, strong minded and will fiercely advocate for whānau and those she respects with what can only be called Ngāti Poroutanga. She has worked as an LMC and Core midwife, contributed to education within the DHB, and is very much respected by her peers. Kendra has the aptitude to thrive in any midwifery situation to which she puts her mind. Currently, she is practising as an LMC midwife in Tairāwhiti and works within a vibrant, successful partnership. As the youngest kahu pōkai in this research, her commitment to birthing whānau and Māori midwifery is evident as she tells her unique story.

Kendra never had prior knowledge of midwifery, nor had she ever met a midwife. There wasn't a significant event or a birth that she had witnessed that made her want to be a midwife. But in her last year at school she had to decide what she wanted to do; all she knew was it would be down a health path. Originally, she explored physiotherapy, but she knew it wasn't right.

Midwifery just came into my head, and it was like, yeah that's it, that's perfect! The more I researched about midwifery the more, there was no question that this was meant to be. So, I didn't choose midwifery, it just came to me and then I couldn't think of anything else that could be any better. I found out after this that my great grandmother, Margaret Peachy was a lay midwife up the Coast. She birthed all the babies in Tiki.

Because she was young and a school leaver, she felt like she had to really prove herself to be accepted into the midwifery programme. So, to help her chances she went to antenatal classes. Successful in her application, she moved to Palmerston North and commenced the programme, she was 18-years-old.

It's hard to prove what you feel in your heart, why would you believe an 18-year-old? My mum spoke to a midwife here before my interview, asking about midwifery and what could I expect in my interview. I did as much as I could to prove that this is me, this is for real and not just a phase. My family were worried because they knew that I was so headset on this path that if I didn't get in they didn't know how they were going to pick up the pieces. But I wasn't concerned, I didn't have a plan B, I knew I was going to get in and I'd be moving.

There were about 19 in her class and 6 were Māori. They had a Māori lecturer who was also Ngāti Porou. The other Māori students were much older than Kendra and had each other, so she would often be in the background, taking in as much as she could. Kendra valued having a Māori lecturer, acknowledging the positive difference she made to her midwifery pathway. Being away from home, Kendra felt her lecturer had a sense of responsibility to check in frequently with her, and although Kendra found it annoying at times, she knew it was to ensure she succeeded, so Kendra appreciated the time she spent with her.

I think I got treated differently by her. I could do no wrong in her eyes, we would have our own little meetings and catch-ups, it might not even have been about midwifery. She may have just come back from home or I had just been home, we'd just talk about home. They weren't random catch-ups, I'd go to her office in the Māori unit or she would find me, we would always meet up outside of class. My other classmates didn't know about it and at the time I didn't really think too much about it.

Kendra was one of the first school leavers that the programme had accepted. When she graduated, they told her that she was a 'trial' because they weren't sure how it was going to go; but after she was successful, the programme opened up to accepting more school leavers.

A Māori guinea pig! I think if they had told me that at the beginning I probably would have worked harder, I would have had more to prove. But, because I was the baby in the class I always felt like I had to prove myself anyway. Today, universities have to prove how much they want students, whereas back then it was us proving to the university our worthiness of being there.

Throughout her midwifery training Kendra was very conscious of her age. The first year of the programme was mostly theory and because she had done much of the science theory she did not find it too challenging. Writing assignments took some time to get used to but she found the practical skill components enjoyable. Kendra always requested to be with a Māori midwife for clinical placements. She ended up with another Māori midwife from home for much of her

training. Her greatest challenge was her own personal development and growth, particularly in finding her confidence and place amidst older, more mature women. In reality, finding confidence didn't happen in the 3-years of the programme, it came much later.

Kendra graduated when she was 21-years-old and went straight into LMC practice. It engrained a strong attitude and a constant facade that said, “yes I know what I am talking about”, to combat the feeling of being questioned about her age and, therefore, ability to be a midwife.

My challenge was always about proving myself, but I'm not sure if I was proving myself to myself or the rest of the world! I wanted women to know that I was worthy of this and my age played a huge part in needing to prove that. I think I lied about my age for a good 5-years, I just added another 5-years, I was always asked about my age.

In her first year of practice, she had a huge amount of growth. Because her partner was another new graduate Māori midwife, some people were very critical of them. However, Kendra found they supported each other well because they were at the same level and they also had great mentors. Kendra's mentor was a Māori midwife with whom she had done two significant placements as a student. She valued all the skills, knowledge, and mātauranga of how to be with women, she learned from her. Her mentor was well respected within the whole community and Kendra held her in very high regard. In Kendra's second year of practice, she was devastated when she got the news that her mentor was unwell. Kendra wanted to support her somehow as she felt she was indebted to her.

So, I decided I was going to repay her by giving her time with her whānau. I would do births for her and her clinics, I had a small caseload so I had the time to be able to do this. She ended up leaving practice, so I took over most of her caseload and then we just lost touch. This was a woman that I spoke to at least once a day, about everything.

As a young woman, Kendra negotiated some difficult dynamics within her working relationships; but to the outside world she adamantly maintained her loyalty to the partnerships.

When you are in a partnership, you keep everything between you both, you don't go telling anybody else all your raruraru. That's how we were. So it took me a long time to find trust again in other Māori midwives.

Kendra also found as an LMC fulfilling commitments to her own whānau, like attending tangi, was sometimes very difficult. When this happened the time away from practice was always laden with a feeling of guilt and not wanting to be gone for too long, so she'd make quick day trips rather than staying with her grieving whānau. Elements like this was part of starting to dislike the LMC lifestyle, and a huge drive for change. After 4-years, to preserve her own well-being she decided to leave LMC practice and eventually Palmerston North.

Kendra moved home to Tairāwhiti. While she was away from home she took a step back from te ao Māori practices. She almost felt intimidated by culturally strong whānau and didn't feel she resonated with their iwi practices. However, if she cared for Tairāwhiti whānau she felt instantly at home and confident in her knowledge of how to look after them.

I feel like when I went away my identity changed a little bit. It was a different iwi, different area and I didn't know their protocols and practices. So, it felt really good caring for whānau knowing they were from home, we had that common ground.

I was also quite young, so there was a huge combination of finding myself and my cultural identity, which I felt like I had that really well growing up but then moving away it kind of got lost, in that 5-hour drive! But now I'm home.

Kendra has found practising in Gisborne completely different. It is normal for the maternity team in Tairāwhiti to integrate culture into their practice. Non-Māori midwives and obstetricians are respectful to whānau Māori. It is not something that is learned in a workshop or on a study day, it's just normal practice that is learned doing the job and observing each other. Kendra had not experienced this level of cultural awareness among non-Māori colleagues until coming home.

So, when I came back here and saw that I was just amazed. That is what made me think, Māori midwifery is really awesome here and why I've only known Māori midwifery since coming home. And it doesn't have a label but, it is all about respect. Even our obstetricians, who are all American, they are just so respectful to our Māori whānau, they get it. So it makes my heart really warm knowing that that's how we practice and how normal it is.

Kendra strives to example a very non-judgemental manner, acknowledging that everyone will come with their history and pathway in life. She strongly believes that if practitioners come from the perspective that everyone is unique, then the way care is offered provides a whole different level of understanding and relationship. Within the maternity unit at Tairāwhiti Kendra believes these are the basic, normal practices that keep 'Māori midwifery' easy to do. From this point, other cultural practices will be on different levels depending on what the whānau want or need, including wāhine who have had a really hard path. They are the ones that need midwives to stand on the same level as them and truly work in partnership.

Women who may have a background of domestic violence, drugs, alcohol, things that they may not choose to be in or do, will often be on the defence and I always know, everyone has a story. Just like you or I, we have a story of where we are and why we are here. If you can plant a seed or half a seed of love and trust then that is going to change their outlook on you as a midwife and all other midwives. Engaging in care will be easier.

I had an experience where a woman who had just had a section wanted to discharge from hospital a couple of hours after the surgery. She wanted to get up and go home, she got up

and fell over. It took a whole afternoon shift to figure out why she needed to go. Once she told me, I totally understood. Everyone had been so judgey toward her, saying 'why would you do that, risking your health?' And, yes why would you want to discharge that night? Straight away, I thought there has to be something else going on. Acknowledging this, and having the skill to be able to get the story out, for women to be able to trust you so quickly that they pretty much share their whole life within a few hours.

Kendra has always felt well supported by her whānau and her colleagues. Whānau create safe spaces on varying levels and are often the first ones as midwives we turn to, but their ability to relate and empathise, particularly in relation to clinical situations, is limited. Therefore, it is crucial to have professional support. Part of this network for Kendra is her 'go-to person', another local Māori midwife. She is the person who understands Kendra's process of debriefing, she knows what to say and, just as importantly, what not to say. Kendra feels that she understands her better than she understands herself. When needed, she provides the space for Kendra to talk and doesn't necessarily give advice. She just listens.

She knows that I'll beat myself up and then I'll start feeling better about myself. And I can do this safely because I know that she is not going to judge me and she just knows the way I react to things. She knows what I am going to react to and how I'm going to react. We had a significant event happen at work, I said to her, well buckle up this is going to be a good debrief ride! She already knew, she was prepared. I feel myself lighten up talking to her and I feel safe with her.

Everyone has a different part to play in supporting you as a midwife and I had a whole circle of support. Debriefing with whānau is different to debriefing with your colleagues, you can only go into so much detail with whānau, colleagues have another depth of understanding. So, everyone had a small part to play in supporting me during my LMC time, whether they knew it or not.

Māori midwifery for Kendra is about whānau and te reo Māori is pertinent to maintaining this worldview. The use of reo Māori by health professionals is one way of keeping a high level of comfort and safety for whānau. Kendra is also very aware that there is often a much deeper context to situations than whānau are expressing. She has grown to appreciate this in the context of her practice. Whānau do not do extreme things just because they choose to or because they are irresponsible, as often assumed. Therefore, working in partnership means not behaving in a way that is condescending or arrogant, so whānau can build trust in you, as the midwife.

You don't just get trust by just being the midwife or being Māori. You have to earn trust. And it's not just about the woman, it's the whole whānau. In fact, most of the time you are trying to get trust from the whānau, not from the actual woman. You can't just focus on the woman, you have to have everyone on board then it makes it a whole lot easier, being equal.

Māori midwifery is a whole circle and it's all about our whānau, because they are at the centre of it. Te reo is spoken in our workplace, our obstetricians use reo when they know. Small things that make a huge difference to the experience that wāhine have. It's not so frightening anymore, because the doctor is on their level. And, there isn't any judgement for who you are or where you come from.

Kendra enjoys learning and is enthusiastic to constantly increase her knowledge base. She has just finished her postgraduate certificate in midwifery and wants to go on to do the diploma. Building on her level of understanding in all areas of midwifery is one way in which she keeps herself safe in practice as it reiterates the infinite process of learning. Other variables she considers is maintaining a good work life balance but is something that Kendra currently struggles to achieve.

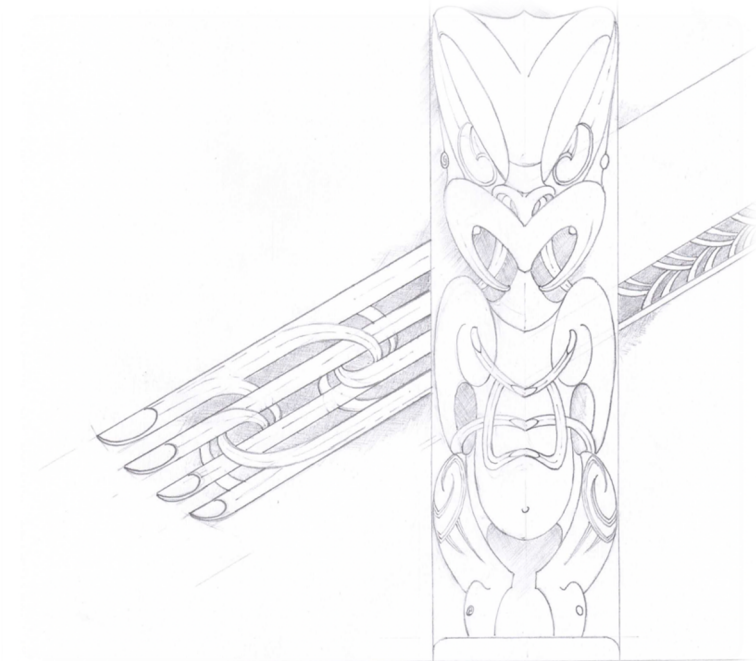
Every year I tell myself, I'm going to do so much better this year, I'm going to have really good work life balance and make sure my down time is my down time. And then, I go and take on another little job or add another paper to do, so that makes keeping the balance and self-care that little bit harder. Because you can't look after anyone else until you look after yourself. Part of it though is staying stimulated and not getting bored!

When I was living in Palmie, I would come home and just being home, being around family, going up the coast and visiting the urupā, it reconnects you, fills your cup. It made me feel really good, I'm home, my feet are on the soil. I'd go home then I could carry on. Now, being home I don't do that as often, I don't make that trip up the Coast and it's crazy it's only 2-hours away. But, it's important to make sure you stay connected spiritually because then you always remember who you are and why you are here. Your purpose in life.

At the beginning of our kōrero Kendra described herself as a 'midwife who is Māori', rather than a 'Māori midwife'. She believes the LMC model of care facilitates being a Māori midwife. As an LMC, you have the autonomy to develop your practice; you are with whānau from the beginning of their childbirth journey to the end; you can build a stronger relationship, practice the use of te reo Māori, karakia, and muka. As a Core midwife there are not as many opportunities to facilitate these practices. However true this may have been, with further contemplation, she has come to another understanding.

After almost 8-years practising midwifery in Palmerston North, I left. I found that transition really hard, saying goodbye to colleagues, friends, and lecturers that had seen me grow as a person, grow into an adult and grow as a midwife. Now, having been a midwife for more than 11-years, I've realised, I actually didn't know Māori midwifery until I came home. And when I came to that realisation I questioned what I meant by that, because obviously I was exposed to Māori midwifery before I came home. I had to think about what I saw and experienced as a student, as a midwife, Māori practices and why that hadn't feature before. I love that every day is so different and I learn something every day, albeit mostly about myself. I love the adrenaline and I have a huge appreciation for women

because they teach me so much. So, the only conclusion I have come to is, it has to be with being home, I'm home. These are my people. Here, I am a Māori midwife.



I te taha o toku papa;
Ko Te Paatu te marae
Ko Te Konoti te whenua
Ko Mangataiore te awa
Ko Rangaunu te moana
Ko Kotipu te maunga
Ko Ngati Kahu te iwi
Ko Kahutianui raua ko Pararata nga Tupuna

I te taha o toku mama;
Ko Tau Henare te marae
Ko Ngati Hine te iwi
Ko Hikurangi te maunga
Ko Kawiti raua ko Hine a Maru nga Tupuna



At the time of **Sharlene's** interview, she was a relatively young practitioner at the end of her new graduate year working as a Core midwife at a tertiary hospital in Auckland and was planning to go into LMC practice early the following year. Shar was a student midwife with me in her last year of studies. She had a natural flow and ease about the way she was with whānau. She has a beautiful calm presence but, at the same time, exudes a strength that is palpable. As we settled into our kōrero, Shar started with karakia and acknowledgement of her whakapapa. This was her space to share her story and she took ownership of that moment.

She began by telling me that no one in her whānau had been in a health profession and, in general, as a whānau, their health literacy was quite poor. However, her mother is a Māori liaison at the local DHB, and Shar had been in social services for over 15-years. This background motivated her to explore Māori health and led her into the academic world of health. Shar is a prolific weaver. She has always been involved in mahi raranga and is interested in the works of muka. For her, midwifery felt like a natural progression.

There wasn't really a connection between having her babies and becoming a midwife. There was no connection, passion, understanding, development, or growing the passion to want to be a midwife during her pregnancies. She was very young, naïve, and relatively immature in her thinking; she was still growing and developing. Midwifery was more a feeling and an idea, a seed that drifted in the wind.

I think I was just put there! Also along the way there have been tohu or signs. One day my dog dug up obsidian¹, it just sort of sniffed it up and it revealed itself as I was mowing the lawn. I've actually got this obsidian today.

¹ Obsidian is one of the stones that was traditionally used to cut the pito or umbilical cord.

But it was actually a natural progression that I fell into midwifery, I don't even really know how to explain how it came about but it just felt right. I literally just fell into midwifery, the idea just came. It was a flowing conversation from someone about midwifery, I sort of just heard it in the wind, I just heard it downwind and it sunk in my ears and fell in my puku.

The first time Shar applied for midwifery she was declined. Twelve years later she applied again and got in. Shar found academia really challenging, and reading information did not come naturally to her but; she could pick up a kete and read that pattern fluently. Raranga made sense to her. So, she was cognisant that her learning style was very different to the average person. Therefore, it was no surprise that from the start, right from the foundational papers, Shar had to work hard to achieve.

I remember the excitement of knowing that I'd passed these papers, I was driving and I got the call telling me you are onto your next stage, you can carry on with the midwifery programme, you're going through. And, honestly I did fist pumps in my car! I'm feeling that elation in my puku now, I cried and cried, then carried on.

Shar's journey through the programme was tough, not just academically. She struggled financially, and her support systems in her home weren't very solid either. She was living rurally, so travel was an added stain. In response, she got creative and courageous, and put a pānui out to her local community, informing them that she intended on becoming a midwife for her community but needed financial support to succeed. Shar had great feedback; the local supermarket and petrol station donated \$150 each for petrol and food per week for the 3-years she was in study.

For 3-years no questions asked, it just got sent, every week the envelopes just kept coming, every week for 3-years. Not a week went past without these vouchers, they were solid. I'd send them updates and transcripts of where I was at, not that they wanted it. My tank would get filled up and I was fortunate that we were able to access kai all the time, kai was easy. We were also fortunate enough to be able have housing, those resources were available.

We fell into housing opportunities, because there was a housing shortage, so it was not by chance either. I feel it was just mandated for us, ordained. It was all part of those tohu I was talking about that came along the way to make it a little easier. But what wasn't easy was the human element! It's hard being human, my ex-partner and I, we suffered a lot. I don't want to make this a thing but these things happened along the way to us and we sacrificed our whānau, it's a lifestyle midwifery.

As well as the financial support from her community businesses, Shar would consistently be at her local weekend markets doing raranga and muka demonstrations while finishing off any

midwifery assignments or getting her reading in for the following week. She would sell her mahi by koha, whether koha of money, kai, petrol for the lawnmower, or whatever people could exchange.

But actually what I got that was more than koha, was the elation of our kaumatua as they'd walk past and their eyes would light up with glee because it would evoke memories in them and then conversations would start. Kaumatua would walk past and they'd say, you know you could do it like this and this. I'd look at her hands and her hands are all arthritic and, she's mahi raranga from way back. She'd give me tips and tricks on, what she used to do and so I was always learning, we always are.

Shar trained in a small rural community, and for much of her training there was a sense of self-doubt. She struggled with the dynamics of the community of midwives; their expectations were high, and style of teaching seemed very stern. Her perception was that it was very territorial. Shar found it hard to study, learn, and comprehend in that environment. She has since come to understand and appreciate the element of protection toward whānau you care for and who, as the midwife, bring into their space. Shar struggled with the clinical learnings. Although she was an expert in certain mātauranga Māori aspects, her academic comprehension and competence took time.

I could whakawhanaungatanga the heck out of the chair but, when it came to the clinical side of things I struggled. Sometimes my clinical skills, my comprehension, and my competence throughout my training, particularly with some of the people who trained me, I struggled with. I struggled with that and I felt defeated, I just had this loop, this negative loop playing in my head that I wasn't good enough.

This time of learning impacted Shar immensely. It blocked her mind from being able to learn. Although Shar was aware of this element, she continued her clinical placement in this setting. She came to realise that because of her background, it was like a toxic relationship that she couldn't leave, but in the end, she left; it was either leave or not succeed in the programme.

We can't grow if we're not tuturu and tika from the start. We need a strong foundation. I reflected on it massively because it was massive, my mana was distraught. I didn't feel like I had a voice. I really felt like a bad midwife and I felt like my reputation as a student was rubbish, so I ran away. I came away and I was received well into another area. I was taken care of and my wounds were healed and I felt strong enough to fly.

I felt strong enough to carry on and continue. But what I learned from that, was actually the resilience to know of humility. Because this job keeps us humble, also what I learned.

In reflection, Shar now acknowledges and understands that she was unsafe. She accepts that she was very unsafe and incompetent in her practice. She believes she was unsafe with mamas, with her colleagues, and herself. Because she was constantly in attack mode, she could not retain and

maintain all the information she was being given. She does not justify it, but in order for her to move forward she has had to address it head-on.

The only way I was able to do that was to shift and be in an environment where I could thrive and that's what happened when I came down. That's exactly what happened when I moved areas. And like the kuia said, know who you are, look inside yourself first. That kōrero resonates. Almost 2-years on and I'm just healing. But I don't have the luxury of time, I've got to get things rolling, as well as earn a buck!

Shar recently completed her Midwifery Standards Review, a process every midwife does on a 3-yearly rotation. She found it hard. Shar had used bullet points as starting points for conversations. The reviewer did not appreciate this style and criticised her for not producing the usual standard of paperwork.

She was pointing to my material saying, what's this? It's just a one-liner. Normally, we have 20 or 30 pages, and you've only given us 10 pages of stuff. I said well, I can say in one whakataukī, that others will need to write in 10 pages, one whakataukī will have the same meaning.

One of Shar's bullet points was CPR. On one of her first days of working at the DHB she was on her way to work and was first on the scene of a koro who was having a heart attack. Shar acted quickly and efficiently and saved his life. She spoke about that experience; for her, it was more important to express it in voice rather than in words on paper. Writing is not her strength and she wanted to give the experience the justice it needed. He was a 75-year-old man who came to her months after the event to thank her in the way he knew how. He mowed her lawns.

They said, oh you should have written this, they said I cut myself short not putting it in. I thought, I'm not even going to play with you guys. I'm not a writer but I wrote to this list that they wanted, the stupid little checklist. And I did the Turanga Kaupapa, I did everything they wanted.

Since starting this research there have been many Kahu Pōkai who have received their moko kauae, but at the time of Shar's interview not many Kahu Pōkai had moko kauae so it was very special for me to sit with her and hear her story of how hers came about.

My moko kauae, I went to a whānau reunion up from where I'm from. My cousin came to me telling me she's having a hui tomorrow, and she really would like me to come and be a part of her hui. I said, "To what capacity?" She said, whatever it is you want to do, just come and bring your presence there. So I thought okay. I talked to mum, I said I think I'm going to get my moko, I think I'm going to receive my markings tomorrow mum. Then I went and talked to dad. Those were the only two people I wanted to talk to. And my girls. Dad couldn't stop kissing my chin, he couldn't, he just kept kissing my chin.

We all went to sleep in the marae, at 4.30 in the morning my nanny comes and pulled the blankets off, I thought I was dreaming. Nanny's alive! Just to clarify that!! She goes come

on, let's go. So we went down to the awa, stripped off, took everything off, jumped in the awa, there were two words exchanged. 'Get in'. That was it. It's 4.30 in the morning, get out and she had a white marae sheet. Nan wrapped me in it, I wasn't cold, I didn't feel the cold at all, I actually felt really, really warm. It was really nice. And then we got in my truck and I drove us. In my sheet, Nan goes, let's go. And so I already knew. She must have talked to the cousin. Nan is 86. We got to Ngunguru about 6.30 and I see mum and dad's car there but only mum is there with my girls and my mokos. I walked in, greeted by my big girl. Jumped on the table, and just held everyone's hands. Had a karakia when it was finished, got up, gave my cousin a hongi and throughout the whole process of receiving my markings, I never felt a thing. I didn't feel a thing. In the cupid's bow it was a little bit sensitive but that was that mental stuff, just that breathing, the ha. Nan was leading the way. I just had to put it out there that I was ready.

Shar has received some indifferent responses from her whānau about having moko kauae, particularly from older whānau members, questioning why she got to get it. The markings of her moko are seven generations deep, seven generations wear the same moko. The lines of her lips go straight into her mouth. This represents the removal of fear for her to speak her truth. She has experienced a level of discomfort with the lines of her lips but at the same time it has been strengthening for her, affirming in who she is as a Māori wahine.

About 10 or 15 years, I went to a supermarket and this old white man came up and says oh you're very pretty don't ever scribble all those things on your face. And at the time, this must be traumatic for me to still remember this, engrained. It's that little girl in me that doesn't say anything and that's how I felt at the time. So yes, some of my whānau were not happy. I challenged the idea, I didn't agree with some of the leadership in our whānau.

But, we do things as Māori so fluidly and naturally without even realising that it's actually a taonga. When I stand up as a midwife, I stand up with all these things, my moko kauae, my reo, and my raranga. There's so much to be said about humility and having the maturity to be humble.

Shar has had amazing growth as a midwife since working within the DHB. She retells the story of caring for a young mama who laboured well but needed an episiotomy, had a shoulder dystocia birth, then proceeded to bleed 2-litres. Shar succinctly retold the clinical story like a pro, not like a midwife who questioned her clinical abilities. She was in control, calm, and astute while leading multiple other health professionals through the situation. She celebrates in the development of her competence and confidence.

Calm. They're all calm, but different people handle those situations differently. I think I brought a little bit of calm. I think because I've seen how calm is and I've also seen chaotic. Five months in there, it's massive. I've seen the difference in my competence and my confidence to really manage and actually facilitate that situation.

As a Māori woman, I believe we've got those intrinsic tools that we integrate in our practice. There is something to be said about whakawhanaunga and whanaungatanga those innate abilities that we have. I've seen midwives relate to people, but that true connection is something different. We can all introduce ourselves and form a partnership but, I really believe that I come into a birthing room and I come because that's how I am at the moment, we're basically just meeting people, just fresh. We're that spotlight that goes on during the night and goes off during the day because we only come in and out of things you know.

Shar has an eloquent way of connecting raranga to the mahi of midwifery. She heard an academic speak who said, *ko au te awa, te awa ko au*. Shar talks to our connections with the whenua and everything that comes from it. For her, raranga is an extension of that. Harakeke is essentially a fibre, and humans are fibrous beings, so there is a connection.

What I'm trying to say is that when you connect the muka to the pito and those fibres are intertwined in one another they become one in itself, and then the pito drops off. I can't really articulate it the way I really want, but I just feel it. It's the connect, that connection. That is thought provoking in itself.

Shar has a beautiful relationship with mahi raranga, she uses the tikanga and processes of raranga in her everyday life. She describes it as a powerful tool that, for her, is therapy and how she maintains her inner safety and sustainability in midwifery. It is her constant connection to her tūpuna.

When I'm weaving, let's say I'm weaving a wahakura, for example, before I fold the corners together I've got to do a lock off, it's basically a support for when I stand it up so it doesn't fall apart. We all need support to stand up. So, I suppose that is the connection between mahi raranga and midwifery. When you are making a piece, you still need to support it with a lock-off, something to keep it together and to keep it strong. As too do we, with wāhine and whānau, and just people, humanity in general, we all need support to stand strong.

Shar goes on to talk about cutting off the hara². When the mahi is finished, the weaver cuts off the hara and takes it to the place it belongs, where it is usually buried. That is the process of finishing the piece, all the hara has been laid to rest, kua mutu. She relates this concept to when you have a conflict or something that needs confronting within whānau. In order to mend and

² Hara is defined in Te Aka Maori dictionary as a violation of a tapu, to commit a sin, violate the law, traditionally it was used primarily for an offence from the violation of tapu (www.maoridictionary.co.nz). An interpretation of hara in the sense of working with raranga, could be reconsidered to mean energy, the breath energy the light energy that sustained the plant to grow, any left overs not needed are taken back to the plant, to return that energy to the plant. When the finished piece is given to recipient, the pure energy of the piece that was made joins with the energy of the recipient, just like the energy of the left overs rejoined the plant. Karakia is done to negate any negative energies.

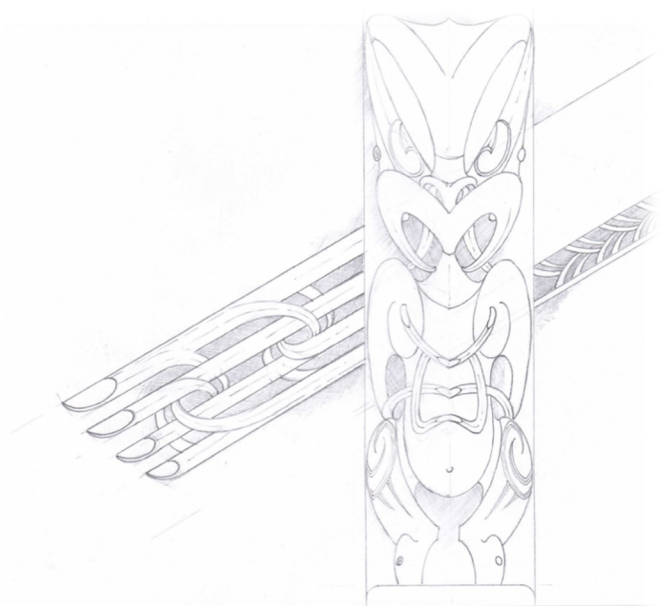
move forward, kōrero will happen at the marae where everyone has the opportunity to have their say, then the issue is 'buried', just like the hara, put to rest where it belongs. This is tikanga.

Shar spent years searching for something, for a purpose. She believes that being a Māori midwife is part of her purpose. When she is in the mahi, it brings her much contentment. Shar talks to the work of being a Māori midwife, like the mahi of raranga, as an extension of herself. It is a living energy that surrounds her and who she is as a wāhine Māori. Her depth of understanding and knowledge of mahi raranga is translated into her mahi with whānau. She utilises it in her work, life, and everything that she does.

I believe that humility and the fact that I'm here to serve, is what I bring. I feel so content about it when I'm in it and while I'm with mama and whānau. I'm not there to take over, I've seen people come in with a very powerful and authoritative manner, but I come from a place of service. I sit over here. I come from this place with our whānau. I know that we're supposed to be in partnership but actually, this is where I am in my way. Who am I to say that I empower them?

The journey to becoming a midwife, we've all got our story and the story continues. It's still continuing. The community was an amazing support and is an amazing support. I owe a lot and they have been very patient and I know I will return. But, they're not calling me back in a hurry, when I'm ready and when it's right. I need to gather my skills first.

Shar expresses herself in a very humble way. She believes as Māori, we do things so fluidly and naturally without even realising that it's a taonga, and this is her strength. When she stands up as a midwife, her reo comes from her love of whānau, hāpori, raranga, and all that surrounds her in her mahi. She acknowledges the small things because she knows they are important, and her strength is her willingness to share her mātauranga. Shar quoted personal communication with Gordon Toi Hatfield, "The individual is the testimony to the moko, not the other way around".



Ko Mamari toku waka
 Ko Ruanui te tangata
 Ko Tawhitirahi toku maunga
 Ko Awapoka toku awa
 Ko Parengarenga toku moana
 Ko Rongo Patu Taonga toku Wharekai
 Ko Waimirirangi toku Whare Tipuna
 Ko Potahi toku Marae
 Ko Toko o te Arawa toku urupa
 Ko Te Aupouri toku iwi
 Ko Te Kao toku turangawaewae
 Ko Aroha Camille Harris-Tutaki toku ingoa



Aroha is a child of whangai⁴⁵. She was raised by her Nan Ngarui Everitt (Te Aupouri – Te Kao) and her Koro Taniwai Harris (Ngapuhi – Mangamuka) from about 6-weeks-old. She grew up, as she says, in the richness of her grandparents and her aunty and uncles as her siblings. Aroha was the youngest, the baby, as she still gets called. Because she was bought up by her nan, she only knows that her mum gave birth to her on a snowy night at a little hospital in Twizel on the South Island. She is a mother of three and a beautiful Māori midwife. Her partner is integral to her being as a Māori midwife and supports her endlessly to be successful. Her whānau sustain her and keep her balanced in her life and in her mahi. She deeply values having been brought up by her nan and koro, giving her unique insights into life and the world around her.

My nan and I were just speaking about how I would never have learned the things I did if I had been brought up by my parents. That's why I say raised in the richness of my grandparents because I'm just so thankful for that. I am thankful my mother gave me that.

Aroha is an impressive Kahu Pōkai. She trained after a long successful career and business ownership. Her dream to become a midwife started when she was a teenager and was fulfilled as a mama of teenagers. She is a proud, strong, and adamant activist of kaupapa Māori; being a midwife simply complements this side of Aroha and allows her to make an impact in important places. From her childhood experiences, Aroha is passionate about enhancing the role of tāne Māori in the birthing arena to promote the well-being of their whānau. She expresses herself with a humbleness that underestimates the influence of her presence and way of being has upon whānau. Her story is inspirational to promote change in the simplest of ways.

⁴⁵ Whangai is defined in Te Aka Māori dictionary as a customary practice. Often a first child was brought up by grandparents or adopted by brothers or sisters of a parent but almost always the foster child was a blood relation, usually a close relation.

Aroha first experienced birth as a 15-year-old, watching her friend's sister give birth. Whether it was seeing a birth, or just being in her, from that moment, she wanted to become a midwife.

At that stage, I was back with my mum, so my world was a bit disrupted, and I wasn't doing very good at school. I went to the career's advisor and I spoke to her about being a midwife, she told me to go and live a little first because no one would want you near them. But, I've always been headstrong. So I got the papers and I saw that you had to do nursing first, that didn't spin my wheels at all. I wanted to work with mums and babies, with the well, not with the sick. That was as far as my brain took me, so I became a hairdresser.

Years later I spoke to my nan who lives up in Awanui. She told me that when she was little, she would wake in the morning and there would be a new baby in the house. Women would come to my great nan, her mum, she was not sure if was because, Papa her dad, was the one with the car to get to Kaitia or if that was just how it was, but often she'd wake and there was a new baby in the house. It's funny when you take the time to sit and speak with our tūpuna, the stories that then get shared. So, after all of that I could say it was the experience back at 15 or I could say it was just in me. I would like to think it was just in me. And, I've always wanted to work with my people.

Significantly, when Aroha was 10-years-old her nan left her papa. She took Aroha and moved to live in a little flat. This event broke her papa and, tragically, he took his life.

From that point everything changed for us. The next sibling up from me, my uncle, my uncle-brother, found dad. He's pretty much been homeless ever since. So I guess a driver for me is the lack of support our whānau had and how broken it still is today. My nan didn't know what to do so she just packed up, sold the house, and moved back to the whenua.

That experience is a real eye opener for me today. I don't know if it's because of my koro but I have a strong passion and focus for our tāne and their involvement in caring for their baby. We know the statistics represent us in all the worst things but I'm a firm believer that in the position that we are in as midwives, the precious space that we share, we have the ability to help reconnect our tāne in a te ao Māori way. Sharing their hapūtanga and the birth of their baby equally. I really believe from that point healing will occur in multiple areas. My experiences probably have something to do with it, but it also breaks my heart when I try to access support and that it is no different now than it was all those years ago. Mental health is so important to me.

Aroha grew up with her nan speaking te reo Māori to her, simple reo, like shut the door, pass the butter, and be quiet. Although te reo was spoken in her home, Aroha was surprised when her nan took a job at a college teaching te reo when Aroha was training to be a hairdresser. She believes she got more te reo from her Nan than her mother did. Aroha would call her nan mum and her birth mother, mum. When she was at primary school the school rang her nan to tell her Aroha is confused, she calls you and her mother mum. They suggested she needed counselling,

but Aroha was very cognisant about who was who, and that their Pākehā worldview was the only thing that was confused.

When Aroha was 21-years-old she had her first baby. She didn't know much about pregnancy or birthing but she knew if she went to hospital things would happen to her that she didn't want to happen and she was a well woman. At that time, homebirth wasn't at all in her thinking so she went to a birthing unit. She had a midwife who was really supportive of what Aroha wanted. Twenty years later, her eldest child was 15 and youngest 11-years-old, and she was very surprised to be hapū with number three. She had a successful hairdressing business, but being pregnant was her catalyst to get off the pathway she was on and get into midwifery.

Aroha has had many special moments as a midwife. She gets very emotional at births and tunes into the wairua of every birth. She feels privileged to be present at all the births she attends and appreciates the learning she gets from whānau. She had a home birth, the first home birth for this whānau in a very long time. When it came time to push, all the whānau left the room, aside from her brother and father. Her whānau knew without speaking that they were the only ones who needed to be in the room. Her father and brother supported her with her breathing, did karakia, and, as baby's head was crowning, her mum, nan, and sister came back in the room and did waiata. As baby was nearly born, the whānau did haka. The whānau shared with Aroha that a few months earlier their koro has passed away in that room, so the process of karakia and karanga was to settle the space. Aroha was in awe of their wairua and the feeling of their koro being present in that moment of birth.

Then once baby is there and all wrapped up like a little burrito and everyone is all happiness, her mum pulled me aside with tears in her eyes and thanked us for, what they had forgotten or had allowed to be lost because she was a little bit sceptical at first. She had tears in her eyes and said, it was just like everything happened so right, the karanga came, the waiata came, it just all came. She was so thankful, that it will never be any different now. That will be how it is for their whānau and there were little ones around so they saw. That birth is one that I'll keep. There are lots of experiences but that is one that I'll keep that was pretty special.

My knowledge is so little I love that when I get to spend time with whānau you're always learning, all the time. And it's so humbling when it's not me to be thanked, but I know that's the only way she could express it what she was trying to say but I'm grateful that I could be the person that facilitated what is always been there in that whānau, just a little bit tucked away.

When Aroha first meets whānau who are requesting her care, she will meet with them at their home. She always wants all the whānau to be present at that meeting. It is important for Aroha

to go into their space for this first visit. She doesn't want a clinical space to create the relationship. As Aroha reiterates, she pays particular attention to encouraging the men to be present at as many visits as they can. She doesn't accept the kōrero that birth is for the women. She makes sure that dads know this is their time, too, encouraging them to talk to their baby in the puku and make a connection to their pēpē just as much as the mama. Aroha also ensures that the whānau has all the information about hapūtanga wānanga, and encourages the whole whānau to attend. Again, her emphasis is on the whole whānau welcoming this baby.

Aroha is committed to homebirth but also does births at primary units. She exclusively cares for whānau Māori. She works alongside another Māori midwife, and when they first make contact with whānau, they will share their whakapapa. But, as much as they want and need to work with whānau, the expectations that come with this are often self-inflicted, extremely high, and can impact their own whānau life.

I'm not here to look after others there's lots to look after others but there's not many to look after our own. That's the whole reason that I put myself out there and did the degree and put my family through all of that, it was really because I want to see my own thrive and I want to bring my own to the front of the line, it's that simple.

Having whānau in your care is more meaningful, and although you always want to be there, things happen in your own life, so I do feel we are under pressure, and it is hard to take time out. But there's not enough of us so it can be pretty relentless. I lost an uncle who I was really close to, he was like a father figure, he passed unexpectedly and I always regret not making the time to spend with him, this job is so taxing.

She has noticed a lot more whānau want to home birth and are motivated to maintain their health to be able to home birth. Aroha provides simple but thorough information to ensure whānau understand why she is advising; for example, iron tablets. She has found once whānau have the knowledge they are enthusiastic and ready to do whatever she suggests.

Women take iron tablets and never know how to take them properly and what the benefits are or how they will greatly impact on their health outcomes. So explaining things as simple as this, creates an equal relationship. Once we share that information with them, they're blown away and are so on board. Often we head into labour and birth with awesome iron levels and nicely hydrated women, drinking 2-3 litres a day, eating iron rich kai, having heaps of boil up or whatever it is they like.

It is important to Aroha to be surrounded in her daily life by other strong Māori midwives. She has nurtured a network of colleagues with whom she is often in contact. Debriefing with other midwives is crucial to her and she is constantly sharing, asking, and questioning anything that doesn't feel 100% in her puku. These are the elements that help to keep her clinically safe, and sometimes the line between clinical and cultural safety is very fine. Aroha and her midwife

partner took time and went through a consultation process to name their practice. These aspects were important to ensure they got it right. Additionally, they also ensure they promote authentic products such as kawakawa treatments or where to source muka. Whānau are always in the forefront of making sure processes are followed to keep everyone safe.

I'm always learning off other whānau. My thinking might go this far on something and they'll broaden it so that I get a more embodied, fuller understanding. I'm always conscious and respectful in the presence of other whānau and what they can teach me. How to do things even down to where we get our muka, first of all it's about whānau going to make their muka and learn together. But, if we get it, we know where we got it from and the tikanga. It's not from a FaceBook site or the kawakawa balm site, we buy kawakawa balm, we have it made for us and we gift it to all our mama once they've had baby. But we know the mama that makes it, where she sources her product and the tikanga that goes into all of that. So then I'm okay to give it.

I saw a beautiful saying the other day and it went something like, that feeling in your puku is your tūpuna telling you to ask or telling you to be wary. I'm quite big on that, so I'm not shy to ask and I'm getting better at listening to that puku, you've got to do that to keep safe. With this mahi, you need to be able to ask because seriously you have lives in your hands and well-being in your hands.

So that's staying safe clinically, listening to the puku, asking the questions. It's hard to put into words what keeps me culturally safe, it is all what we do just naturally, that we think is normal, but it's not. Like listening to your puku. Taking time to name our practice. That keeps me culturally safe. The other side of staying safe for me is, coming home to the whenua around me. Then the energies of people like yourself and the rest of our Māori midwifery whānau and sharing because you get a real, heartfelt, caring answer, whether you want to hear it or not. So the real picture, not just a clinical perspective. Immersing myself in more learning to understand more. That is the sort of stuff that keeps me safe.

Aroha is very aware that there are times as a midwife when you have to 'tap-out', whether it's for a holiday or even just a break from caring for someone in labour. She was looking after a first-time mama in labour, Aroha had not expected the labour environment that this mama created. She was birthing in the pool.

She turned into this crazy beast, she was in the pool splashing around from side to side as she was contracting, the water is flying out as she had this hard core, metal, rap, swearing f-bombs, aggressive music that I would never have thought she'd have. I had to say to my midwife partner, I've got to tap out girlfriend, I'm getting sucked out of my energy in there. So she'd go in for a little while and then she'd come out, then I'd have to go in and then afterwards she was this lovely Māori first-time mama with her baby but during the labour.... Shucks it can be hard work. That's listening to your puku, to look after yourself and the wahine you are looking after.

Aroha cared for a mama who previously had witnessed a traumatic birth, and the whānau were feeling very defensive and distrusting in how their care would be. The nan arrived with very aggressive energy at an appointment, ready to protect her daughter in any way needed. Aroha showed her manaaki and aroha to calm her presence and start to build some trust, she broke the negative energy simply by giving her a hug and holding her hands.

Because you approach things the way you do, I gave her a kiss, it was only natural. And, held her, then by the time they left it was all okay. She just had to come and suss it. It's just that distrust that they carry. They carry the distrust of how others have treated them, and they're ready to be treated like crap all over again.

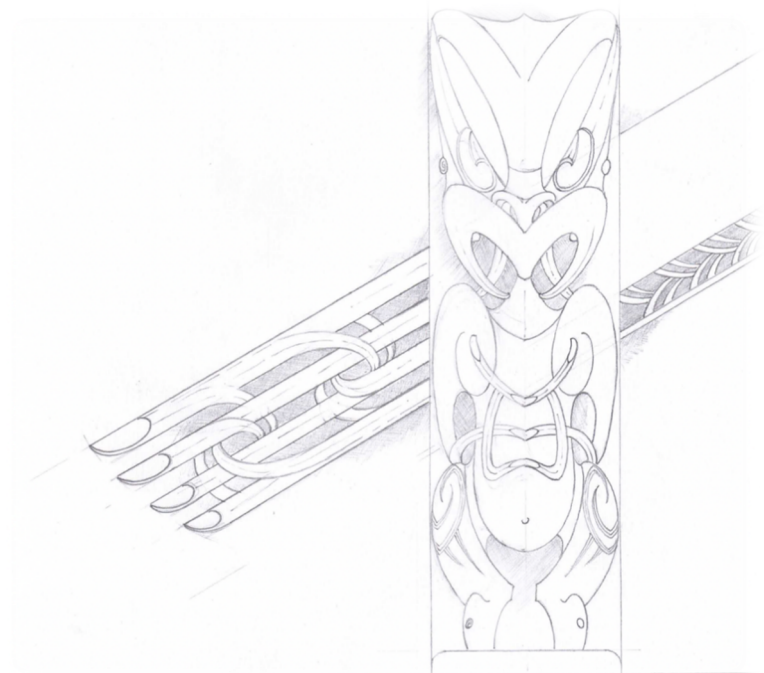
Aroha is not afraid to be confronted by whānau about issues that impact them or to address situations that inhibit her ability to create safe environments for whānau. She would rather be in a position to make change or at least highlight change needs to happen than not. Aroha has multiple examples such as: she challenged the midwifery professional body to provide cover to allow Māori midwives to be able to do te reo Māori, she has activated change within a large DHB of signage that Aroha pointed out was racist in its suggestion, she brought attention to inappropriate documentation systems that left Māori names incorrect, and she has no hesitation in addressing institutional processes and attitudes that inaccurately label whānau.

It's tiring though, because it's constant, why should we put up with it? Again and again. Just get names right. I had a mama that I found out was being discharged with baby, then I have staff saying to me, did you have a mum that you didn't even know she was in labour, she had a baby and she was a first-time mother? I said yes, she asks, "why do you think that was?" I say, "really?" She was judged and assumed to have no midwife and that was it. End of story. Because it's pretty clear on her notes that she had a LMC. But no one bothered to look. But, sometimes time goes on and there is so much that whānau bring it back to your attention to remind you to act.

Being a Māori midwife to Aroha means that she has the opportunity to share with whānau her skills and what she has learned so they can thrive as Māori. Her motivation is to elevate and inspire whānau to be healthy, educated, and successful in their own definition of what that means for them. She is very humble in her ability to be the midwife; but for her that simply means she has the opportunity to be in that position and share her knowledge.

That is what being a midwife means to me. It's not the title of midwife. It's nothing. I value the opportunity to be in that position, to share. And I don't know if I'm dreaming but I fully believe we make such a difference. Like the homebirth, that is one more whānau that have healed something, have gained and those kids have witnessed that. It was just so normal as it always is to kids, oh aunty's had a baby, cool. And for that young tāne, her brother, who was probably early 20s, so normal for him. I would like to think that is the growth of the tāne we used to have, that he will be like that to his wife and to his daughters. I love that. Whānau breaking down why that karakia was there and why that haka was done,

the dedication of the words in the oriori to their pepi. I'm so blessed to even be able to be your midwife. To be there to witness and learn all of that. You did it all, I just happened to be there. So without sounding cheesy, I'm seriously here to work with my people. I'm a Māori midwife. But first and foremost, I'm Māori.



Ko Taupiri te maunga
Ko Waikato te Awa
Ko Tainui te Waka
Ko Ngati Wairere tōku Hapū
Ko Hukanui tōku Marae
Ko Pōtatau Te Wherowhero te tangata



Hine (pseudonym) was born and grew up in Hawkes Bay with her six siblings. Her mother is Pākehā from New Plymouth and her father is a descendant of Tainui. She is married and, between them, they have 3 children and 2 mokopuna. At the time of our kōrero, Hine was at the end of her third year as a qualified midwife, practising as an LMC midwife. She did her midwifery training in the Tainui region, and although she didn't find it that inspiring, she felt like she was at home on her whenua. Hine's true passion is to support whānau Māori to home birth.

Hine describes herself as a 'developing Māori midwife'. However, her story embodies distinctive attributes of a Kahu Pōkai and weaves the tangible with the intangible. As her pūrākau unravels it conveys an innate connection to te ao Māori, her tīpuna, and humbly reveals the mana of her whakapapa.

I can't really pinpoint one particular thing that made me want to become a midwife. I always feel stumped when people ask me, what made you want to be a midwife? I don't really know but I feel like I'm just drawn to it. I knew I needed to be in this woman centred kind of world. There were little things in my childhood that resonated and then just stuck in my mind, I remember running around at my aunty's house, my cousin was having a baby inside the house, my aunties were delivering the baby. I thought, what's going on but then, okay is that what you do?

Hine's first baby was born in 1997, she was 17-years-old. At the time, she had her GP, the same GP her mother had had with her brothers and sisters. In labour, she had a midwife who was renowned as one of the wise midwives in her community. However, Hine did not have a good experience with her first labour and ended up having a caesarean section. She has no idea why and has no record of the birth.

At 28-years-old Hine had her second baby in Australia. During the pregnancy a midwife gave her confidence to have a vaginal birth. She went into labour, arrived at the hospital 8cm dilated and went on to have a vaginal birth. It was such a healing birth experience, and it has influenced how she is as a midwife and the way she cares for whānau. In particular, it made her very

protective of young Māori mama, ensuring their voice is heard throughout their childbirth journey. As a 17-year-old having her first baby, Hine did not have autonomy over her care.

During her training, she decided she did not want to do secondary midwifery care. However, she now realises that whānau require this level of care, so Hine acknowledges the need for Māori input within the DHB. But LMC practice resonated strongly with her and she felt it was where she was meant to be. She wanted to bring her own whakaaro into her practice and gain her own autonomy in how she offered midwifery care. She had clear foundational ideas about how she wanted to practice. When she graduated, her midwifery tutors advised to start the way you intend to go on. This is a mantra that Hine has instilled in her LMC practice life. Along with this, her husband has exemplified work ethics and boundaries that Hine has reflected to keep the balance between work and homelife. He has been her primary support right from the beginning, attending her interview when she applied for midwifery to now being her number one sounding board when she needs to debrief about difficult practice situations.

Prior to doing midwifery Hine had spent time with a Māori midwife in the Waikato region. She found her authentic and inspiring, so she wanted to replicate this feeling in her own practice. When she joined the established midwifery practice of three other Māori midwives, she was given the option to pick whichever midwife she wanted as a partner. She had worked with two of the midwives during her training, but decided to partner with the midwife that she hadn't worked with. Her choice was strategic; the midwife she chose lived in the same locality as Hine so she knew her clients would be local too. She also did the most homebirths and that was what Hine wanted to do. But mostly she chose her because she had the strongest Māori identity.

She was the most Māori feeling midwife, that's why I chose her. They are all Māori, but she practiced and felt Māori, that's how she came across.

When the COVID vaccination mandate came in, Hine's midwifery partner opted out of getting vaccinated which that meant she could no longer practice. Up to that point they were alternating weekends off so losing her work partner has impacted her ability for time off from being on-call. However, she has adjusted and now feels that in some ways it is better for her because she only needs to focus on her own small caseload.

I'm looking for a midwife that I can practice with again, but I can't feel that midwife. I haven't found that feeling yet.

Hine really feels like her journey in midwifery has also been her journey as a wāhine Māori. It has ignited her desire to explore te ao Māori. Although there is a strong presence of Māori midwives she has never seen or learnt any traditional practices from other Māori midwives. She

tends to search on Google and reads prolifically. Her kaumātua had passed, so this mātauranga would now come from her parents' generation. However, her dad nearing 70-years-old, only had limited knowledge. She recognises innate knowing from just being Māori, like the experience of hearing her cousin birthing and understanding as a young child that was a normal process.

Building on her mātauranga, Hine has been learning te reo Māori for the past couple of years, a journey both her and her husband are on. Her ultimate goal is to be a Māori midwife completely fluent and able to conduct all appointments and communication in te reo Māori. More recently, she has gotten to use te reo more in her practice; and since gaining some confidence, she feels her tīpuna are sending her more wāhine who are fluent speakers. She is very philosophical and strongly believes the things that have happened in her practice have led her to where and who she is meant to be with, including her clients. The connection that she develops with wāhine always surprises her.

Almost every woman that comes to me, and I don't even know how they come to me sometimes! But we have a such a good connection. I guess your vibe attracts your tribe.

I had a client call me last week and she was full, hard out kōrero Māori to me Hine rah, rah, rah I'm trying to keep up with her, I'm thinking, oh my gosh what is she saying? She was saying, I've lost my phone and I've not gone to my appointment and I don't know when my next appointment or my scan is, can you please help? I was thinking how am I going to say this back in Māori. It was hard, but when I did reply to her, I had to say it back in English. I can understand what you're saying and I'm going to let you know by actually responding with the correct answers. I think that's been a real big driving force for me to learn.

Hine looked after a couple that had very specific ideas about how they wanted their birth to be. Mama was a nurse. In the past Hine had found wāhine who were in the nursing or teaching profession to be more medically orientated in their approach so she was not expecting to have an experience filled with beautiful tikanga. The couple wanted to birth at the primary unit but due to it closing they had to go to a secondary unit. Mama laboured well and gave birth in the pool. Papa called his pēpē in with an oriori. His hands were the first to touch pēpē, and Hine made sure that his voice was the first pēpē heard. They ended up having a haemorrhage and baby had to go to the neonatal unit, but they were amazed by their experience and felt very appreciative.

Being the critical midwife, I debriefed with them about it. I was thinking was that okay? Dad had learned an oriori to bring his baby into the world, that was amazing. They had a muka tie, dad was the first one to touch baby and the first voice that baby heard. I didn't want my voice to be heard first, I wanted it to be Dad's. I'm quite aware of that with other

births as well, it shouldn't be me that baby hears. I don't even want to touch the baby because that's not my place. So, even though they couldn't be where they wanted to be, they had a PPH [post-partum haemorrhage] and baby went to SCBU [special baby care unit] they were totally awestruck and thankful, they thought the birth was amazing because they had some autonomy and choices over what they wanted. I think what made it special for them was, I just supported them with what they wanted to do.

Because Hine didn't grow up immersed in te ao Māori she has found the combination of developing as a young midwife while strengthening her identity as a Māori midwife challenging. She is inspired by the resurgence of Māoritanga and the expectation of whānau but catches herself feeling like a “watered-down” version of being a Māori midwife. Clients have come to her and said they have watched ‘My Māori Midwife,’ and want a ‘Māori midwife’. She believes there isn't specific pre-requisites to being a Māori midwife. However, having a deep understanding of mātauranga Māori and a strong connection to tipuna, knowing your marae and papakāinga, are foundational elements that strengthen your base. Hine thrives in these environments, particularly in births where whānau are confident in te ao Māori, connected and grounded to each other. She finds it a privilege to be there and find whānau show mutual respect for her and what she needs to do to keep the baby, mama, and whānau safe.

Some clients that I care for, they've got their papa and their nana. And they grew up having to saying karakia for 2-hours before the sun came and they have that massive understanding of what it is to be Māori, it's thick in their blood, through and through. I feel like I'm the watered down version!

Because we've had this big resurgence of claiming our identity in the last few years, that in itself has been a huge maunga to climb. And digest it, bite chunks off it and try and process it but it's right in my face now. How am I going to process this and how am I going to work with this? That's why I'm starting my te reo journey. I think that I'm still a baby midwife but becoming a Māori midwife. Each month it sits better and better with me. Like I'm more comfortable and flowing into it.

In her first year of practice, Hine experienced her first stillbirth. This very quickly brought to the forefront to never become arrogant in your experience, as she immediately questioned what she had done wrong. At a home antenatal visit of a full-term mama, Hine could not find a heartbeat.

I couldn't find a heartbeat. I couldn't even hear a placenta, couldn't hear anything, nothing. And I thought, I think I know what this is but I'd never heard a stillbirth baby, but I knew what this was. I said I'm going to get another doppler, because my doppler was quite old and it was a bit staticky. But really, I was trying to buy time to think, how am I going to deal with this, how am I going to talk to her.

She also experienced a home birth that was clinically very normal until it wasn't. Hine had a second midwife with her. Mama was fully dilated when the baby had a prolonged bradycardia. Baby's heart rate did not recover as they urged her to push as hard as she could. Baby was born 15-minutes later and required full resuscitation. Eventually baby was transferred to a tertiary unit and was later diagnosed with brain damage.

It was a Māori whānau and they were amazing. They've been amazing, we had a really good relationship I met her mum with the wahine on the first booking visit. At the home birth. I had my practice partner there, and the couple wanted it to be just the two of them in the whare. They weren't answering phone calls to their family or anything. When I knew that something was wrong, surprisingly her mum turned up! Her mum thought everything was all good until baby came and we started CPR, she was a really good help, I had to get her involved in my CPR because I needed someone else to help me because the other midwife was dealing with a PPH.

The whānau spent 2-weeks in the tertiary unit. During that time. Hine considered how to maintain contact but also give them space, wanting to be as transparent as she could provide information on how to complain if that was what they wanted to do. To complicate matters when they returned to the local SCBU it was during COVID lockdowns making it more difficult to negotiate these relationship dynamics.

She messaged me, I'm home now come and see us. So that was cool, her mum came and I thought I'm going to feel the wrath of her mother! But she just gave me a big huge awahi and said, thank you so much for what you did, that was amazing what you guys did. I was worried, what were the whānau going to think about me, because they were there watching. They've all been very graceful. So that's been so good.

On the night, Hine hadn't had any bad feelings about the labour or birth, she was really happy to be there; but, ironically, had done the most intense karakia. She had also called her second midwife much sooner than she normally would have, so she had support with her about 3-hours before the baby got distressed. Hine reflects on these moments as her tīpuna looking after her, and another amazing attribute of being a Māori midwife.

Karakia is a large component of Hine's practice. Every time she is driving to attend a birth she intuitively tunes into te ao Māori and will recite karakia. She will also do this after the birth on her way home before she gets into her whare. Sometimes, karakia just happens unconsciously, and other times, it is a more considered moment.

When I first meet a whānau, even if they are not Māori, I do the same thing. I don't tell women that I do this, but when I touch their puku for the first time I do a 10-second karakia. It is to protect me and protect the wahine and baby so we are two separate energies. I do it so our energies don't cross over into each other but in some sense we will still connect. We're meant to connect.

Hine has a strong sense that whānau can relate to her as she can relate to them. She uses language that is not clinical, and is very good at reading her audience because that audience is her own people. She assures whānau, she unequivocally supports them, and they appreciate that she is genuine. In saying this, she is very cognisant when there is a problem or whānau are challenged by institutional expectations. In these moments she will approach things differently and often finds herself saying, 'I'm just being honest with you or I'm going to tell you how it is', so that whānau are realistic of the situation. Her relaxed but honest energy creates an atmosphere that influences positive outcomes for whānau. To date she has not experienced negative conflict.

Building good relationships is important to Hine as it creates a better environment for herself and birthing whānau. She feels she has a good rapport with most colleagues but when she goes into the birthing units she likes to stay focused on her job and avoid the 'politics' or dynamics, particularly in the hospital. She has a sense that other midwives outside of LMC practice find them closed off but Hine perceives this as a protective mode. Her personal circle of midwives is quite small, kept to those that she trusts and would ask for help if needed. This, in part, is how she keeps herself safe as a Māori midwife.

I try to stay in my own circle! If I ask them to help me, it will always be, where do you want me? Where do you need me? And vice versa, but if I can't help right now, I'll find someone that can help. If they're in a bind and need someone else or something, and I can't then it's my job, I'm going to find someone for you.

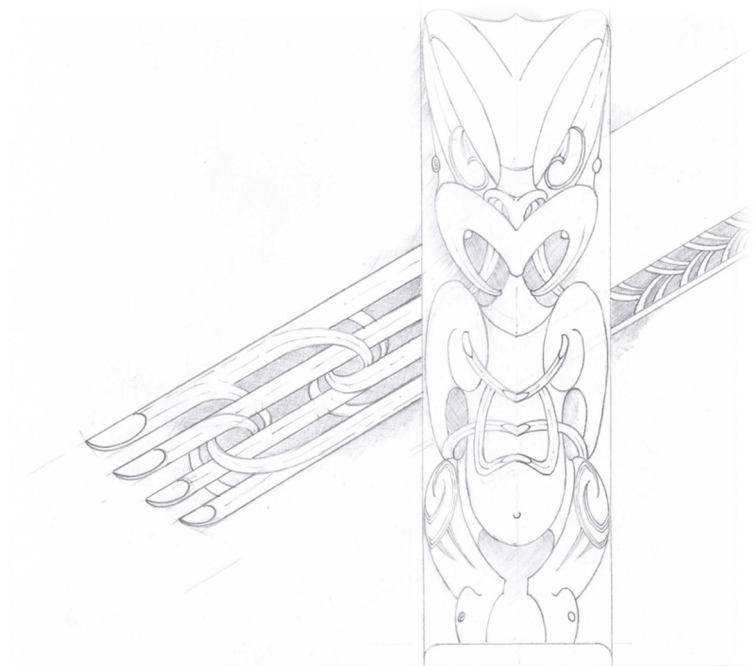
I also find that when I have situations that happen I internalise it for a long time before I speak about it. When I was studying we got told you have to reflect, but in the western model of reflection it had to be done straightaway. I just can't do that, I need to beat myself up first, I need to mull it over. It takes days. And then maybe 4-days later it all comes out. But I can't do it with a non-Māori person, it has to be with a Māori person.

A couple of days after the adverse home birth event, a midwife asked Hine how she now felt about homebirth. She told her, she still loves it and the experience hadn't scared her or damaged her belief in home birthing. Along the same line, when she was training, she had no intention of doing secondary maternity care because although there are elements that she really enjoys, there are parts of it that she really doesn't enjoy. However, now she values the fact that mama and whānau need her in that environment, so her whakaaro has changed. She is philosophical about her experiences and the learnings she gains from them all. Although Hine clearly expresses that she is still learning in all aspects of being a Māori midwife she feels she is such a different practitioner to when she first started. She continues to love the job and be humbled by the reality of actually just being a midwife.

I was such a different person from when I went into the midwifery degree to when I came out and I think almost every woman that goes through the degree will feel that. The amazing thing now is I listen to these wise women, these wise midwives that know, sitting there at 2 o'clock in the morning, with a birthing mum and I'm out there having a cup of tea and this wise midwife saying, "Oh I had this situation, I don't know what the heck was happening, I don't know, what do you think?" And I'm thinking, what are you asking me for? But I'm in awe of that because it brings you back down, you don't have to know everything even when you've got all these years of experience.

Hine displays such strong integrity to her belief in birth, her belief in whānau and her fellow Māori midwives. She appreciates and values the chance to contribute to kōrero and research in any way, and is quietly confident that she positively influences the well-being of whānau. For Hine, being a Māori midwife means just being there for the women and her whānau.

That's all I have to do, just be here. I feel like if you're the wahine, then all I have to do is sit here and you tell me what you need. That's the environment I want to create. That's what being a Māori midwife means to me.



Tihei mauri ora
Waerea Waerea i a rangi a tū ake nei.
Waerea Waerea i a papa e takoto nei.
He tangata kau kia whakatangata
Whānō Whānō haramai te toki
Haumi e, Hui e, Tāiki e

Tēnā koutou katoa
Ko Moumoukai tōku Maunga
Ko Ngauroro tōku Awa
Ko Tākitimu tōku Waka
Ko Ngati Kahungunu, Ngati Rongomaiwahine,
Ngati Porou tōku Iwi
Ko Rākaipaaka tōku Hapu
Ko Nga Tamakahu, Iwitea, tōku Marae
Ko Myra White tōku māmā
Ko Arthur Ripley tōku pāpā
Ko Kiley Clark tōku ingoa
Ko Tapuhi kura tōku mahi
No reira tēnā koutou, tēnā koutou, tēnā tatou katoa



Kiley Clark grew up in a very rural Māori community of Ngati Kahungunu. She was connected to many marae around Kahungunu and spent lots of time at the marae for different whānau gatherings. When she was 18-years-old she joined the New Zealand Navy where she served 8-years. Kiley married and had her first baby at 18-years-old; they now have four children. She trained and first worked as a midwife in Auckland. She is now living home in Waipawa (approximately 40km south of Hastings) with her whānau.

Kiley has had a range of maternity experiences, from working within maternity units to LMC self-employed practice, and is now on the regulatory board as the tangata whenua chairperson for the NZMC. This is a huge role and not without its challenges. Kiley has a calm yet strong presence and an ability to astutely articulate herself with genuine Māori focussed whakaaro. Her intent, in all that she does, is, first and foremost, to uphold the mana of her people, and it is this expectation of herself that drives her willingness to challenge spaces to be better for tangata whenua. Kiley feels a commitment to participating in research, especially research that projects the purpose of Māori midwifery. She finds the opportunity therapeutic and helpful in informing her practice as a midwife.

While she was in the navy, a very good friend of hers started her midwifery training. Kiley got to hear about the programme and decided it was something that she was interested in doing. More importantly, Kiley recognised how empowering giving birth had been for her.

I felt that was something that out of everything in my life, no one else could ever take away. It was something that I had done, that I felt really empowered by. And because of that, I wanted to be a part of empowering other wāhine to have that strength. I liked that element of empowering myself to support other mums through their childbirth journey. That's how I started.

Kiley commenced the midwifery programme in 2008. During her second year she was pregnant and when she informed the University she was pregnant, they told her she needed to take the year off. At that time, there was no option to stop training. She needed to finish and start working. She adjusted her clinical placements and completed all her exams and assignments. Baby was 1-week-old and she was doing her breastfeeding exam while breastfeeding!

I told them I can't take time out, and carried on, but that made me more determined to keep going and keep going successfully! And pass everything. I did that, graduated, made it to the end, with only one other Māori midwife in our group.

In her first year of practice, while doing the DHB new-graduate programme and MFYP programme, Kiley got pregnant with their fourth baby and continued working. Kiley found being employed gave her regular income and some work life balance. But being hapū throughout her first year of working was not easy. Also, due to the parameters of the MFYP programme, she could only take 4-months maternity leave and then had to return at a high FTE. Kiley found these restrictions tough for her and her whānau. One month shy of finishing the new graduate programme, Kiley decided to leave the DHB to join a Māori maternity team contracted to a primary health organisation (PHO). It was a team of four or five other midwives, mostly Māori. There she practiced as an LMC community midwife on a rotational roster. It was here that she really started to learn about being a midwife.

Her first insight into traditional knowledge outside of her whakapapa and knowing in te ao Māori was attending a 2-day Ngā Maia wānanga where she learnt about the practice of muka and ipu whenua. But now that she was in a Māori midwifery team, she was surrounded by te ao Māori practices and, importantly, Māori leadership. Kiley loved it there and felt like it was home.

The daily happenings of a health practice that was drenched in te ao Māori, Māori people and kaumātua. Te ao Māori flowed through all of the services and we were like a working whānau. I loved it, it was great. Being primary focussed and working alongside the other midwives is where I learned a lot of midwifery skill, that I hadn't previously had. We did home birth, we didn't do any secondary care, so no medicalised pain relief or inductions, even though I knew how to do all of that, it wasn't the philosophy of our team.

Although Kiley thrived as a midwife working in Auckland, and particularly at this practice, she became exasperated with the work and constantly witnessing trauma, that was always whānau Māori. She was feeling frustrated with whānau who were not self-motivated to improve their outcomes, even though she knew these dynamics were not entirely their fault. She was tired of all the interventions, politics, and the disparaging way whānau Māori, especially young ones, were treated. Kiley was feeling traumatised and considered leaving midwifery. In part this motivated her to move home.

Once home, Kiley committed to the DHB in a leadership role. It facilitated reconnecting to her community and the community of Māori midwives. Consequently, she successfully developed some good relationships with her peers. Having just had their cultural review, it was apparent the DHB had major work to do to achieve the Māori health gains necessary to reduce inequities. During this process, Kiley did not find the DHB Māori department helpful, so she leaned on senior colleagues, particularly from Auckland, for supervision and unofficial guidance. Kiley regularly checks in with other colleagues all over the motu to make sure she is on the right track, particularly in a position whereby decisions impact other practitioners and, more so, whānau.

In this role, Kiley transversed some really challenging situations that put her into positions she did not anticipate, such as the politics between community midwifery and the DHB. She became very aware that there was a history between these two entities, which caused a level of distrust. Kiley also struggled with the lack of a cohesive approach between services and no emphasis placed on reducing barriers for whānau who did not or were not able to access health services.

If there is one whānau that isn't able to access services then that is one too many as far as I'm concerned. We have all this money and all these things that should be accessible to every whānau, if there is a barrier then we need to look at why. That should be how we see it, including ourselves as Māori midwives."

In her role, Kiley attended many hui between the DHB and community organisations who were providing services to birthing whānau, and although Kiley fully supported these kaupapa to improve the service for whānau, she identified the repetitive need for more cohesive approaches particularly with key stakeholders, like Māori midwives.

I'm really grateful for everything you guys are doing and that you share, but I actually believe that moving forward there needs to be more collaboration with your Māori midwifery community, I said as a Māori midwife within this DHB there are missing connections, I'm very aware that there are Māori midwives with clients that don't access the service and we need to understand, what are the barriers and how do we come together to work it all out and move forward in the interests of whānau? They didn't respond, didn't

say nothing. I support this kaupapa but you guys don't support us and our kaupapa and we're the ones that are bringing the horse to the water, so to speak.

I feel like we're the ones that are hands on, seeing it, doing it. We're the ones that have the actual connection. The reality is, the key people that actually should be in these rooms having this kōrero are never present. They're never there and I'm only ever there as a DHB representative, so I find it dis-ingenuine.

Since being home, Kiley has developed her leadership skills and knowledge in traditional practices and mātauranga in the tikanga of muka. She is now able to harvest herself and knows where the right harakeke patches are, the different names, and the different grains. Kiley can identify which harakeke make muka and which ones do not, how to treat the harakeke, and how to dispose of the unused parts. She has taught her children these skills. She has just started using a new method that uses water to roll and twist the muka so that DNA is not shared. In their wānanga, they teach whānau the traditional way of making muka using saliva; they explain that by making it this way, whanau can share their cells with their pēpē or their moko. Whānau can then choose how they do this process either with their saliva or with water.

It allows me to be able to be safe in the knowledge that when I'm actually making muka I'm making it so that I'm safe for any pēpē. It's got my aroha in it and my skill and technique but, it's not me sharing myself, my cells with the muka like traditionally is done. Whenever I share my muka I tell people, other midwives, when I've harvest, where I've harvested it from and what our process is of making the muka.

It was another Māori midwife that really helped me grow that knowledge in myself and it's been amazing learning. It's really helped me reconnect, I love it. We are also trying to get out to hikoī with kaumātua here to find out what is traditional for us here and what can we use. I'm just really grateful to be able to come home and reconnect and reclaim some of those things. It takes a long time.

Kiley's role at the DHB does not include clinical practice. However, she took on the care of a young first time mama with addiction and severe mental health challenges. Oranga Tamariki indicated early in the pregnancy that they would uplift this baby. Because of her history, particularly her mental health history it was difficult to find a midwife to care for this young lady, so Kiley took on her midwifery care.

I took her on because it needed to happen, I needed to be doing it because there was no one else that would and if I hadn't, who knows what would have happened. I think mama like her are hard work but that's our work. We have to start owning it. I was the one that everybody was to contact if there was anything going on. I have to say that was never easy, because I had a clinical manager who worked in opposite way. It was difficult, but I was able to do it because I'm aware of the institutional systems, enough to ignore what I need to and just do the mahi that needs to be done. What made the difference with a lot of her

care while she was at the hospital for the six days was the fact that the mental health worker and I got on really well and we worked together really well.

But, while I'm doing all this work, I'm not an LMC and this was all on top of my mahi to support his mama.

Kiley spent many, many hours working with this young mama to improve her chances of keeping her baby. The plan was for her labour to be induced; however, at 38 weeks, she went into spontaneous labour and arrived at the hospital via ambulance contracting strongly. She had progressed so well that Kiley had to get into the back of the ambulance to catch baby. The day she went into labour Kiley was actually on sick-leave due to her son being unwell. Instead of taking her son to the doctor, she took him to her office so she could attend to this young mama's labour care and the birth, then sort her postnatal plan and hand over to staff to make sure they didn't get it wrong. Although Oranga Tamariki had not committed to a plan, they had requested for her to be on 24-hour watch.

During the postnatal stay, staff called security because she was outside crying. Kiley was astounded by this, she thought, *"Is security going to stop her from crying?"* Luckily, there was one person there with the sense to say no, let the partner go and check on her, and send security away. Experiences like this are not uncommon for Māori midwives to negotiate. Kiley expresses the irony of making plans and having a watch is not about the safety of the whānau, it's about the safety of everyone else, to reduce their anxiety levels and, sadly, to ensure processes have been done. The foundations of these policies and mindsets have not evolved from how to best support the whānau, but how best to support the institution.

When it was time for mum and baby to go home Kiley drove them home to ensure that they arrived home safely together, as one unit. She went home to her whānau. It wasn't until then that social workers and mental health workers showed up. Unsurprisingly, while she provided midwifery care for this young lady, Kiley was constantly reminded that her role was purely strategic and that she should not cross over to clinical areas. She would respond with, *"But I'm Māori and that is what we do"*. This is what it is to be Māori. Being a Māori midwife, that is strategic!

If a Māori midwife comes in, sees me and wants me in a room for some sort of reason whether it's a second or to just do something for her, I'm going to do it because that's what it is to be Māori. I can't say, no sorry I'm only here for strategic development. My name would be mud.

Being a Māori midwife, actually you can't put boundaries around what it is to be a Māori midwife because we are whatever we need to be in our scope, in our element whatever that

is and sometimes it's actually just about being a mum, an aunty, a cousin, or a driver. Going to pick up some nappies. Or giving out petrol money.

Kiley wants to establish a practice like she had in Auckland, but better. That practice was the perfect fit for her, so she is very keen to replicate the feeling of being at home. As a rōpū of Māori midwives, they decided they wanted to create a Māori birthing unit, a purpose-built space that promotes whānau, whakapapa, reconnecting and reclaiming mātauranga. The aim is for it to be on a papakāinga site and not connected to a hospital or to be a replica of a primary birthing unit. The name for their papakāinga birthing unit is Tapuhikura. They created this name in consultation with te reo Māori experts and kaumātua from their community. They wanted the name to symbolise their togetherness, their identity as wāhine Māori, and their collective mahi as midwives. Ultimately, they want to create something uniquely Māori.

We don't have years to give to try and change how things are done. We can't keep teaching them or telling them how their governance and their policies are wrong for our people, when they don't want to have a bar of it. That's why we went with the idea that we just need to have our own papakāinga site. So, our idea is a purpose built place where whānau can stay, it can offer other services that can come in, but it would be a hub for Māori midwives and Māori midwifery. It could even be a hub for Māori training Māori midwives from the ground up and then when they graduate that's where they go to practice.

It needs to be a place and space that's not just about birthing and postnatal, it needs to incorporate whānau in the hapūtanga space as well as revitalising whakapapa for our whānau. It's just about improving health outcomes for our people and that's it.

When I ask mama where they're from, and they say, I'm from Flaxmere, and then you ask, but where are your whānau from? They respond, yeah from Flaxmere. I'm like, okay kei te pai. And that's fine, but we know for ourselves that reclaiming and reconnecting is hard and it's a personal journey.

That is our gift of kaupapa, to whānau. That is what we want to do, and how we want to function. We actually want to be living and breathing what we are trying to instil in whānau. And like you say, you have to be doing the mahi to have the same capability to grow and evolve with it. You can't be outside of it and try to develop it, that is why I need to go back into the community."

Growing up in Kahungunu Kiley knew who she was and what it was to be Māori, this close connection continued into her life in the navy. However, doing midwifery was a whole other realm for her, and she made connections to her identity that she had not made before. During these years, she began to acknowledge her Samoan side, and became confident with saying that she is Māori Samoan. She was reclaiming her cultural identity, curious and wanted to know more.

Learning about the Treaty was pivotal in her feeling proud to be Māori. Paradoxically, up to that point she had felt she needed to be 'white' to succeed and achieve in the midwifery programme. She has had periods when she questioned her depth of Māori-ness, particularly as a young midwife in Auckland, when she often felt she was trying to survive in a mainstream space and place. These experiences have given her the lens to recognise the cultural disconnect in whānau and she can truly empathise.

I feel sad for Māori midwives because I know what that feels like when you feel like you're not Māori enough, I think this year I've managed to get all of those things into good perspective. It's like actually I was raised Māori and sometimes you meet people that are fluent reo but they don't know what it was like to grow up Māori, because they grew up in a Pākehā world.

I was born in Waipukurau and grew up in Takapau, I've lived here in Waipa, Bridge Pa, Flaxmere, all around here and my parents have always been here. I've met so many people throughout the hospital that know my parents on both sides. My family are well known, it's been me who's been MIA [missing in action] for the last 20-years, so it takes a bit of time to reconnect. I've thought how amazing that I'm around people that grew up or went to school with my mum, I love it! I've ridden really high on all of this and I find that so mana enhancing for me in my purpose and it adds to the drive of why am I actually doing this.

Also, what has been reaffirming is, a Māori midwife (who is actually my aunty) said to me, and she was comparing me to somebody else who had not grown up here. She said, you know what it's like to be Māori, you grew up around marae, you grew up around te ao Māori, it's just that we never said this is te ao Māori because that's not how we talked back in those days. It just was. That's why you understand and get it differently because it's who you are, it's in you. This person might be able to do these things but they never grew up here, you've grown up around this and you know, it's the way you've been raised!

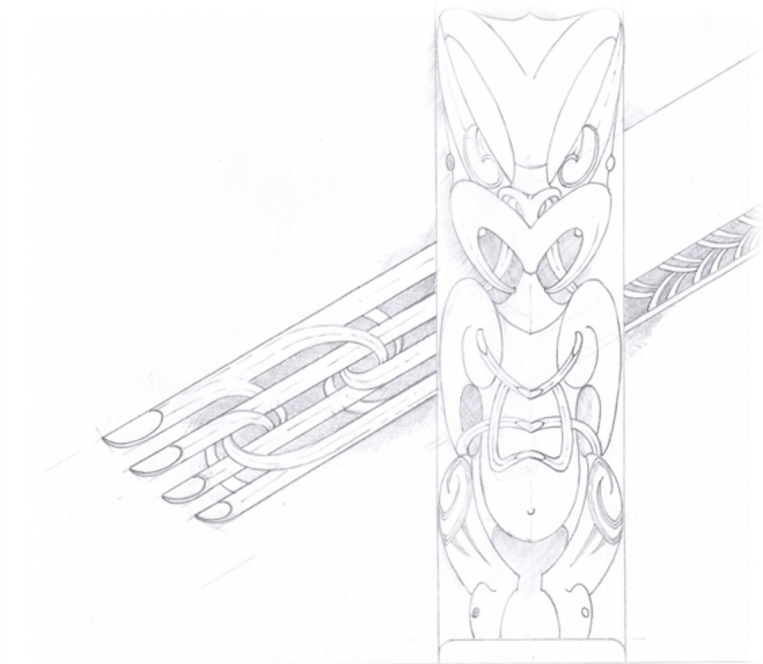
Although Kiley found it extremely difficult, at times, when she practiced in Auckland, she was with a very tight and supportive practice. They were all there for each other especially when times were particularly tough or they needed to debrief. As an LMC practice they were very much in each other's pockets, always checking in and constantly maintaining that close connection. Due to processes out of their control the team in Auckland dissolved. Kiley moved on to a different job but even though her mates were still in the same city, she felt she was not able to cope with the feeling of trauma and decided it was time to leave. However, returning home the level of trauma in her own rohe was worse. Culturally unsafe practices and experiences are so concentrated and there is no multicultural plethora, like there was in Auckland, it is mostly Māori and Pākehā. Believing being home would make a difference, without the support systems she had in Auckland, within the year the same feelings of leaving midwifery resurfaced.

However, this year she has found her community of Māori midwives and Kiley hasn't had that feeling of wanting to leave, although she has wanted to quit many times. She has voiced her desire to leave the DHB but has been told no, you are needed where you are and you are making a difference for us (Māori midwives) so you can't leave. Kiley understands the importance of her being there but her heart is in LMC practice, that is where she believes she belongs. So she has commenced the process of going back into LMC practice and is in the middle of organising the administrative things. She is really looking forward to it.

I think that's what happened to me and that's where and why I struggled because I didn't have my whānau of Māori midwives that understand, we could all sit, have a big feed, have a big laugh and 'debrief'. And just be there for each other. I've realised it's so important. It's such a crucial aspect of surviving and being sustainable in this job.

Kiley will always describe herself as a Māori midwife. She chooses this definition because she is Māori first then she was a midwife. She feels really strong about identifying as a Māori midwife, for her it means more than just saying she is a midwife. Kiley celebrates the uniqueness and pride in being a Māori midwife, it's about being with her sisters, being with whānau, being with mama and reclaiming what we use to have.

To me, there is more mana in being a Māori midwife and I just like to be able to celebrate that every time I tell anybody who asks me.



CHAPTER SIX

He Matatauihi I Ngā Ururei Whēako Hei Kahu Pōkai

Prelude

This chapter presents the research findings as they relate to “He Matatauihi I Ngā Ururei Whēako Hei Kahu Pōkai”; the experiences of being a Māori midwife. As outlined earlier, the aim was to explore the uniqueness of Kahu Pōkai and to reflect upon these notions as they apply in contemporary maternity care. Being in wānanga of the Whare-kōrero ā Kahu Pōkai provided the environment to focus Māori midwifery thought. Particular attention was given to how Kahu Pōkai influenced the well-being of birthing whānau. It was hypothesised that doing this would identify the environment in which whānau Māori birth and highlight how Kahu Pōkai navigate these spaces to embed key components of care.

The pūrākau showed Kahu Pōkai work in ways that exhibit the tenets held within Matatauihi, Ngā Ururei, Whēako, and Kahu Pōkai. Each of these have their individual value and knowledge system, legitimised by ancient mātauranga. These pieces of knowledge go beyond what is taught or understood from the Western model of midwifery care. They are elements that dwell deeply within te ao Māori and show an inherent ability to transverse dominant worldviews to nurture what creates safe, distinctly Māori midwifery care. Quotes from the pūrākau of each realm are presented to emphasise the mātauranga. Each discussion is concluded with one-line quotes highlighting unique whakaaro or thoughts of each Kahu Pōkai.

Matatauihi

Matatauihi encapsulates the calling of spiritual and physical energies to the kaupapa by the ancient female reo of Hine. Pou Tuarongo is the medium to the ancient ones residing in Te Ao Marama, the link between the spiritual and physical. It embodies life’s procreation, design, and potential from where all things are preordained. This element reflects the deep relationship to ethereal realms that manifest in the physical world. Therefore, as a platform of mātauranga, Matatauihi relates the intangible thought to the tangible feelings. These ‘feelings’ or ‘voices’ connect the subconscious activation of the whatumanawa. Kahu Pōkai reveal their innate but overt link to their whatumanawa throughout this research, each expressing active elements of Matatauihi. Heather eloquently talked about becoming a midwife as something that was already set in her life pathway.

I became a midwife because it was my turn, but I didn’t know that at the time. I just knew, one day, I needed to be a midwife. It hadn’t been in my head before that day, at all. Honestly. I woke up, I can remember it vividly. And it was there.

Kendra also had this experience of knowing that midwifery was the pathway that was right for her.

Midwifery just came into my head, and it was like, yeah that's it, that's perfect! The more I researched about midwifery the more, there was no question that this was meant to be. So, I didn't choose midwifery, it just came to me and then I couldn't think of anything else...

Shar's connection to her whatumanawa is also undeniable, she exemplifies a strength of listening and trusting these knowledge conduits. Shar spoke to midwifery as a feeling, "a seed that drifted in the wind". Her kupu powerfully express the emotional connection she has to tūpuna through her pumanawa⁴⁶.

I think I was just put there! I fell into midwifery... I literally just fell into midwifery, the idea just came. I sort of just heard it in the wind, I just heard it downwind and it sunk in my ears and fell in my puku.

Nerissa expressed her experience of being witness to a birth as a young woman and the impressionable care given by a midwife. The feeling stayed with Nerissa, and she acted upon the messages she heard, saw, and felt, when the time was right, without question. In this sense, the midwife exhibited the 'voice' of the whatumanawa and, in recollection of the moment, Nerissa provides a seamless link to Matatauihi.

She would whisper to her now and then you've got this, you can do this. I watched her massage her back and tell her, breathe, she was just beautiful.... She was just an observer on the side and she would step in whenever she felt she needed to. And I thought as I watched her, I can be her, I want to be her. I can do that for women. I knew it couldn't be then, and I now know I needed all the experiences I've had to be the midwife I am today.

Hine had a similar experience to Nerissa when she was young. She 'heard' a birth happening at her aunty's whare. This stayed with her, unquestioning the normality of 'what happens' in birth.

I don't really know but I feel like I'm just drawn to it. I knew I needed to be in this woman-centred kind of world. There were little things in my childhood that resonated and then just stuck in my mind, I remember running around at my aunty's house, my cousin was having a baby inside the house, my Aunties were delivering the baby. I thought, what's going on but then, okay is that what you do?

From a young age Nicole had an innate connection to birthing. This was then reinforced as a young mother.

Growing up and listening to my grandmother talking about her mum. I used to always ask her questions about when my dad was born. I was curious in my youth She used to tell me,

⁴⁶ Pumanawa – seat of emotions.

when my father was born it was her first child so she had to go to hospital, she didn't have a choice. So her first pēpē and her last pēpē were both born in hospital all the middle were born at home.

I was a teenage mum and it changed my world, it made me think that (midwifery) was something I could to.

Kiley's desire to become a midwife was also ignited by giving birth. The karanga of the female element revealed to Kiley the potential of birth and the influence she could have in this space.

I felt that was something that out of everything in my life, no one else could ever take away. It was something that I had done, that I felt really empowered by. And because of that, I wanted to be a part of empowering other wāhine to have that strength. I liked that element of empowering myself to support other mums through their childbirth journey. That's how I started.

Unlike Heather, Nicole, Kendra, and Shar, Joanne did not express a 'moment of realisation' toward wanting to be a midwife. However, she shows she is strongly attuned to this way of knowing. For example, from a young age, she had an innate desire to learn as much as she could within te ao Māori, so she deliberately exposed herself to as much as possible. Later in her story, she expresses her realisation of racism and the need to act.

All of a sudden I had to make a stand and I had to learn to use my voice, believe it or not but I used to be really shy. I used to say nothing. Awakening to the realisation that you live in a racist world and it is normalised, bought out the activist in me.

These instances show her inherent ability to be guided by her feelings to strive for a balance within her cultural-self. Joanne shows a deeper connection to those in Te Ao Marama in describing the birth of her pēpē. She indicates pēpē was in direct communication with Atua.

I felt that there was a tupuna intervention at this birth. They showed me where Ray should be, where I should be, the men being there, the balance. Crystal created that, she created what she wanted when she arrived, she is so good at creating the world that she wants. Because it wasn't within me to create that for me.

Again, Joanne gives an example of the connection to Te Ao Marama as she powerfully described birthing 'a star'.

Baby was born in his membranes and I remember thinking why is there no water? The heartrate through the labour was perfect. Then I'm thinking, wow, he's glowing. It was like I caught a star. It wasn't like any other baby I've caught before... Then breaking the, why did I cut his cord? I hadn't started using pounamu then. He was floppy so I did have to cut. I cut his cord, I cut his lifeline and in that moment I felt his wairua go...

From this perspective, in questioning why she cut the cord, the grapple between the whatumanawa and the hinengaro (mind or intellect) is exhibited. Although she may not have

realised at the moment, she birthed a pēpē teetering between Te Ao Marama and Te Ao Tūroa. Her deep appreciation of this experience is expressed later when she says, “*I caught a god*”.

Hine practises in ways that constantly acknowledge the presence of a higher energy or higher divinity. She showed throughout her kōrero that the element of Matatauihi is naturally present and in automatic drive. Hine acts instinctively at a level that allows others to feel her intuitiveness.

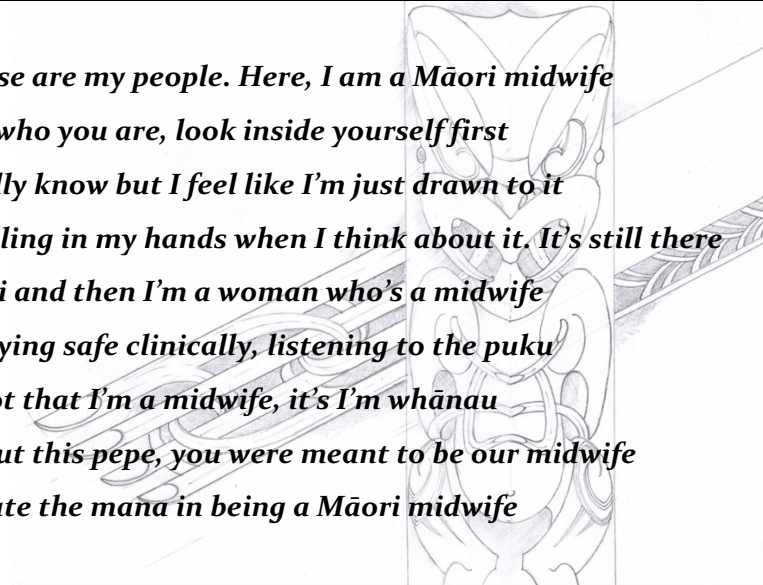
When I touch their puku for the first time I do a 10 second karakia. It is to protect me and protect the wahine and baby so we are two separate energies. I do it so our energies don't cross over into each other, but in some sense, we will still connect. We're meant to connect.

Dad had learned an oriori to bring his baby into the world, that was amazing. They had a muka tie, dad was the first one to touch baby and the first voice that baby heard. ...I'm quite aware of that with other births as well, it shouldn't be me that baby hears. I don't even want to touch the baby because that's not my place.

The influence of Hines' tīpuna sending her fluent te reo Māori speakers unveiled another level of Matatauihi. Her consciousness of the subconscious connection acknowledges the intertwine between the physical and metaphysical. “*Almost every woman that comes to me, and I don't even know how they come to me sometimes! But we have a such a good connection. I guess your vibe attracts your tribe*”.

Matatauihi connects to ancient knowledge systems that dwell within at a metaphysical level. It encapsulates the intangible and tangible energies that are activated by kaupapa. Hine's comment, her “*vibe attracts her tribe*”, signals the potential of energy transmission reinforcing those innate feelings stimulated by the whatumanawa. Comprehension of Matatauihi extends from the spiritual realm rather than the mental intellect. The kōrero of Kahu Pōkai displayed Matatauihi at multiple levels, exemplifying that this mātauranga is intrinsically active in their practice. The following kōrero acknowledge intuitive connections to the sacred energies of Ariki.

NGĀ KUPU O MATATAUIHI



*I'm home. These are my people. Here, I am a Māori midwife
Know who you are, look inside yourself first
I don't really know but I feel like I'm just drawn to it
I can still feel that, feeling in my hands when I think about it. It's still there
I'm Māori and then I'm a woman who's a midwife
That's staying safe clinically, listening to the puku
It's not that I'm a midwife, it's I'm whānau
It's not just about this pepe, you were meant to be our midwife
Celebrate the mana in being a Māori midwife*

Ngā Ururei

Ngā Ururei, offered the next level of analysis. This element revealed itself strongly within the kōrero of Kahu Pōkai. Ngā Ururei encompasses the ancient threads of applied mātauranga that guide the practitioner through the knowledge of deities. In other words, this is where pūrākau showed the presence of Atua within the practice of being a Kahu Pōkai. It encompassed how Kahu Pōkai expressed unique cultural knowledge sources. Poutokomanawa is the place within the Whare-kōrero ā Kahu Pokai in which this understanding belongs. It is where alignment to oneself occurs. The same location in the Whare-tangata where pēpē registers to his or herself while connecting to its environment. Self-awareness is a key element of Ngā Ururei, aligning to one's innate purpose and potential of kaupapa.

As Kahu Pōkai told their story they revealed the presence of Atua within their practice. This then exposed how Kahu Pōkai hold themselves in kaupapa, such as birth. In this way, their intention within the mahi of being a Kahu Pōkai is unveiled. A potent feature of Ngā Ururei was the aspect of tikanga and how tikanga was conveyed. Tikanga indicates the thought behind the action and, therefore, the behaviour of that tikanga.

Both Heather and Kiley expressed the importance of fulfilling roles that were not 'taught' or within the scope of mainstream midwifery but jobs that just needed to be done because it is tikanga Māori. Heather tells us;

So that was my job to go to the mortuary and sit down in the bowels of the hospital with baby. The pathologist found me a chair to sit outside his room while he did the autopsy, the mama had asked me to be as close as possible to baby. So I sat out here to be by baby. Then took baby to the funeral directors where I met the whānau and we dressed baby, singing to him throughout. We put him in his cocoon on the seat next to me in the car, and drove back to her house."

And I'm sure not just Māori midwives do that stuff, but they (others) get a choice, we as Māori midwives are expected to. And those moments are desperately sad highlights, of the places that I've had the privilege to be in.

Kiley highlights this same sense of tikanga:

If a Māori midwife comes in, sees me and wants me in a room for some sort of reason, whether it's a second or to just do something for her, I'm going to do it because that's what it is to be Māori. I can't say, no, sorry, I'm only here for strategic development. My name would be mud.

Heather and Kiley show the importance of acting and give examples of practising tikanga as an extension of sharing aroha. This was also highlighted by Nerissa, who described the ability of Māori midwives to see 'opportunities' rather than contentious situations. This reflection

exemplifies the gathering of experiences and knowledge as guided by tīpuna and, again, tikanga driven by aroha. *“Those are the opportunities we need to take to make birth better. I think Māori midwives do this well, I think we do those things better”*.

Shar shared this same sense of cultural ease with whānau. She discussed this as a unique attribute, a taonga that comes naturally to Māori: *“we do things as Māori so fluidly and naturally without even realising that it’s actually a taonga”*.

Kendra’s illustration of this aspect showed a grounded level of judgement and reaction developed from life lessons. She builds upon this sense of sharing aroha with the ability to express empathy. Like Nerissa, she is very aware of our role in contributing to positive experiences for whānau.

Women who may have a background of domestic violence, drugs, alcohol, things that they may not choose to be in or do, will often be on the defence and I always know, everyone has a story. Just like you or I, we have a story of where we are and why we are here. If you can plant a seed or half a seed of love and trust then that is going to change their outlook on you as a midwife and all other midwives. Engaging in care will be easier.

Ngā Ururei reminds us of the physical connection and innate influence of whakapapa. Kendra discovered that her great-grandmother was a lay midwife that had birthed all the babies from their rohe. *“I found out after this that my great grandmother, Margaret Peachy was a lay midwife up the Coast. She birthed all the babies in Tiki”*.

Whakapapa emphasises continuity and succession planning inherently linked to Atua. Heather shared this experience and notion that becoming a midwife was part of her whakapapa, so it was merely her turn. *“My kuia had been a lay midwife, but I didn’t know that at that time, I didn’t know that until after she died. She was a lay midwife for our hapū and wider. So, it was just my turn”*.

Reciprocity and humility are integral constructs for Kahu Pōkai. The importance of giving back is a trait that was strongly reflected in kōrero. Kendra and Heather’s connection to being a midwife reflects the concept of reciprocity held within the construct of whakapapa. Mātauranga passed down from the spiritual realm of tīpuna. Shar exposed this way of being twofold, firstly in the physical representation of Atua in her reo and on her body in moko⁴⁷. Then as paying tribute to kaumātua and kuia who took time to share their mātauranga in the physical world. Both exerts are an expression of her humility to serve.

⁴⁷ Moko – traditional markings or Māori tattoo.

When I stand up as a midwife, I stand up with all these things, my moko kauae, my reo and my raranga. There's so much to be said about humility and having the maturity to be humble.

But actually what I got that was more than koha, was the elation of our kaumatua as they'd walk past and their eyes would light up with glee because it would evoke memories in them and then conversations would start. Kaumatua would walk past and they'd say, you know you could do it like this and this. I'd look at her hands and her hands are all arthritic and, she's mahi raranga from way back. She'd give me tips and tricks on what she used to do, and so I was always learning, as we always are.

The idea of reciprocity is expressed in another way by Aroha. The tragic loss of Aroha's papa was an event that changed the trajectory of her whānau. Although Aroha says she is unsure if that is why she is passionate about including tāne in the birthing arena, she acknowledges this is a role Kahu Pōkai are privileged to undertake. In this way, Atua have guided Aroha's purpose in the kaupapa of immersing the presence of tāne at birth.

We know the statistics represent us in all the worst things but I'm a firm believer that in the position that we are in as midwives, the precious space that we share, we have the ability to help reconnect our tāne in a te ao Māori way.

The pedagogy or tikanga ako of Atua directing the physical interpretation of moments is shared by Hine, Joanne, and Shar. They all make references to tangible realities of tīpuna looking after them. Hine reflected upon this when she attended a home birth that required life support for the baby. She recognised she had prepared certain things in advance, like ensuring her backup midwife was there earlier than expected and just as importantly, performing the most intense karakia prior to the birth.

Joanne extends on this to attribute her evolution amid the Māori midwifery context to her babies. Crystal-Lee and Chaz were in direct contact with those in Te Ao Marama. Atua created the birth environment to guide Joanne in the manner she required unequivocally.

Chaz coming early, was like him telling me, if you don't get this, you're going to get this. My births had drawn me into this Māori midwifery world. Chaz had to be born at hospital for me to reconnect to my first midwife, to then find my soul sister.

Those present at births often embody the theory of Atua creating mātauranga exchange. Aroha conveys this and the learning that comes from sharing experiences with whānau.

I'm always learning off other whānau. My thinking might go this far on something and they'll broaden it so that I get a more embodied, fuller understanding. I'm always conscious and respectful in the presence of other whānau and what they can teach me.

Additionally, Aroha's cultural awareness enables whānau to birth in their own way. This level of advocacy and confidence in whānau capacity again illustrates the provision of tikanga. It also reveals the depth of humility to know when to step back to instil whānau autonomy. Whānau expressed the experience in this way: *"everything happened so right, the karanga came, the waiata came, it just all came. ...it will never be any different now"*.

These practice realities acknowledge the commitment of Kahu Pōkai in redressing the loss of autonomy for whānau birthing. Nicole remembers listening to her nan tell the stories of her births and the tikanga she practised, like birthing at home 'under the Totara Tree'. These experiences have influenced the way in which Nicole practices and the importance of whānau and in particular, their place at birth.

It wasn't actually a choice, it was more like, whānau this is your pēpē you're going to be touching them first. Then, it got to a point, when you're looking after the same whānau they just do it. I step back and I'm only needed if they want help... those are special times.

Joanne expressed the idea of whānau birthing their pēpē as a point of 'arrival'. It was a stage in her practice where she felt she had accomplished what she set out to do, returning birth to whānau. *"I knew that I had arrived because I never got to do anything anymore, all I did was write notes. Whānau did their own births"*.

Kahu Pokai revealed that Ngā Ururei creates the space to practice tikanga from a place of aroha, advocacy, and humility. In these excerpts, Kahu Pōkai show the importance of staying connected to the mahi of their kaupapa and the communities they serve. They are in tune with the guidance of Tipuna and share this mātauranga in a way that ensures others' progress. Aroha's papa reminds her of the importance of tāne Māori. Shar relates the mahi of raranga to the physicality of the birth process. She refers to the physical connection between muka and the pito (umbilical cord). The intertwining of these fibres then returns to its source of energy, Papatūānuku. *"What I'm trying to say is that when you connect the muka to the pito, those fibres are intertwined in one another, and they become one in itself. Then, the pito drops off"*.

These are tangible links to kaupapa, directed by Tipuna and Atua. Aroha upholds the mana of her papa and, therefore, her purpose to serve. Shar upholds the integrity of mātauranga raranga to align with her sphere of being a Kahu Pōkai. Kiley reiterates the value and responsibility of being Māori and being a midwife.

Being a Māori midwife, actually you can't put boundaries around what it is to be a Māori midwife because we are whatever we need to be in our scope, in our element whatever that

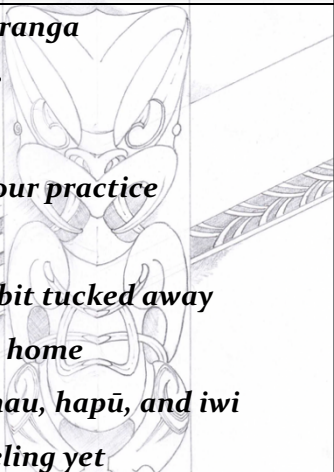
is and sometimes it's actually just about being a mum, an aunty, a cousin, or a driver. Going to pick up some nappies. Or giving out petrol money.

One of Joanne's first midwifery experiences revealed to her the power of tikanga and, more profoundly, the beauty of being Māori. Baby's kuia did karanga to birth baby and then the whenua. Following the birth, the papa gave mihi to the midwives. The encounter brought deep feelings to a surface that she did not realise were there. Joanne shed the "purest tears".

I didn't even know what it was, I'd just been a part of. It just happened. The Māori midwife looking after a Māori woman... That's why I love my journey, I didn't know any of that, but what I know is, sitting in it, and being a part of it, I could not deny any of it. The power of those taonga that not all whānau have, so when you experience it, you don't ever want to be anything but Māori.

Ngā Ururei acknowledges Atua and Tīpuna's influence on Kahu Pōkai's practice. Tikanga driven by cultural repositories of knowledge were shown throughout the kōrero. This awareness expressed an undeniable link to a higher purpose. Heather emphasises this by saying, "We are there to protect their wairua, their mauri, and their birth". These are predominantly spiritual realms that Atua uphold and protect. Poutokomanawa is where you connect to your primary source of sustenance. It is here that your natural potential and purpose come into alignment. This mātauranga is a constant reminder that our Atua are present and guide us in the service to iwi, hapū and whānau.

NGĀ KUPU O NGĀ URUREI



***The kuia birthed her moko with a beautiful karanga
My mokopuna will have a Māori midwife
I was chosen to catch a God
We've got those intrinsic tools that we integrate in our practice
Revitalising whakapapa for our whānau
That has always been there in that whānau, just a little bit tucked away
I've only known Māori midwifery since coming home
Traditional home birth will be different for different whānau, hapū, and iwi
I can't feel that midwife. I haven't found that feeling yet***

Whēako

Whēako encompasses the experiences that the human being has gained. They build upon how Kahu Pokai express themselves professionally and within the context of caring for whānau Māori. Many of these experiences were stimulus to being a Kahu Pōkai. Pou Tahūhū is the space in the whare that affirms the purpose and intention of one's role. The following excerpts show the expertise in navigating opposing worldviews, activism, and, in particular, manaakitanga⁴⁸. For many Kahu Pōkai, their births initiated the determination and commitment to support whānau through their childbirth experience.

Heather and Nerissa describe their birth experiences as having a major impact on how and why they practice as Kahu Pokai. Heather;

Injustice is what drives me and my big sisters, probably because we were born into it. In whatever shape or form. I can't sit back, I do not want to perpetuate what happened to me, for my girl and my mokos and the women that I really love and care about and I don't care if it gets me in trouble.

Nerissa had multiple experiences that impacted the way in which she now expresses her Kahu Pōkaitanga.

I remember a midwife saying to me, while I was labouring "did you not want to grow up first?" Then saying to my husband (my boyfriend at the time but now husband), "Did you not want to let her grow up? You guys have got your whole lives ahead of you".

... that whole time in the maternity room was really about power. The prejudice around us being teen parents, Māori in a system that really wasn't supportive.

Unfortunately, these moments were not supportive for Nerissa. They have however impacted upon her practice in a positive way. She shared it in this way.

I felt because she was young and Māori she was a statistic. She was just put to the side. So I started being a bit more verbal about things like that, especially for those women. Because, I was that woman.

Joanne also faced particularly challenging birthing moments with her children, especially her twins. Loss of control during that birth led to ongoing post-traumatic stress. These experiences had accumulated, and she became acutely aware of racism and the need to respond: "racism was normalised, inequity was normalised". Joanne built a level of resilience to institutional structures of healthcare but emphasised "it was never easy making a stand". Her reaction was to

⁴⁸Manaakitanga – hospitality, kindness, generosity, support - the process of showing respect, generosity and care for others.

manaaki whānau and create safer passage through the system. This defined her as a Māori midwife.

Being a Māori midwife to me has been about going to those Oranga Tamariki meetings and walking out with good outcomes because I have committed to visiting that mama every morning. Or, it's taking mothers that have a little bit of PND up to spend time getting some healing. Listening to them. It's all of that. It's being a nanny, it's being a good nanny to my mokopuna.

Nicole's experiences as a young mother subjected to prejudices strengthened the way in which she reacted to situations. She utilises tangible guidance provided by her tūpuna.

In a Pākehā way you respond in writing, but our tūpuna didn't do that. They sat in front of one another and they would kōrero. They would put it all out there on the floor. I guess that's another practice that I do that our tūpuna did, I don't sit back and on technology to do the talking for me. You're much better to have those conversations and get a resolution face to face. It is in this process that education and understanding can happen for both parties, including me.

Kendra is critically aware of her character and the impact personal experience has had on her practice as a Kahu Pōkai. From the start of her career, she felt challenged by her age. However, she never let this interrupt her pathway and desire to build her character as a Kahu Pōkai.

My challenge was always about proving myself... I wanted women to know that I was worthy of this and my age played a huge part in needing to prove that... why would you believe a 18-year-old?

...there was a huge combination of finding myself and my cultural identity, which I felt like I had that really well growing up but then moving away it kind of got lost, in that 5-hour drive! But now I'm home.

Living away from home made Kendra cognisant of the importance of whānau and whenua. Kendra's story shows the depth of her learning from experiences in life and explicitly points to the tenets of Pou Tāhuhu that underpin her worldview.

When I was living in Palmie, I would come home and just being home, being around family, going up the coast and visiting the urupa, it reconnects you, fills your cup. It made me feel really good, I'm home, my feet are on the soil. I'd go home then I could carry on. Now, being home I don't do that as often, I don't make that trip up the Coast and it's crazy it's only 2-hours away. But, it's important to make sure you stay connected spiritually because then you always remember who you are and why you are here. Your purpose in life.

Aroha displays a strong relationship to this platform of mātauranga. She talks about compromises that need to be made at times to ensure whānau get the care they require. This level of commitment requires an intrinsic understanding of manaakitanga, which reinforces her passion for the role of being a Kahu Pōkai.

Having whānau in your care is more meaningful and although you always want to be there things happen in your own life, so I do feel we are under pressure and it is hard to take time out. But there's not enough of us so it can be pretty relentless. I lost an uncle who I was really close to, he was like a father figure, he passed unexpectedly and I always regret not making the time to spend with him, this job is so taxing.

Nicole also reiterates the importance of manaakitanga and the ability to ensure multiple worlds are acknowledged to keep whānau safe.

I was my cousin's midwife, that was really special but the outcome wasn't a good one. It's really hard because although the outcome wasn't good, I felt, in hindsight, that I was the right person to be there. We, she, we experienced a stillbirth at term.

Aroha goes on to explain the importance of empathy in allowing mutual understanding to develop. She refers to her approach in a familial way.

Because you approach things the way you do, I gave her a kiss, it was only natural. And, held her, then by the time they left it was all okay. She just had to come and suss it. It's just that distrust that they carry.

These characteristics are shared by Shar, emphasising the fundamental importance of relationships or whānaungatanga. Like Aroha, she shows how manaakitanga is a crucial attribute that nurtures humility and resilience.

We can't grow if we're not tuturu and tika from the start. We need a strong foundation. I reflected on it massively because it was massive, my mana was distraught. I didn't feel like I had a voice. I really felt like a bad midwife and I felt like my reputation as a student was rubbish, so I ran away. I came away and I was received well into another area. I was taken care of and my wounds were healed and I felt strong enough to fly.

I felt strong enough to carry on and continue. But what I learned from that, was actually the resilience to know of humility.

Kiley also acknowledges the centrality of whakawhānaungatanga, or relationships, to enhancing resilience.

I think that's what happened to me and that's where and why I struggled because I didn't have my whānau of Māori midwives that understand, we could all sit, have a big feed, have a big laugh, and 'debrief'. And just be there for each other. I've realised it's so important. It's such a crucial aspect of surviving and being sustainable in this job.

Hine shared this same sense of manaakitanga with a whānau who experienced a traumatic event. Her ability to create an environment that made whānau feel valued and safe is evident in her kōrero.

She messaged me, I'm home now come and see us. So that was cool, her mum came and I thought I'm going to feel the wrath of her mother! But she just gave me a big huge awhi and said, thank you so much for what you did, that was amazing what you guys did. I was

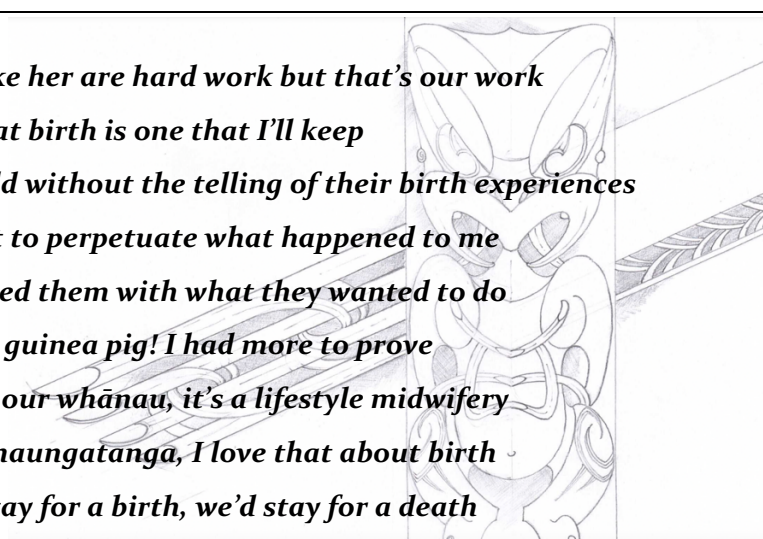
worried, what were the whānau going to think about me, because they were there watching. They've all been very graceful.

Kahu Pōkai have shown they negotiate multiple platforms in caring for whānau. The influence of their personal journeys evident in their practices. Kiley challenges services to get it right for all whānau. Mediocracy and complacency are not acceptable.

If there is one whānau that isn't able to access services then that is one too many as far as I'm concerned. We have all this money and all these things that should be accessible to every whānau, if there is a barrier then we need to look at why. That should be how we see it, including ourselves as Māori midwives.

Whēako encompasses the experiences past and present that have directly impacted the way in which Kahu Pōkai practice. Pou Tāhuhu refers to the innate confirmation and affirmation of identity and purpose. It is where confidence in kaupapa is resolute. Whēako recognises how life encounters have reinforced the passion, purpose and potential as Kahu Pōkai. Resilience was a strong feature that was often revealed by the experience of prejudice. In turn, creating avenues to support whānau through their birthing journey. So, rather than becoming resistant, a stronger sense of manaakitanga emerged. The quotes below are examples of this layer of mātauranga.

NGA KUPU O WHĒAKO



*I think mama like her are hard work but that's our work
That birth is one that I'll keep
The story cannot be told without the telling of their birth experiences
I do not want to perpetuate what happened to me
I just supported them with what they wanted to do
A Māori guinea pig! I had more to prove
We sacrificed our whānau, it's a lifestyle midwifery
That, is whanaungatanga, I love that about birth
Like we'd stay for a birth, we'd stay for a death*

Kahu Pōkai

Kahu Pōkai encompasses the dynamics held within the kupu itself. Kahu integrates the skill and knowledge required to guide birthing whānau safely. It incorporates the element of protection toward this life phase of reproduction. Pōkai or pōkaitanga references the pregnancy cycle, inclusive of pre- and post-pregnancy. This is where the culmination of Matatauihi, Ngā Ururei, and Whēako mātauranga is expressed. Hence, Kahu Pōkai embodies the astute expertise, passion, and commitment for mama and pēpē. Pou Koukouaro is where this dimension belongs. It is situated outside of the whare, a physical representation that once at this stage you have exited the whare and are ready to share in the kaupapa of pōkaitanga. Much of what was expressed from this realm revealed the aptitude required to navigate multiple perspectives, including kaitiakitanga⁴⁹ and tino rangatiratanga.

As the features of Kahu Pōkai began to emerge it was clear that injustices or prejudices personally experienced or witnessed gave ngā ringa hapai motivation and courage to practice in ways that were safer for whānau Māori. Heather reflected upon the power of her kuia working in an era that did not have the constraints of another worldview that was in direct contrast to her own, and that of whānau. Identifying the challenge of adhering to Western modes while providing and promoting whānau-centred care.

In lots of ways, I wished I'd lived in the era of my kuia. I couldn't practice like the book said. I knew what the book said and whānau and I talked about what the book said, and I could do that stuff but that was not what these wāhine and whānau wanted.

Later, Heather emphasises her strong sense of resistance to mainstream modes. She talked about supporting a mama who needed to birth via caesarean section but the mama would not allow the operation to start unless her tohunga was present in the theatre. In an environment controlled by strict medical protocols, a very restrictive worldview, Heather advocated for this to happen.

For me, those are highlights because it was another piece of the jigsaw of, what do I do about institutional racism? Why do I fight so hard about that? Stories like this have fuelled my fight against institutional racism. Being accused and blamed because you chose that "Māori stuff".

Other Kahu Pōkai exhibited feelings of annoyance and again, intolerance toward culturally unacceptable insensitive behaviours. Aroha expressed her feeling toward this. *"It's tiring though, because it's constant, why should we put up with it? Again and again. Just get names right".* Frustrating experiences like these diminish the mana of someone's name and nurture unrest

⁴⁹ Kaitiakitanga - guardianship, stewardship, trusteeship, trustee.

amidst the Māori midwifery workforce. As Aroha has implied, and Nerissa has stated, these scenarios are not new, nor are they improving.

Aroha shared another situation that exposed outright racially charged assumptions. Aroha's mama had birthed without Aroha being there.

I had a mama that I found out was being discharged with baby, then I have staff saying to me, did you have a mum that you didn't even know she was in labour, she had a baby and she was a first-time mother?

Staff assumed this mama had no LMC midwife. However, no one had checked. Aroha was the named LMC on her file. These types of practices are neglectful, based upon unfair bias and predetermined ideas that young brown women do not care about their health or the health of their baby enough to enrol in maternity care. Nicole shared another example of colleagues making assumptive predisposed evaluations of a situation.

She said, I thought you were an aunty and I said, that's a good thing isn't it? Wouldn't it be good thing that I'm looking after my own whānau? How would that be a disadvantage that I was their aunty?

Regardless of the extenuating scenario, the idea that an aunty could have a professional role in the care of wāhine was rejected and regarded as dangerous. Differing worldviews are the basis of many incidences that Kahu Pōkai must fight against. Nerissa is cognisant of the influence the dominant worldview can have upon birthing whānau. She has used her understanding as a whānau who was confronted by the limitation of prejudice during their birthing journey to model her Kahu Pōkaitanga. Nerissa recognises uniqueness in others, rejecting the ideology of superiority.

I felt because she was young and Māori she was a statistic. She was just put to the side. So I started being a bit more verbal about things like that, especially for those women. Because, I was that woman.

This awareness has nurtured strong practice ethics and the importance of acknowledging the mātauranga each whānau share.

I learned a lot from that girl. She was a beautiful girl, and she's a beautiful mother. She still makes her son call me nanny, and she calls me mummy!! I saw in her, me. But she didn't have support like I had. So, I became that person for her.

Kiley highlights the relationship Kahu Pōkai foster with birthing whānau. She points out; "we're the ones that are hands-on, seeing it, doing it. We're the ones that have the actual connection". Kiley goes on to emphasise the frustration of being asked for Indigenous perspectives, offering advice, but the prospect of what has been given exceeds monocultural boundaries, therefore not

followed through. *“We can’t keep teaching them or telling them how their governance and their policies are wrong for our people, when they don’t want to have a bar of it”.*

The insistence of one worldview imposing its framework upon another is reiterated by Shar.

They said, oh you should have written this, they said I cut myself short not putting it in. I thought, I’m not even going to play with you guys... I can say in one whakataukī, that others will need to write in 10 pages, one whakataukī will have the same meaning.

Heather goes on to point out her drive to address the barriers, in particular racism, that whānau endure. Her reference to the ‘battles’ is the institutional structures that eventuate in inequitable outcomes, especially for mokopuna. Heather has grown intolerant toward time-wasting that is unbeneficial for whānau.

The battlefield is just in a different place now, same battle. And I’ve learned that you only do the battles not the skirmishes. Skirmishes are not worth the time, pick the big ones. The big ones because they are the long term and they will benefit my moko girls and all whānau.

The ultimate insult directed at Joanne insinuated that she would act in a way to deliberately cause harm is, in itself professionally incomprehensible. This statement confronted her: *“are you happy you’ve killed one now? Joanne’s immediate response was; “well by the looks of him he’s still alive so no I haven’t, I haven’t killed anybody”.*

Joanne then had the complete opposite reaction from the whānau. They understood the intensity of what she had done for them and their baby. Acknowledging how exhausted she must have been. *“I’d been up all night and they sent me home. I didn’t go home. I went to the house, and I cleaned up so that they didn’t come home to all the birth mess”.* Rather than go home, Joanne chose to return to the whare and clean up. A simple act of manaakitanga and aroha.

Kendra shared her experience receiving manaakitanga during her training, particularly from a senior Māori midwife. The feeling of being treated special because of their whakapapa connection made a difference to Kendra.

I think I got treated differently by her. I could do no wrong in her eyes, we would have our own little meetings and catch-ups, it might not even have been about midwifery. She may have just come back from home or I had just been home.

The sentiment of instilling tino rangatiratanga and kaitiakitanga toward birthing whānau was common among Kahu Pōkai. Nicole shared her experience of caring for whānau as a bigger responsibility than just being the midwifery expert.

As midwives we advocate for women but in this case it was more than the midwifery, it was whānau and it was special for me because I knew that I could support her in a way that nobody else could have. I was her midwife, but also I was her whānau.

There is a greater sense of responsibility toward birthing whānau when they are whānau. The epitome of whakawhānaungatanga ensures care is both culturally and whānau-safe. Kahu Pōkai have acknowledged an inherent ease in providing care uniquely Māori. However, Kendra recognises being Māori does not always allow birthing whānau to feel safe. This can be a hard-earned privilege that requires specific skills and aptitude. Kendra implies the ability to create a true partnership with whānau starts with building trust.

You don't just get trust by just being the midwife or being Māori. You have to earn trust. And it's not just about the woman, it's the whole whānau. In fact, most of the time you are trying to get trust from the whānau, not from the actual woman. You can't just focus on the woman, you have to have everyone on board then it makes it a whole lot easier, being equal.

These moments of connection are important to Kahu Pōkai. Kiley expressed the importance of being surrounded by things and people of te ao Māori. Aroha takes that further by highlighting that she is not a midwife to care for others, her passion and purpose is to serve whānau Māori.

The daily happenings of a health practice that was drenched in te ao Māori, Māori people and kaumātua. Te ao Māori flowed through all of the services and we were like a working whānau. I loved it, it was great.

I'm not here to look after others there's lots to look after others but there's not many to look after our own.

Notions such as these overlap and intertwine. The following excerpt highlights the physical, spiritual, and clinical nuances of being Kahu Pokai. Hine talks about “hearing” a pēpē that was stillborn, poised in a moment of hearing silence. The quiet a sound of its own. “I couldn't find a heartbeat. I couldn't even hear a placenta, couldn't hear anything, nothing. And I thought, I think I know what this is, but I'd never heard a stillbirth baby”.

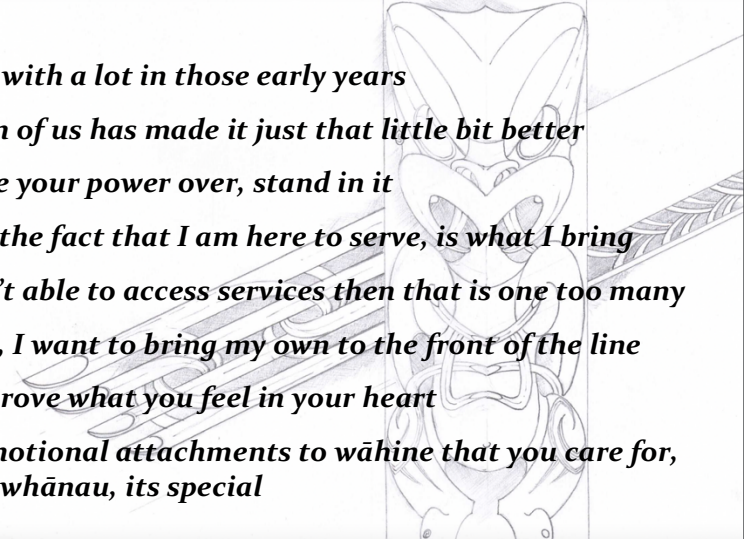
The whakataauakī below expresses the connection to Atua and tīpuna, uniting the most important element, tangata. In the same sense, Kahu Pōkai as a dynamic of being a Kahu Pōkai is an accumulation of the mātauranga gathered from Matatauihi, Ngā Ururei, and Whēako. Pou Koukouaro provides the stability to share in the expertise and passion of Pōkaitanga nurturing the well-being of birthing whānau.

Tuhia ki te rangi, tuhia ki te whenua, tuhia ki te ngakau i te tangata.
He mea pai ko te aroha ki te tangata Maori
It is written in the sky, it is written in the land

The greatest of all is love toward the Māori nation. (Paraone Tai Tin)

As descendants of Atua, Ariki, and tīpuna, Kahu Pōkai encompasses an absolute point of knowing one's passion and drive to provide for mama and pēpē. Ngā ringa hāpai demonstrated Kahu Pōkai in a way that exposed moments of resilience and determination to do better for others whilst celebrating being Māori. Kaitiakitanga, manaakitanga, and tino rangatiratanga were weaved throughout their stories. The following excerpts highlight this realm of thinking affirming the confidence, passion and purpose of being a Kahu Pōkai.

NGĀ KUPU O KAHU PŌKAI



*We put up with a lot in those early years
I think every generation of us has made it just that little bit better
Don't give your power over, stand in it
I believe that humility and the fact that I am here to serve, is what I bring
If there is one whānau that isn't able to access services then that is one too many
I want to see my own thrive, I want to bring my own to the front of the line
It's hard to prove what you feel in your heart
It's really humbling to have emotional attachments to wāhine that you care for,
whānau, its special*

CHAPTER SEVEN

Whakawhiti Kōrero (Discussion)

This research offered Kahu Pōkai the opportunity to have their stories told. It was important to privilege Indigenous knowledge to show how Kahu Pōkai embed their expertise within their practice. Therefore, grounding the research in Kaupapa Māori and Mana Wāhine ensured the process, analysis, and outcomes prioritised Māori thinking. In doing so, a theoretical examination of Māori midwifery is offered. The findings have been presented and expose knowledge that had not yet been recorded. This chapter summarises the main features while emphasising the mana of Kahu Pōkai mātauranga. As Pihama (2019a) stated;

Mana wahine aligns with an urgent need to rebalance. There are components of mana wahine that are about the essence of mana itself, and there are components that are about redressing the impact of oppressive colonising views and practices that deny the place and position of Indigenous women. (p. 195)

In the beginning of this thesis, several research priorities were identified. These included to show how Kahu Pōkai embed Indigenous knowledge and governance in practice, embrace whānau well-being, and improve the cultural awareness of non-Indigenous colleagues (Hickey, 2021). It was also crucial for this research to find tangible evidence that Kahu Pōkai influence pathways to improve whānau well-being and make birthing safer for whānau. Therefore, this discussion will define how Kahu Pōkai practice in a way that extends upon these notions with particular emphasis upon the relationship Kahu Pōkai have with Matatauihi, Ngā Ururei, Whēako, and Kahu Pōkai. I have framed the discussion under four key areas; Mana Atua, Mana Tīpuna, Mana Whenua, and Mana Tangata. These concepts provide the platform to summarise the key themes and was inspired by Kiley; *“there is more mana in being a Māori midwife”*.

Framing the kōrero around Mana also uncovers the characteristics that Kahu Pōkai innately hold and the difference they make for birthing whānau. Processes of oppression have in the past, rendered wāhine Māori irrelevant and invisible (Irwin, 1992). Kahu Pōkai actively resist that kōrero and re-position wāhine, whānau Māori to a place of control and autonomy. This study conceptualised the expertise of Kahu Pōkai revealing how oppressive environments are addressed in a manner that enhances Māori maternities. Aroha highlights this when she tells us, she is not there for others, her intention is to bring whānau Māori to the front.

Pere (1982) discussed the concept of mana as reciprocal and intergenerational. She added, no matter how it is obtained, “mana permeates the ethos of Māori life and encompasses aroha and

reciprocity” (p. 37). Pere goes on to emphasise, whether as collective or an individual, anything that has been received (positive or negative) will be reciprocated. Kahu Pōkai shared their experience of humility, gratitude, and privilege of being present for birthing whānau. In response to personal and professional experiences of prejudice, bias, and racism, many talked about the responsibility of protecting the mana of childbirth. Tikanga were driven by and responded to with aroha. Aroha, defined as ‘aro’ to focus, and ‘ha’ the energy, then becomes a reciprocal space to uphold someone with compassion and consideration of their energy (wānanga, Paraone Tai Tin, July 2024).

Te Whare-kōrero ā Kahu Pōkai created the environment to focus upon the notions that underpin the experience of being a Māori midwife. Nine Kahu Pōkai exposed how they value and protect the sacred space of birth and revealed innate mātauranga constantly in play. These were the principles held in He Matatauihi I Ngā Ururei Whēako hei Kahu Pōkai. Further discussion showed how each dimension strengthens the provision of Māori midwifery. Matatauihi mātauranga reinforces the concepts of Whēako and Kahu Pōkai as directed by Ngā Ururei. Each element intertwining and overlapping to support each other. To date, Western knowledge dominates the discourse of childbirth propagating its superiority in all platforms. However, the findings of this research validate mātauranga Māori and assert childbirth is made safer by Kahu Pōkai in ways that go beyond the current models and philosophy of maternity care.

Mana Atua

Mana is the enduring, indestructible power of the gods. It is the sacred fire that is without beginning and without end... In modern times the term mana has taken on various meanings, including the power of the gods, the power of ancestors, the power of the land and the power of the individual. (Barlow, 1991, p. 61)

It is believed that all things in life, including the procreation of the human being, are designed by those in Te Ao Marama. Pou Tuarongo provides the connection to the Atua and tīpuna that reside in Te Ao Marama. Matatauihi is the inner sense that draws you to follow a calling founded and grounded in whakapapa, it is innate to the wairua (wānanga, Paraone Tai Tin, July 2024).

The whatumanawa plays a key role in Matatauihi as the knowledge source that links the tangible manifestations of physical and spiritual experiences. Kahu Pōkai conveyed being a midwife was an intuitive, instinctive awareness or calling, rather than a career they had consciously sought. These innate feelings that many Kahu Pōkai spoke about come from the mātauranga of the

whatumanawa. Melbourne (2009) further explained the presence of the whatumanawa is felt when the conscious mind surrenders to ubiquity. Intuition is the prominent action, it is to act by not thinking, defined as cellular memory. Transmitted intergenerationally, activation of cellular memory is also the practice of the whatumanawa. Shar and Aroha talked about “*that feeling in your puku*”, the pumanawa in action. When these structures are working in unison there is synergy between Atua and tīpuna (wānanga, Paraone Tai Tin, July 2024).

Recognition of our whatumanawa has been stifled by the many sounds of the Western dominant worldview including colonisation, the fear of professionally culpability, and potential reputational contempt. Therefore, over time, the influence of non-Māori thinking has reduced our ability to respond to this mātauranga (Tapiata, 2024; wānanga, Paraone Tai Tin, July 2024). However, Kahu Pōkai have shown that although the hinengaro can disregard the intention of the messages, the whatumanawa is innately active. Melbourne (2009) added it is also the practice of “divine nature” (p. 44) and further advised, “Once the mind is clear, the whatumanawa becomes prominent and instinct and intuition prevail but remains under constant pressure from the hinengaro that strives to dominate – to be heard” (Melbourne, 2009, p. 45).

Kahu Pōkai showed the ability to tune into spiritual dimensions. They described these as intentional messages directing their pathway in life, affirming the presence of Atua in the way in which they practice. It is this spiritual mātauranga that contributes to intellectual mātauranga. These sources of mātauranga embrace and acknowledge the power of wāhine Māori. Hineahuone, the first ira tangata or human being took shape from the physical and metaphysical expression of Atua. Tapiata (2024) described, “Of Hineteiwaiwa²⁰, we see her cyclical nature, attuned with the natural world. Of Tāwhirimātea²¹, we see the respiratory system. Of Rongomātāne²² and Hinepūtehue²³, the parasympathetic nervous system, of Tūmatauenga²⁴, the muscles and so on” (p. 1).

Once the physical form had been completed, Tāne Mahuta gave Hineahuone hongī, passing the breath life. Hineahuone represents the whakapapa of te ira atua and te ira tangata, spiritual being and humankind. Tapiata (2024) goes on to explain the make-up of Hineahuone was very

²⁰ Hineteiwaiwa – Deity of birth and weaving.

²¹ Tāwhiriātea – Deity of winds.

²² Rongomātāne – Deity of cultivated food.

²³ Hinepūtehue – Deity of hue (or gourd).

²⁴ Tūmatauenga – Deity of warfare and man.

intentional, she only got what she needed to fulfil her purpose. Just as her descendants are created with intention and as outlined in Matatauihi with purpose. This pūrākau reminds Māori that Atua are within us and we are an expression of them. “Koirā te mana o te wāhine – the prestige, power and grace of women. To be born from, through and into this world to bring about change and create new worlds in the process” (Tapiata, 2024, p. 2).

Through wāhine the iwi receive continuity (Mahuika, 1973) and it is kōrero such as this, that provide wāhine Māori evidence to be guided in life both personally and professionally. Kahu Pōkai exemplify these characteristics; the feeling in the ‘puku’, recognising they are there to protect the wairua, mauri, and, therefore, the mana of whakapapa. They possess the humility to know that each whānau and every pēpē are born in their own mana or greatness of their whakapapa, Atua ever-present. Kahu Pōkai recognise the integral capacity of wāhine Māori and their inherent connection to the mana of Atua. As Shar expressed; “*Who am I to say I empower them?*”.

Mana Tīpuna

This is the power or authority handed down through chiefly lineage; that is, from the paramount chiefs and others who possessed it. The power is passed down from generation to generation. Those who inherit mana must carry out the various rituals and duties to maintain this power handed down from the ancient ones. (Barlow, 1991, p. 61)

Atua wāhine were powerful figures, vital to the creation of humankind, as much as, if not more, than tāne Atua. Hence, the status of wāhine depicted in whakapapa tell of authorities of knowledge, communication, physical and mental strength. Wāhine were held in the highest regard, in many cases their prowess unmatched (Mahuika, 1973).

Hinerupe, esteemed tīpuna wāhine of Ngāti Porou, held mana whenua and mana tangata, authority of the land and people. Her mana and, therefore, leadership of Te Whānau-a-Hinerupe was such that her two older sisters gave their land to her. The extent of her mana whenua is expressed in this Ngāti Porou saying: “Mai te moana tae noa atu ki te ao parauri. From the sea to as far as the eye can see” (Mahuika, 1973, p. 39). Pūrākau such as these hold validity for every hapū and iwi, each have their own wāhine tīpuna that exhibit such qualities. Unlike the re-told tales from settler ethnographers, wāhine were never considered less than tāne. They were revered as holding the power to bring life into the world, the life source of mana and tapu (Murphy, 2023).

Ngā Ururei are the ancient practices that are driven by the knowledge of such tīpuna. They are the taonga tuku iho and tikanga that keep Māori physically and spiritually safe as well as provide practical guidance. Poutokomanawa facilitates the continual process of aligning to kaupapa through the stages of growth. Kahu Pōkai identified in multiple ways being led by Atua and tīpuna. Their feats of greatness may not be that of Hinerupe; however, Kahu Pōkai constantly navigate multiple complexities in dual worlds. Many of these domains often denying a Māori way of being (Tupara & Tahere, 2020). Nevertheless, Kahu Pōkai are skilled in promoting tikanga amid dominant Pākehā environments. Like Heather displayed in ensuring tohunga presence during a surgical procedure. Nicole exposed the normality of whānau caring for whānau. Nerissa traversed environments that potentially threatened her safety to provide care. These platforms actively resisting societal definitions of what is considered normal, particularly amid midwifery care. They demand astute intellectual and cultural awareness. Kahu Pōkai excel in these domains of mātauranga.

Kaitiakitanga was an important attribute that emerged, the active awareness of keeping knowledge in its absolute state upholding the mana and integrity of those sources (wānanga, Paraone Tai Tin, August 2024). Kahu Pōkai showed a deep affinity and recognition to the place they hold in protecting these practices. So, while Matauihi encompasses the sacred role of calling spiritual and physical energies to the kaupapa by the female voice, Ngā Ururei brings forward the practices guided by Tīpuna such as during karanga. Rhonda Tibble expressed so eloquently in her kōrero;

while you might be afraid of this taonga, what this taonga does is, it forces you to take your place in whakapapa to pull together all of the assest classes of cultural objects that need to be feed to your mokopuna's mokopuna. (wananga, May 2024)

Barlow (1991) highlighted the comparison between karanga on the marae and the sound of wāhine giving birth. Like the karanga calling to those that have passed into the spiritual world, when wāhine cry out in childbirth they are calling their pēpē to Te Ao Marama. Wāhine have the ability to activate a state of scaredness or tapu and, when the time is right, return that space to noa or neutral again. It is the pitch of wāhine's voice that penetrates the realms of the spiritual world, a powerful tool that is often heard in childbirth. Barlow offered this expression;

He wahine te kaitohu i te tapu

He wahine hoki te kaiwhakanoa i te tapu.

A woman instigates the sacred; a woman dissipates the sacred. (p. 38)

Kahu Pōkai actively facilitate the practice of tikanga such as karanga, karakia, and muka. Beyond this, they acknowledge the importance of whānau taking control of their births. The subtlety of practices that ensure the human voice and touch belong to whānau. These are empowering examples of tikanga that protect birthing and, more importantly, the mana of whānau. Kaitiakitanga encapsulates maintaining the integrity of tikanga, such as these, and the connection to whakapapa of both ancestral lineage and knowledge. Through sound vibrations and tactile experience these pēpē are welcomed to Te Ao Marama by the mana of their tīpuna.

Mana Whenua

This is the power associated with the possession of lands; it is also the power associated with the ability of the land to produce the bounties of nature. When the world was created, the gods implanted this procreative power within the womb of the Mother Earth. By the power of mana mauri all things have the potential for growth and development towards maturity. (Barlow, 1991, p. 61)

The analogy of the umbilical cord bonding humankind to earth is both relevant and predicated upon whakapapa lineage that can be traced back to human creation. Hone Sadler (2014) stated, “genealogy is more than the genealogy of man” (p. 149); it includes everything from cosmology, Atua, and anthropological accounts. They are interrelated and connected to the human element. Legitimate taxonomy that instils a level of responsibility beyond the sphere of the current generations.

Whēako brought forward the shared experience of discrimination and prejudice. These encounters embedded the importance of making birthing a safer space for whānau and Kahu Pōkai alike. Kahu Pōkai understand traditional knowledge is sacred, resources are limited; hence, the influence of the practitioner is crucial to birthing whānau. This encouraged Kahu Pōkai to create ways to manaaki whānau with integrity and humility.

The practical and secular lens Kahu Pōkai apply is critical to the survival and promotion of these worldviews. Hickey et al. (2021) urged an active stance to influence the cultural awareness of colleagues. Kendra highlighted the fluid use of te reo Māori and traditional practices such as muka have influenced the normalisation of these tikanga in mainstream settings, along with promoting support from non-Māori practitioners.

Kahu Pōkai consistently drew attention to the accountability of these Indigenous perspectives. Joanne made the point in stating that all whenua (placenta) she had birthed had returned to

the whenua (land). Shar highlighted her relationship to the whenua in the tikanga of muka. She describes the intertwining of the muka fibres with the pito to become one then it gets returned to Papatūānuku. Kendra put it simply, being home on her whenua, with people of her uri (descent), is what makes her a Māori midwife. These epistemological accounts literally connect to Papatūānuku and in many ways ground the logic of being a Kahu Pōkai.

Upholding tikanga, such as returning whenua to Papatūānuku, acknowledges the mana of whenua and the mana of birthing. Pou Tāhuhu facilitates the confidence in who each practitioner is and how they present their mātauranga to birthing whānau. To some extent Kahu Pōkai are seen as guardians of this knowledge; however, Kahu Pōkai showed the importance of sharing mātauranga to strengthen whānau well-being as well as their own.

Mana Tangata

This is the power acquired by an individual according to his or her ability and effort to develop skills and to gain knowledge in particular areas. For example, a skilled warrior was able to acquire mana through the arts of combat and warfare under the code of law of Tūmataunga the god of war. Women have personal power in respect of their role in taking care of children and, on the marae, in welcoming and caring for visitors. (Barlow, 1991, p. 62)

The accumulation of knowledge and development of skills to express the absolute commitment, unique passion, and purpose activated for mama and their baby is captured in Kahu Pōkai. Sadler (2014) noted, “mana is able to be dispersed from mana atua to be inherited through mana whenua and then to mana tangata” (p. 143). This gives effect to the roles of tangata whenua in their communities. According to Sadler (2014) mana is not a human element, it comes from Atua that is then bestowed to men and women through whakapapa. Therefore the way in which mana is perceived is by the level of inspiration or mutual charismatic respect. Pere (1982) aligned to this thinking, highlighting mana as encompassing sacred inspiration, captivating confidence and values that exert the thoughts of our ancestors.

Whanaungatanga or the ability to create relationships was a seemingly obvious connector of Kahu Pōkai and birthing whānau. However, the idea often went beyond a meaningful intimate connection and confirmed the association of Matatauihi. Kahu Pōkai recognised the power and energy of the pēpē emerging from the realm of Atua to human life. The privilege of being there to witness that moment was often expressed. Shar emphasised the maturity to be humble, that she is there to serve whānau as the quality she brings to the birthing arena. Nicole expressed

this in the emotional attachments that occur when wāhine are actual whānau, the existing level of whanaungatanga that deepens through birthing together.

Pou Koukouaro indicates a readiness to be tangibly able and ready to disseminate mātauranga (wānanga, Paraone Tai Tin, August 2021). Like Nēpia Mahuika (2021) highlighted, our ancestors were “not passive or powerless bystanders” they were “agents of change that negotiated their own experiences” (p. 156). He continued to say, historical intellect, linguistic astuteness, and theoretical foundations build upon inherent Indigenous intelligence to create avenues for whānau to thrive. Kahu Pōkai excel in these platforms of mātauranga.

Conclusion

The Whare-kōrero ā Kahu Pōkai provided founding ideologies that represent te ao Māori. As an arena of mātauranga the Whare-kōrero has endured competing worldviews, nurtures evolutionary vision whilst protecting taonga tuku iho. For this reason, Matatauihi, Ngā Ururei, Whēako, and Kahu Pōkai actively promotes tino rangatiratanga. It is a sphere of mātauranga that embodies transformative praxis and solutions embedded mātauranga Māori (wānanga, Paraone Tai Tin, July 2024). This research exposed specific knowledge sources unique to Kahu Pōkai and explicitly brought forward the voice of Indigenous midwives of Aotearoa.

Matatauihi is the thread that connects the whatumanawa. Ngā Ururei is the component that facilitates the presence of Atua. Matatauihi driven by the whatumanawa and Ngā Ururei directed by Tīpuna and Atua, are elements that connect whakapapa. Thus, whether or not there is conscious awareness, guidance from this realm is constant. Sequentially, Ngā Ururei influences the way in which Whēako and Kahu Pokai are expressed. Five pou make up the Whare-kōrero, this research focused upon four: Pou Tuarongo, Poutokomanawa, Pou Tāhuhu, and Pou Koukouaro. The fifth pou, Pou Roua, acknowledges all things in life need both physical and spiritual protection. Pou Roua overarched all the phases of mātauranga in recognition that all areas require protection. Kahu Pōkai create multiple layers of protection including physical, spiritual and cultural.

Kahu Pokai created avenues to support tino rangatiratanga and empower wāhine to intuitively be their Māori-selves. Their practice encapsulated a restorative approach to intergenerational experiences of assimilation, oppression and trauma. It was underpinned by the notion of interconnectedness to ancient realms of whakapapa, tikanga, and mātauranga. Within this, the expression of kaitiakitanga, manaakitanga and whanaungatanga were central. The institution

of the maternity system merely provided the infrastructure to offer midwifery care as defined by Kahu Pōkai.

Individually and collectively Kahu Pōkai exhibited their commitment to the future of Māori midwifery. More importantly they exposed their dedication to enhancing the mana of whānau, hapū, and iwi. Comments such as; *“You might have midwife title but you’re way more than that to whānau. Otherwise you wouldn’t be there”* (Heather) accentuates the responsibility of being there is for more than is outlined in the midwifery scope of practice. It unequivocally acknowledges the broader responsibility to whakapapa and incorporates the importance of whanaungatanga, the nurturing of relationships.

Fundamentally Kahu Pōkai practice in ways that extend beyond the boundaries of mainstream midwifery expectations. Kahu Pōkai attend to whānau, not just woman, they attend to birth and death in the same way, recognising the sphere in which these life events dwell are intimately entwined. Each Kahu Pōkai showed their connection to being a midwife was pre-ordained, within their whakapapa or driven by tīpuna. Therefore, their place in the profession, in their communities, and in their whānau was enabled by their inherent understanding of a role they are meant to fulfil. They exemplified their intrinsic ability to intertwine concepts that are influenced by Atua, tīpuna, and the physical connection to whakapapa. These cultural knowledge sources are what makes Kahu Pōkai unique.

CHAPTER EIGHT

Kōrero Whakamutunga

At the recent Ngā Maia Hui a Tau (2024) Ngāhuia Murphy presented. Her opening remarks passionately stated that the first insult to Indigenous knowledge started by settlers redefining spiritual beliefs and practices. This began the undeniable, deliberate subjugation of te ao Māori in a way that particularly denied the position and prominence of wāhine Māori. Ethnographers re-shaped chronicles to favour their patriarchal, male-centric worldview. Wāhine Māori, Atua, wāhine, and Indigenous female knowledges were defined as myths and legends lending understandings to the realm of the imagination (Jenkins & Pihama, 2001; Mikaere, 2017). Jacqueline Martin (2023) described these incorrect interpretations as “Pākehā myths masquerading as facts” (p. 227).

Wāhine Māori have experienced and continue to experience, a unique history of colonisation. Patriarchal models served to suppress and ignore the status of wāhine. Many wāhine scholars including Martin (2023); Mikaere (2017); Murphy (2011a), and (Simmonds, 2014) highlighted the insidious nature of patriarchal power to the reshaping of Indigenous mātauranga, particularly for birthing. So although avenues to authentic discourses are increasing (Melbourne, 2009; Mikaere, 2017; Mildon, 2018; Murphy, 2023; Sadler, 2014) many stories will continue to require processes of decolonisation to reveal an accurate Māori worldview (Simmonds, 2014).

In a very timely conversation, the use of pounamu to cut the pito (umbilical cord) was discussed. An expert of whakapapa and mātauranga taiao (Māori environmental science), Ihirangi Heke (kōrero, November 2024), queried the use of pounamu and my thoughts on this tikanga. He went on to highlight his research in the whakapapa of pōhatu (stone), specifically tūhua (obsidian) and kūtai (mussel shell), as tools for this practice. Both of these materials are used by Kahu Pōkai; however, pounamu is also commonly promoted for this practice. In his exploration of this mātauranga he has found whakapapa to tūhua and kūtai but, as yet, not to pounamu. The use of tūhua instils warrior qualities and kūtai will enhance a child’s skill in the water. These theories make sense. They also highlight practitioners of mātauranga Māori go beyond the common threads of knowledge to examine deeper understanding that belong in whakapapa. My point to this kōrero is that although tangata whenua have reclaimed much mātauranga, there is so much more to discover and uncover. However, we no longer need to rely on kōrero that have been constructed by others. We have our own.

Kōrero such as this is critical in revealing the value of resilience and qualities of transformative practice. They also provide additional validation to the mātauranga this research has revealed, particularly for Kahu Pōkai. As Kathie Irwin (1992) said;

We need to actively honour, to celebrate the contributions, and affirm the mana of Māori women: those tūpuna wahine who have gone before us; those wahine toa who give strength to our culture and people today; and those kōtiro and mokopuna who are being born now, and who will be born in the future to fulfil our dreams. (p. 1)

Warbrick et al. (2023) showed there is growing momentum to support health structures that are underpinned by mātauranga Māori approaches and tikanga Māori based rather than colonial systems of knowledge. Therefore, traditional mātauranga are key drivers for change, along with Indigenous epistemologies that intertwine the human, ecological, and spiritual networks. These modes of knowledge are integral to health. Māori maternities innately incorporate the relationship with Papatūānuku to healthier outcomes. This is deeply entrenched within the pūrākau of Māori evolution and conception of humankind. As well as the pūrākau presented in this thesis.

However, there is no avenue that teaches tauira how to thrive in this mātauranga. Nor would it be wise to advocate for kaupapa such as this to be taught in the current midwifery educational pathway. Mātauranga like this demands an environment that is immersed in te ao Māori. It requires experts, such as Paraone Tai tin, Ngahuia Murphy, and Ihirangi Heke, to evolve the learning of being a Kahu Pōkai. Cultural astuteness is as crucial as clinical aptitude. This research has revealed tangata whenua have clinical indicators that extend beyond the physicality of the human body. These knowledges need further attention. Murphy (2023) described her examination of Māori menstrual lore as more than a restorative process. It was a political statement, an opportunity for transformative action that re-positioned and re-aligned wāhine Māori knowledges to “uphold the laws of balance” (p. 16). So, like, Murphy (2023) this research deliberately puts forward mātauranga Māori as exceptionally normal and essential.

Clinical safety has not feature greatly in this thesis. This is not to say that Kahu Pōkai are not clinically safe, far from it. It does, however, emphasise the intersectional difference of worldviews and what counts as important. Attention to the sacred versus secular highlighted the focus that defined what was important. Although it was taken for granted that clinical safety was entwined in the practice of Kahu Pōkai, these traits were displayed in their kōrero. Many described clinical emergency and birthing situations that required acute competent clinical

attention. Although it was obvious in the kōrero that clinical skills were of a high level, they were spoken about as almost secondary to the importance of ensuring the environment continued to empower tikanga and mātauranga. Joanne described her astute life-support skills, Nicole talked about an emergency situation in a car park, Hine tuned into the silence of stillbirth. Heather told us she knew all the textbook knowledge and could do what the textbooks told her to do but whānau deserved more.

The statistical difference that Kahu Pōkai make did not feature in the kōrero and unfortunately (or opportunely) is not where the data took me. However, as a midwife that has examined maternal and infant outcomes, I know my statistics are equivalent to non-Māori outcomes. So, I hypothesise Kahu Pōkai make a statistical difference to outcomes. This, however, will take further research to confirm. More importantly, Kahu Pōkai have displayed a commitment to whānau that is unequivocal. Their cultural expertise and confidence are astute despite the hostile institutions that have informed their clinical expertise. In fact, in most cases it has been the personal experience of these environments that has grown the desire to resist and, therefore, protect whānau, promoting restorative praxis.

Recommendations

Tauira Kahu Pōkai Education

This research supports the impetus for change (Warbrick et al., 2023) to the way in which health services, particularly maternity services, are founded. Some years ago Tupara (2001) highlighted the need for midwifery education to work in partnership with tangata whenua so that the diversity of Māori is recognised. Martin (2023) also highlighted the role midwifery education has in recognising and responding to distinct Māori worldview. Experience of racism, or lack of, is crucial to retention and sustainability of the Māori midwifery workforce (Tupara & Tahere, 2020).

This research has shown a strong indication for Kahu Pōkai education that is kaupapa driven and mokopuna inspired. Cultural application in midwifery practice is critically relevant. The surge of Kura Kaupapa educated rangatahi (young people) will demand tertiary educational institutions support their cultural intelligence so they continue to thrive. Alongside this, I argue tauira (Māori students) require midwifery education that is more than just culturally responsive. Te Tiriti o Waitangi and Turanga Kaupapa education alone are no longer sufficient. This is not to undermine the absolute value of these topics in mainstream education; however, tangata whenua require environments that go beyond these arenas. Kahu Pōkai elevate metaphysical understandings that reveal an ongoing relationship between Atua and tīpuna. Therefore, to

support this mātauranga and advance its application in Māori maternities our educational environment needs to merge into a pedagogy of Whare-wānanga.

Kahu Pōkai Aspiration

At the time of interviewing, the te reo Māori fluency of the Kahu Pōkai was limited. This is by no means a critique on Kahu Pōkai. Te reo deficiency is the fallout of intergenerational insult and impact of colonial acts. However, the forecast of Māori population growth and increase in Māori birth rates, along with expectation that services are culturally appropriate, mean te reo Māori proficiency will be an expectation. Currently there are no mechanisms in place that allow Kahu Pōkai to take time (without losing remuneration) to develop te reo Māori fluency. Further, the midwifery professional bodies are yet to recognise te reo Māori as a critical element to being a Māori midwife.

The purpose of the Pae Ora Act (New Zealand Government, 2023b) was to provide the provision for services to be equitable, that they protect, promote, and improve health for all, but especially Māori. From that, Kahu Taurima was established and has recently undertaken the commissioning framework for maternity and early years services. The framework will ultimately be nationally enabled, regionally led, and locally driven. Along with this, midwifery professional bodies have recently undertaken processes to align to be Te Tiriti honouring organisations (Milne et al., 2023; Te Tatau o te Whare Kahu Midwifery Council, n.d). It is possible that professional cultural aspirations such as reo fluency will be supported by the Kahu Taurima commissioning framework. However, it would be advantageous for the profession of midwifery to substantially support Kahu Pōkai to advance their cultural capability, especially in te reo Māori. More importantly, it would significantly indicate a true commitment to honouring Te Tiriti o Waitangi and the place tangata whenua rightly hold in the birthing arena.

Te Tiriti Partnership

The Waitangi Tribunal (2019) advised the need to advance the idea of partnership, protection, and participation to include tino rangatiratanga, active protection and equity. This requires significant review of current models and their application. It is no surprise then, that the renowned Partnership model (Guilliland & Pairman, 1994, 2010) of midwifery in Aotearoa did not feature in the kōrero of Kahu Pōkai. Although reference was made to partnership as something midwives are meant to be in with women, a stronger perspective emerged that included service to whānau and advancing whānau well-being; rather than the assumption of implicating another's power. This context highlights a fundamental difference in the idea of power-sharing. For Māori to consider they are able to directly impact anyone's power or mana

is to suppose their mana is greater than the other. Pere (1982), Barlow (1991), and Sadler (2014) discuss the source of mana being from Atua, bestowed by whakapapa. In this sense, it is not for another human to feel they have the ability to disperse mana. This is only one dynamic of the Partnership model that from a Māori perspective is illogical.

If the idea of 'working in partnership' is to hold validity and enhance Māori maternities then, at the very least, a complete review of its primary elements is crucial. First and foremost, the notion of partnership is based upon the tenets set out in Treaty of Waitangi. This is an outdated idea that has yet to yield substantial outcomes for Māori. Therefore, the foundational value of the model is inherently flawed. As well, the individualised, women-centred approach disregards the importance of whānau and the value of an interconnected environment. Also, the concept of shared responsibility assumes the practitioner and the woman are of equal status. However, it is well documented that Māori maternity consumers are overwhelmingly disadvantaged socially, economically and culturally (MOH, 2019c, 2020b); therefore, it is unreasonable to suggest equal status exists between the midwife and wāhine.

Kenney (2011) provided an in-depth critique of the Partnership model and how it relates to Māori, highlighting its inadequacies over a decade ago. Along with Kenney, B. Te Huia (2020) and Tupara (2001) argued the partnership framework is not consistent with Māori worldview. It would seem the eagerness of the midwifery profession to consider change is not forthcoming. Unfortunately, the persistent inequities evident in Māori maternities (PMMRC, 2017; 2018, 2022) are unable to be ignored. Addressing these disparities are critical. So, although attention is required by broader sectors outside of maternity, it is well documented the current model of partnership is not serving whānau Māori well. Therefore Aotearoa midwifery needs to advance the conceptual value of this model to reflect the Indigenous worldview of Aotearoa.

Further Research

In doing this research, it has become apparent that although the researcher is guided by the dynamics of the chosen methodology, the findings emerge as a reflection of not only the researched but, more specifically, the researcher. Another review of the pūrākau could reveal a whole other thesis with completely different, yet (most likely) similar findings. I do not propose to do this again. However, I have come to conclusion findings are subjective. This realisation has reinforced the value of holding the pūrākau as a whole rather than offering a dismantled version. So, although I am not suggesting further research on this research, I recognise the possibility and significance of publishing these pūrākau as a taonga in themselves. This may be

considered as part of the dissemination process, and in consultation with the story-tellers themselves.

This study poses the need for further research in the statistical difference Kahu Pōkai make for birthing whānau. It proposes the current model of Partnership is urgently reviewed in response to the multiple recommendations that have been made in the past (Kenney, 2009; 2011; Leatham, 2014; Tupara, 2001; Waitangi Tribunal, 2019). Martin (2023) provided a comprehensive exploration of Māori maternities including educational pathways; therefore, it would be advantageous to advance these notions in the development of Kahu Pōkai education construct. However, it is with caution that I recommend further research to justify the development of Māori educational pathways as further delay in this process will only disadvantage tangata whenua.

Conclusion

Drawing to a close, this thesis provided a comprehensive overview of the historical and contemporary context of midwifery in Aotearoa. Kenney (2011) advised to respond effectively to the enduring disparities the maternity sector requires a robust understanding of this context. I contend that evidenced by the devastating Māori maternal and infant outcomes, the Aotearoa midwifery sector is yet to truly comprehend the significance of this knowledge. Dawson et al. (2019) and Ratima and Crengle (2013) iterated a multifaceted approach will be required to address the complex nature of environments such as these.

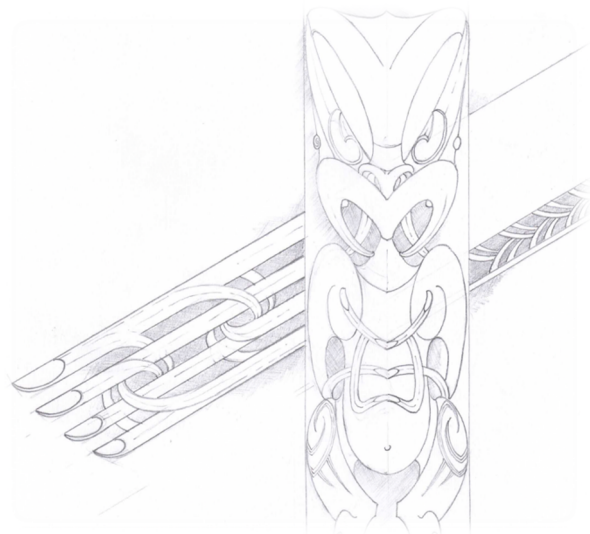
Kahu Pōkai are cognisant that to occupy the maternity sector requires the aptitude to navigate two, often opposing, worlds—Māori and non-Māori. An integral component or tikanga particular to Te Whare ā Kahu Pōkai encourages all Māori midwives to nohotahi (sit together), kōrerotahi (speak together), and mahitahi (work together) to support the mechanisms of our whānau, hapū, and future Māori nations. Therefore, the kaupapa of Te Whare-kōrero ā Kahu Pōkai provides a point of return, acknowledging mātauranga as an ongoing evolutionary process. Kathie Irwin (1992) advised, “theories in which mana tāne and mana wahine are equally powerful is crucial if our culture is to retain mana as Māori culture” (p. 80). Te Whare-kōrero ā Kahu Pōkai is an expression of intuitive Indigenous intelligence. These discussions will provide the evidence to support universal integration of Māori praxis in professional midwifery organisations such as NZCOM and midwifery educational institutions.

This chapter completes the process of this research. It now becomes a contribution to the documented knowledge on Māori maternities, and particularly Māori midwives. The stories of

the nine Kahu Pōkai are as much my own. They are not told to define a universal understanding of Māori midwifery but to offer an Indigenous lens upon a sector that is dominantly Eurocentric and Pākehā informed. Kahu Pōkai have shown they innately bring forward their Māori-ness, exhibiting manaakitanga, kaitiakitanga, whanaungatanga, and tino rangatiratanga. These ideologies have been described within the kaupapa of Te Whare-kōrero. It engages analysis to the impact of our past, present, and future. Indigenous discourse critiques such positions and poses solutions that encapsulate these ideas (Smith, 2012a). However, this is merely a vehicle to understand traditional pedagogy, there are many other Indigenous platforms to express Indigenous knowledge systems.

Mana Atua provided the tangible connection to Ariki. Mana Tīpuna is the status bequeathed upon generations below through whakapapa. Mana Whenua acknowledges our mana as tangata whenua and the procreative power within Papatūānuku. Finally, Mana Tangata engages our intellect and cultural knowledge sources to influence the well-being of all around us. The mana of our whakapapa is eloquently expressed by Rhonda Tibble:

You are the majesty that your tipuna imagined you to be. And every minute that you take the space to bless others with the fantastic-ness of who you are, is every minute they clap and praise you. Remember you are never alone in what you do and that you are the beloved of thousands and the matriarch or the patriarch of thousands beneath you yet to come. Understand this and you will always stay connected to the past. Be present now and connected to the future realities of your descendants and all those who you have the responsibility and the privilege to lead. You are awesome and you are meant to be because you were born to be the head and never the tail because that is what our tipuna said about us. Mauri Ora! (Wānanga, May 2024)



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APPENDICES

Appendix A Partnership and Mutual Understanding between Ngā Maia (Tangata Whenua) and New Zealand College of Midwives (Tangata Tiriti)



PARTNERSHIP AND MUTUAL UNDERSTANDING

between

NGĀ MAIA TRUST (Tangata Whenua)

and

NEW ZEALAND COLLEGE OF MIDWIVES (Tangata Tiriti)

The parties involved in this relationship

Ngā Maia Māori Midwives ō Aotearoa was formed in 1993 by Māori midwives, midwifery tutors, and their students, to address the inconsistencies in maternity services for Māori in New Zealand and is the recognised 'voice' for Māori within midwifery and maternity.

Ngā Maia is committed to Māori birthing practices that promote the health and well-being of whānau. To whakamana and nurture kahu pōkai/ kaiwhakawhānau in providing holistic, sustainable, quality care steeped in tikanga Māori.

Nga Maia's values are Mana Motuhake, Whanaungatanga, Manaakitanga, and He Taonga Tuku Iho.

Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa | New Zealand College of Midwives (the College) was established in 1989 and is the professional organisation and recognised 'voice' for midwives and student midwives in Aotearoa New Zealand.

The College represents more than 95% of all practising midwives and works in partnership with tangata whenua, Pasifika and maternity consumer groups to ensure high quality maternity services in New Zealand.

The College sets and actively promotes high standards for midwifery practice and assists midwives to meet these standards.

The purpose of establishing this relationship

To formalise the relationship between Ngā Maia and the College to enhance and facilitate the aims of each organisation to ensure equitable outcomes for wāhine hapū and whānau Māori.

That New Zealand College of Midwives recognize Ngā Maia Trust – Māori Midwives ō Aotearoa as the Te Tiriti O Waitangi partner within each respective rohe. Rohe are made up of iwi and hapu.

This partnership and mutual agreement have the best interest of each other's organisations at heart.

The goals of this relationship

- To work together in a collaborative way that ensures equitable access to high quality, culturally safe midwifery care for wāhine hapū and whānau Māori;
- To inform each other of what is happening around Aotearoa so we can come together to offer support to each other, and solutions;
- Work cohesively with each other on initiatives instigated by national entities such as Midwifery Council of New Zealand, Te Whatu Ora, Te Aka Whai Ora and Manatū Hauora;
- To continue representation with one another's governance structures and processes;
- To support the realisation of the recommendations of the College's cultural review;
- To support workforce development through a Māori Midwifery workforce strategy.

Each party's role and responsibilities in reaching these goals

- Continue current Ngā Maia representation on the College Board in its present governance and any future structure;
- Establish a position on Ngā Maia board for the College's Māori Co-president in an advisory role;
- Have a Ngā Maia representative on the College conference and JDMRC forum organising committees to ensure content being delivered and presented is inclusive of Tangata Whenua;
- To share with each other outcomes of any surveys, questionnaires or research that involves Ngā Maia members and or Māori midwives and tauira;
- Both parties to maintain respectful conduct at all times;
- Regular hui with representatives from both parties;

- To support our regions to work collaboratively and manaaki each other towards achieving equitable health outcomes for whanau Māori.

Any matters that are essential to you, or the other parties involved

Decision-making process, and resolution of conflicts or disputes that may arise in the relationship

Decisions may be made by whole group discussion or, when necessary, requested or desired by either party we engage the three-whare model.

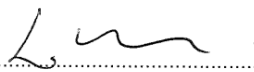
- First step: The respective groups go into respective whare to share and clarify whakairo;
- Second step: reconvene back into one group in Te Tiriti whare for further kōrero. Establish the shared principles to support the group to reach a joint decision;
- It is important to note this is not about equal numbers or even numbers but about representation based on Tiriti partnership. It is also possible within Māori and Tauīwi whare to have other smaller whare eg., in Māori whare iwi, hapū and in tauīwi whare eg., Pasifika or Indian.

Agreement review

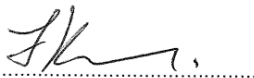
This agreement will be reviewed every two years.

Signed on the 21st of February 2024

On behalf of Ngā Maia

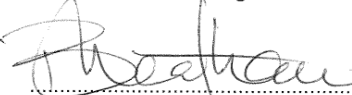


Lisa Kelly
Ngā Maia Chairperson

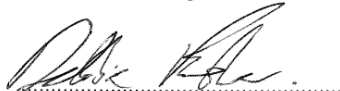


Tamara Karu
Ngā Maia General Manager

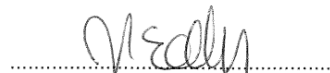
On behalf of the College



Beatrice Leatham
Co-president Tangata Whenua



Debbie Fisher
Co-president Tangata Tiriti



Alison Eddy
Chief Executive

Appendix B: Information Sheet



Participant Information Sheet

Date Information Sheet Produced:

19 June 2018

Project Title

He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.

An Invitation

Tena koe, ko Pukeāmaru toku maunga, ko Karakatuwhero toku awa, ko Te Whānau a Te Aopare toku hapū, ko Ngāti Porou toku iwi, ko Beatrice-Ann Materoa Leatham toku ingoa.

I have been a practising midwife for the past 18 years, predominantly practising in the West Auckland region as a LMC. I am also studying toward my Doctorate in Health Science in the Faculty of Health and Environmental Sciences at AUT University. My supervisors are Professor Denise Wilson (Ngāti Tahinga, Tainui) and Professor Liz Smythe. I will also have cultural supervision provided to me by Paraone Tai Tin (Ngāti Hine, Ngā Puhī, Ngāti Tuwharetoa). This research will contribute toward my DHSc qualification but it is also an integral part of my place in te ao Māori.

I would like to invite you to take part in this study about that is about the experience of Māori midwives. Due to the small population of Māori midwives in Aotearoa, it is likely that we will have a familiarity to each other to some degree. Any conflict of interests will be identified early in the interview process. Your participation is completely voluntary and confidential (unless you state otherwise), you will be free to withdraw both yourself and your data at any time.

What is the purpose of this research?

This study intends to explore the intricate nature of Indigenous midwifery within Aotearoa New Zealand. The context of childbirth in Aotearoa has largely been constructed through the worldview of non-Māori and currently there is very little written that explores the understandings of being a Māori midwife. This has exposed the importance of documenting distinctively Māori maternity knowledge. Therefore, the purpose of this study is to share the unique experiences of being Māori and being a midwife.

Cultural identity is crucial to the health of an Indigenous person; poor health of wāhine birthing is testament to the demise of identity within te ao Māori (Māori world). Cosmological narratives exhibit powerful female leadership influencing the wellbeing of tangata whenua (Indigenous people of Aotearoa). Regarded as the safekeepers to our genealogy any form of disruption to the health of wāhine is detrimental to the preservation of whānau (family), hapū (sub-tribe) and iwi (tribe). By giving Māori midwives the opportunity to tell the stories of their experiences this research aims to reveal the uniqueness of Māori midwifery practice exposing knowledge that has not yet been recorded. This knowledge may then enhance such things as maternity service provision, midwifery education and future maternity strategies. It is likely that outcomes of this research will include publications, presentations and resources, in these cases any personal information will not be identifiable.

How was I identified and why am I being invited to participate in this research?

I am contacting you as you may have indicated that you wish to be involved in this study. You may have seen the advertisement in selected midwifery publications or organisations or you may have been informed about this study via maternity colleagues or whānau. I am wanting to talk to midwives whom have Māori whakapapa that have been or is, a practising midwife.

How do I agree to participate in this research?

A copy of the consent form will be sent to you with all the information you will need. Once a time has been confirmed I will go through the information and the consent form. You will need to sign the consent form. This gives permission for me as the researcher to talk with you and record your information. All those that want to be involved will need to sign a consent form.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as

belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you are midwife with Māori whakapapa, who fits the criteria I will make contact with you and arrange to meet to talk with you about your experiences of being a midwife. These are more likely to happen as an individual interview however, some may happen within a focus group environment.

These interviews will take approximately 60-90 minutes and will be recorded to ensure I have accurate information. They may also be video recorded. You may have a support person or persons with you and/or whānau members. Individual interviews will occur at a place of your choosing. Focus group interviews may occur within a wananga environment possibly in a marae setting. Confirmation of time and place will be given to participants within a reasonable time-frame to allow for preparation and ensure resources are available. All those that agree to be involved will need to sign a consent form giving permission to be interviewed by myself and to include their information in the research.

Over the time of the research there will be opportunities for me to meet with you again to ensure that I have recorded and written your story correctly. It will also be a chance for you to be updated about where the research is at and ask any further questions. These occasions may occur on an individual basis or within Māori maternity hui that I may organise.

What are the discomforts and risks?

I understand that you will be sharing your experiences of being a midwife with Māori whakapapa and due to the nature of our work this may include stories that bring up feelings of distress or include controversial information. At any time, you can stop the recording of your story and you can choose to withdraw your information. If you need, we can take a break or re-schedule the interview if you wish to continue at a later date.

How will these discomforts and risks be alleviated?

It is envisaged that these interviews and focus groups will inadvertently provide an additional support network for Māori midwives who take part in this research. However, aside from contacting our professional body NZCOM if warranted, AUT may also provide counselling services.

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on <http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling>.

What are the benefits?

In 2016, of 3023 registered midwives 285 identified as being Māori. As one of these Māori midwives you have the unique opportunity to tell your story, a worthy story that is yet to be heard. I believe the passion, knowledge and resilience found in our voices may empower a maternity system to better support the needs of birthing wāhine and her whānau. It is also envisaged that the information gathered in this study will enhance the sustainability of our workforce.

As mentioned, this research is part of the requirements for the Doctorate of Health Science – Midwifery.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

Although our Māori midwifery workforce is relatively small, your privacy will be protected by your information being coded so that it is unidentifiable to anyone else except me as the researcher and my supervisor Associate Professor Denise Wilson. You will be given a chance to see what you have said in your interview and can change or

withdraw any information at any time. Please note information such your years of practice and location of practice will be included to provide context to your story. For example; 13 years as urban LMC in Auckland region.

What are the costs of participating in this research?

It is not envisaged that taking part in this research will have any monetary costs to the participants.

What opportunity do I have to consider this invitation?

You will have 3 weeks to consider the invitation to take part in this research.

Will I receive feedback on the results of this research?

Yes, there will be different opportunities during the research process to get feedback on the research. These are outlined in the consent form with a range of options on how you would like to receive these. They include, email, hui/meetings or text.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Denise Wilson, dwilson@aut.ac.nz or (09) 921-9999 ext. 7392 or 027 407 00222.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Beatrice Leatham
bealeatham@hotmail.com
Ph 021 836 567

Project Supervisor Contact Details:

Primary Supervisor
Denise Wilson
dwilson@aut.ac.nz
Ph (09) 921 9999 ext. 7392

Secondary Supervisor
Liz Smythe
lsmythe@aut.ac.nz
(09) 921 9999 ext.7561

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTC Reference number *type the reference number*.

Appendix C: Extended Research Brief

He Matatauihi i ngā Ururei Whēako hei Kahu Pōkai: experiences of Māori midwives

Ko Horouta tōku waka. Ko Whetumatarau tōku maunga. Ko Awatere tōku awa. Ko Te Whānau-a-Te Hinerupe tōku hapū. Ko Ngāti Porou tōku iwi. Ko Beatrice-Ann Materoa tōku ingoa.

I grew up in Turanganui-a-Kiwa (Gisborne) and throughout my childhood, our mother instilled a strong connection to whānau. Stories of tīpuna (ancestors) shape our whakapapa, our lands and our worldview, they are fundamental to the essence of te ao Māori. As the youngest of five children, I maintain a close relationship with my whānau, hapū and iwi.

I have recently moved home to the East Coast and returned to employment at Hauora Tairāwhiti. Prior to this and for the majority of my working life I lived in Tamaki Mākaaurau (Auckland). I have been practising as a midwife for the past 20 years, predominantly working as an LMC (lead maternity carer Midwife) with whānau in the West Auckland region. During 2004-2014, I was employed at AUT as an undergraduate paper leader and lecturer in Māori health. Practising midwifery while engaging in academia has kept me clinically up-to-date and given me access to educational pathways that I may not have participated in otherwise. These two roles complimented each other as well as my postgraduate studies that have focused on Māori health, particularly within the maternity sector.

As a midwife, I constantly witness the health disparities of wāhine Māori and the challenges they experience within the New Zealand maternity sector. Wāhine Māori and their babies have higher health needs than non-Māori. They are likely to birth at a younger age, live in higher deprivation and be at a higher risk of intervention both clinically and socially. As such, Māori babies have an increased likelihood of neonatal morbidities (Perinatal and Maternal Mortality Review Committee, 2018) (PMMRC). Anecdotal evidence in my own practice has shown I achieve equitable outcomes to those of non-Māori midwives. I have found that understanding and being empathetic to the worldview of wāhine Māori allows me to negotiate their specific needs within the maternity sector and facilitate appropriate, timely access to healthcare.

During my years of practice, I have been privileged to work with many whānau, sharing intimate and empowering moments as they bring their peepi (baby) into te ao Māori. Sadly, while some of these times have been the most devastating moments a mother and whānau could go through, I have witnessed strength, courage and resilience that is insurmountable. I have also advocated and cared for wāhine who face life challenges that defies common understandings of what are safe and acceptable living situations.

Providing safe pregnancy care in such environments requires a diverse skill range and inherent appreciation to the worldview of others. This research will provide a valuable opportunity to explore the influence culturally responsive and appropriate maternity care has upon the health of wāhine and her baby. It aims to contribute much-needed evidence for Māori midwifery practices that achieve positive change and outcomes.

Aims and objectives

The construction of the practice of assisting childbirth in Aotearoa is largely through the Western ethnocentric worldview of non-Māori. Currently very little of that written examines the understandings of being a Māori midwife. This study intends to explore the nature of Indigenous midwifery within Aotearoa, New Zealand.

‘He Matatauihi i ngā Ururei Whēako hei Kahu Pōkai’ (the full name of the study) resonates the focus of this study. ‘Matatauihi’ refers to the sacred role of calling spiritual and physical energies to kaupapa (topic, focus) by the female voice. ‘Ngā Ururei’ denotes the ancient practices that are guided by the knowledge of deities. ‘Wheako’ is the experiences gained by, the being that is human and ‘Wahine Pōkai’ refers to the absolute commitment, unique passion and purpose that is activated for mothers and their babies. This title locates the study within the nature of Māori midwifery and childbirth. It exerts knowledge systems of both the tangible and intangible, acknowledges the responsibility of nurturing whakapapa and offers an insight into the privileged potential of this position.

Cultural identity is crucial to the health of an Indigenous person (Durie, 2003); poor health of wāhine birthing is testament to the demise of identity within te ao Māori (Māori world). Regarded as the safe-keepers to our genealogy, any form of disruption to the health of wāhine is detrimental to the preservation of whānau (family), hapū (sub-tribe) and iwi (tribe).

Cosmological narratives exhibit powerful female leadership influencing the wellbeing of tangata whenua (Indigenous people of Aotearoa). In giving Māori midwives an opportunity to tell the stories of their experiences, this research **aims to reveal the uniqueness of Māori midwifery practice exposing knowledge that has not yet been recorded**. The objectives are to:

- 1) Explore the notions of Indigenous identity, the idea of cultural identity and hence cultural assurance.
- 2) Define the meanings of Māori midwife, Māori midwifery or being Māori and being a midwife.
- 3) Clarify the Māori practice paradigm(s).
- 4) Investigate how midwives identify themselves, so they can practice safely and effectively with wāhine Māori and their whanau.
- 5) Complete and submit a doctoral thesis for examination.

Health significance

The implementation of conceptual Māori models of health within the health sector is broad, and reflect the recognition that their use can enhance Māori health outcomes. However, despite their use epidemiological statistics continue to report unacceptable health inequities (Ministry of Health (MoH), 2015; PMMRC, 2018). Currently midwives practice within a partnership model, many as Lead Maternity Carers [LMC]. The LMC role allows unique insights into the primary health needs of Māori and provides a valuable opportunity to analyse current health services provision in the maternity sector. During 2015, 92% of Māori women

registered with an LMC midwife. While the LMC platform of care has been shown to suit wāhine Māori and whānau (MoH, 2017), statistics repeatedly demonstrate that Māori remain at a disadvantage and are marginalised in just about all areas of maternity care provision (MoH, 2015).

Regrettably, almost half of birthing wāhine reside in the most deprived areas and over a third smoke at the time of registration with an LMC (MoH, 2015). Māori have increased rates of preterm and low birth weight infants, and any Māori baby is more likely to die within 7 days of birth than non-Māori (excluding Pacific babies), this is particularly so for teenage mothers (PMMRC, 2018; MoH, 2015). Infant mortality rates are one and a half times higher than non-Māori and Māori babies are less likely to breastfeed. Further, wāhine Māori comprise more than half of the maternal suicides occurring between 2006 and 2015, most having multiple risk factors evident during pregnancy (PMMRC, 2018). Makowharemahihi et al. (2014) found young Māori women encountered health system barriers when trying to engage in maternity care early in their pregnancy, and along with the Perinatal and Maternal Mortality Review Committee highlighted the need for culturally responsive services for wāhine Māori.

Statistical population projections indicate Māori demographics are progressively increasing (Durie, 2005). The forecasted estimated growth of the Māori population is approximately 16% by 2030, a 3% greater increase compared to non-Māori. This higher growth rate is explained by higher fertility rates of Maori and Māori being a younger population (MoH, 2015). Given the growing Māori population, Māori are more likely to require the care of a midwife.

An increasing Māori population coupled with a low cohort of Māori midwives (9% of the midwifery population) is problematic as it is less likely that birthing wāhine (and their whānau) will receive culturally responsive and culturally acceptable maternity care (MoH, 2015). The PMMRC report revealed inequitable outcomes, particularly for Māori, were in part associated with implicit bias and racism (PMMRC, 2018).

Article 3 of Te Tiriti o Waitangi (1840) outlines the constitutional guarantee of equity for Māori and other citizens of New Zealand. Article 3 affirms that Māori should experience equal enjoyment of all of the benefits of New Zealand citizenship, which implies the inclusion of good health. The inferences of Te Tiriti o Waitangi, specifically the relationship between Māori and the Crown, have been woven through health strategies such as He Korowai Oranga (MoH, 2014) and the New Zealand Health Strategy (MoH, 2016) signifying health providers' obligation to adhere to the articles (and principles) embedded within this document. However, government policy requires robust development, implementation and monitoring to ensure such policies effects equitable and positive changes for Māori health (MoH, 2016; 2014). Considerable workforce development is required to address the current negative Māori maternity outcomes, which must include equity and concordance of midwifery care.

In 1994, Guilliland and Pairman offered a practice model within midwifery built upon partnership. The partnership model used the constitutional base of Te Tiriti o Waitangi as a springboard. Together with the philosophical basis of midwifery in Aotearoa, it recognises pregnancy and birth as a normal physiological process placing the total childbirth experience within its social and cultural framework (Guilliland & Pairman, 2010). This philosophy and midwifery code of ethics are the foundation for midwifery practice in Aotearoa. Evolving from

this are ten standards for practice that identify actions that are integral to the partnership relationship with wāhine. A cultural framework developed by Nga Maia o Aotearoa, the Turanga Kaupapa acknowledges Māori ideologies and further strengthens the partnership model. It is, therefore, expected midwives incorporate the Turanga Kaupapa principles together with the ten standards into their daily midwifery practice.

This research will explore how Māori midwives in Aotearoa practice within the current context of midwifery, whilst integrating Māori practices to enhance aspects such as whānau capacity. It will be important to reveal explicitly how and if Māori midwives achieve this in their practice. The PMMRC (2018) have made direct recommendations to address persistent disparities in maternity sector that includes ensuring priority populations have a voice in health policy development through consultation with high risk populations to improve access and engagement with health care. The PMMRC also invited the Ministry of Health to consider how best to support LMCs (e.g. midwives) that care for high risk mothers (PMMRC, 2018).

Durie (2011) identified the incorporation of Indigenous practices into mainstream structures would enhance Indigenous wellbeing locally, nationally and globally. Several discussions have identified strategies required to increase whānau capacity, Māori workforce development, governance and leadership (Russell, Smiler & Stace, 2013; Ratima, Waetford & Wikaire, 2006). This study will provide important information to ongoing discussions and will inform and enhance Māori midwifery development and contribute to the dearth of available knowledge that currently exists.

Whakapapa (genealogy) is a fundamental attribute and gift of birth (Mead, 2003). It is also one of the strongest identity measures for Māori (Hudson, Ahuriri-Driscoll, Lea & Lea, 2007). At birth, these connections move from being within Te Ao Mārama into Te Ao Tūroa. Traditional understandings of these two realms define Te Ao Mārama as the spiritual world and Te Ao Tūroa is the physical world. Those that assist wāhine transition their peepi (baby) through this stage of life have enormous potential in the expansion of whakapapa. Concepts such as these will be a focal point in this research, documenting distinctively Māori knowledge that will not only empower whānau but also the meaning of being Indigenous and being a midwife.

Research design and methods

A qualitative design using Kaupapa Māori and Mana Wāhine methodologies will provide a robust platform for this research to unfold. Māori require methodological frameworks that support the complexities of an Indigenous worldview. Kaupapa Māori theory allows me, as a Maori researcher to operate from Māori values and tikanga that include:

- whakawhānaungatanga (establishing relationships),
- manaakitanga (hospitality, kindness, and generosity),
- whakapapa, tikanga (practices), and
- rangatiratanga (autonomy).

Mana wāhine challenges dominant discourses that denies the status of wāhine Māori within their communities and position wāhine Māori as 'Other' (Pihama, 2001). Explicit

consideration is, therefore, given to the complexities faced by wāhine Māori (Simmonds, 2014) exposing the interface between what it is to be Māori and what it is to be wāhine. The utilisation of these methodologies demands transformative action and outcomes (Pihama, 2001).

As a theoretical position, Mana Wāhine enables the re-presentation and re-claiming of mātauranga wāhine (Māori knowledge), experience and practices. This seamlessly aligns to the exploration of Māori midwives narratives, providing a space that validates their stories, their mātauranga wāhine and hence mātauranga Māori (Simmonds 2011). The Mana Wāhine approach will strongly inform the gathering, organising, analysing and re-presenting of stories. From this standpoint, these principles of decolonisation, whakawhānaungatanga, manaakitanga and rangatiratanga convey the way and conduct of this research. For example, recruitment techniques will draw on my networks within the Māori midwifery community, referred to as snowballing from a mainstream perspective, however, from the platform of Mana Wāhine I will be drawing on whānaungatanga and my midwifery whakapapa (Simmonds, 2014).

I will recruit up to 15 participants who are registered midwives, who whakapapa Māori and have been or are currently practising. It will be important to consider a range of participants who practice in urban and rural areas, and who are employed and self-employed Māori midwives to ensure the research represents diverse midwifery perspectives.

Data collection and analysis

a) **Kanohi ki te kanohi Interviews.** Data will be gathered by kanohi ki te kanohi (face to face) in-depth interviews, which will begin with whakawhānaungatanga and mihimihi (introduction) process. The interview will use guiding questions which may include:

- Tell me about yourself, and how you came to be a midwife.
- How do you practice in a way that integrates your Māori heritage?
- Tell me about a recent experience of caring for a wahine and her whānau.
- Tell me about a midwifery experience that stands out in your mind.
- Tell me about a time when it felt like the maternity context got in the way of being Māori.

Interviews will occur within mutually agreed upon environments that most suit the participant, which may include their home, their clinic room or a marae. I will adhere to tikanga, such as the process of karakia and whakawhānaungatanga. If a participant has requested the presence of a whānau member, kaumātua or kuia I will be follow appropriate tikanga under the advisement of a cultural advisor and with the permission of the participant. The interview will be audio recorded and then transcribed, and then will be checked against the audio recording for accuracy. At this stage, I will remove all identifying information.

Simmonds (2014) and Ruakere (2016) affirm that Kaupapa Māori does not prescribe a way of working with the data; rather it informs the values from which the data is analysed. This does not lessen the integrity of analysis instead; it mandates processes that maintain the mana and wairua of the information shared by the participants. Similar to that of Naomi Simmonds

(2014) in her acclaimed research on Māori women's maternities, I will employ analytical tools of "reduction, organisation, thematic analysis and verification" (p.94). Mātauranga (knowledge) will be uncovered during the reading, listening, re-reading and re-listening of data (Grbich, 1999) and gaining deeper appreciation from on-going kōrero with key stakeholders and the participants.

To ensure participants' stories are reflected, throughout the process of analysis I will consult with them, for example they will be asked to review transcripts once initial editing of irrelevant material has occurred. By doing this Māori midwives will maintain rangatiratanga over their knowledge (Simmonds, 2014).

The analysis will adhere to the assumptions that:

- The legitimacy and validity of a Māori worldview is taken for granted, particularly wāhine Māori worldview and their views expressed, and therefore, I do not seek to justify Māori knowledge and tino rangatiratanga (self-determination, autonomy) (Simmonds, 2014; Smith, 1999),
- Māori childbirth is a normal physiological event, and the concept of Māori interconnectedness recognises the tangible and intangible connection between the physical, spiritual and environment (Pitama, Ririnui & Mikaere, 2002), and
- Wāhine have defined the period they recognised to be 'the childbirth experience' that may span from pre-conception to the postnatal period.

b) **Mātauranga Māori.** Aside from the participant interviews, I will gather mātauranga Māori from other sources to contextualize the narratives. These may include a literature search of myths, legends, waiata (song) and moteatea (lament, traditional chant). Resources such as these hold mātauranga and provide guidance to such things as the analysis process. Pūrākau, for instance, trace the descent between the supernatural and human, express a Māori way of doing and hold repositories of knowledge. Kōrero with kuia (elderly women), kaumātua (elderly man), mātanga tikanga (expert in tikanga) and mātanga hauora (expert in health) will provide further context to the research and enhance the analytic process of information sourced amid this mātauranga.

c) **Wananga/hui.** It is also common practice of Māori midwives to regularly hui both nationally and regionally to consider issues of importance. The understanding of wananga includes a space that attendees can gather to discuss a common kaupapa, agenda or goal. Key qualities include, respect, consideration, patience and cooperation to allow the time for participants to express their perspectives and ideas (Simmonds, 2014). As part of the consultation process, and with the permission of the participants, I will hold wananga to share their experiences and offer insights to the process of knowledge production. This forum, while related to the processes of focus groups; is firmly located within a Mana wāhine context.

Ethics refers to the regulations of conduct, in research this conduct is concerned with the protection of the researched from physical, mental or psychological harm (Chilisa, 2012). It is vital to consider the accountability of the researcher, ethical planning and administration of the research (Grbich, 1999). The participants will entrust me with their stories, as such I am

accountable to the integrity and validity of this research. As part of this responsibility, the mandate to conduct this research has been sought and hence an expectation of transparency throughout this process.

Cram (2001) offers seven guidelines for Māori research ethics that when operationalised will enhance the uptake and validity of the research process within a Māori worldview. These guidelines will provide a platform for this research to encompass the universal principles discussed above. They are articulated as:

- 'aroha ki te tangata' (respect for people their space and terms),
- 'he kanohi kitea' (meeting face to face),
- 'titiro, whakarongo...kōrero' (look, listen...then speak),
- 'manaaki ki te tangata' (sharing, hosting and generosity),
- 'kia tūpato' (be cautious),
- 'kaua e takahia te mana o te tangata' (do not trample the dignity of a person) and
- 'kia māhaki' (be humble).

I will also attend to issues of respect and decolonisation that will direct orthographic stances such as Ka'ai-Mahuta (2010) made like capitalising Indigenous as it corresponds with the use of 'Western'. Cultural values such as manaakitanga and aroha embody respect for people and all that encompasses their being, particularly wāhine Maori will guide the researcher in this study. Manaakitanga and aroha in this sense, encapsulate the absolute appreciation of each other and the intention of the encounter; inclusive of research, researcher and the researched.

Dissemination of results

The Mataatua Declaration on Cultural and Intellectual Property Rights of Indigenous Peoples (1993) (The Commission on Human Rights) declares that Indigenous peoples have the right to self-determination. This determines their right for recognition as the owners of their cultural and intellectual property. Further to this Smith (2012) points out that the first recipients of this knowledge must be the direct Indigenous descendants to that knowledge, in this case Māori midwives and their whānau, upholding their rangatiratanga in this research process. Therefore, I will disseminate the research findings formally and informally, first with the participants and then in Māori midwifery hui regionally and nationally. Following that, findings will be disseminated in conference proceedings both nationally and internationally such as, the New Zealand College of Midwives (NZCOM) Biannual Conference and International Confederation of Midwives (ICM) Triannual Conference. Furthermore, I will submit manuscripts for publication in midwifery and Indigenous journals.

This research is a culmination of my experiences as a birthing wahine, mother, sister, daughter, student midwife, midwife and nanny, who has been the midwife to her mokopuna. Our stories are precious, our stories are valuable. It will be a honour to hear and share yours.

Appendix D: Consent Form



Consent Form

For use when interviews are involved.

Project title: *He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.*

Project Supervisor: *Professor Denise Wilson*

Researcher: *Beatrice-Ann Materoa Leatham*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐
If yes, by email ☐ txt ☐ hui/meeting ☐ or Please specify
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

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.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number

Note: The Participant should retain a copy of this form.



Consent Form

For use when focus groups are involved.

Project title: *He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.*

Project Supervisor: *Professor Denise Wilson*

Researcher: *Beatrice-Ann Materoa Leatham*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ☐ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐
If yes, by email ☐ txt ☐ hui/meeting ☐ or Please specify
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number

Note: The Participant should retain a copy of this form.



Consent and Release Form

For use when photographs, videos or other image recording is being used

Project title: *He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.*

Project Supervisor: *Professor Denise Wilson*

Researcher: *Beatrice-Ann Materoa Leatham*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I permit the researcher to use the photographs that are part of this project and/or any drawings from them and any other reproductions or adaptations from them, either complete or in part, alone or in conjunction with any wording and/or drawings solely and exclusively for (a) the researcher's portfolio; and (b) educational exhibition and examination purposes and related design works.
- ☐ I understand that the photographs will be used for academic purposes only and will not be published in any form outside of this project without my written permission.
- ☐ I understand that any copyright material created by the photographic sessions is deemed to be owned by the researcher and that I do not own copyright of any of the photographs.
- ☐ I agree to take part in this research.

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number*

Note: The Participant should retain a copy of this form.

Appendix E: Research Questions

The logo for the Auckland University of Technology (AUT) is displayed in white text on a black rectangular background.

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

He Matatauihi I ngā Ururei Whēako hei Wāhine Pōkai:

The experience of being a Māori midwife

INDICATIVE INTERVIEW QUESTIONS: Wāhine Pōkai, Midwives

Can you tell me about yourself, where are you from, how did you come to be a midwife?

Tell me about where you practice, the context of your practice, e.g. are you a urban/rural self-employed midwife or staff midwife?

NOTE: Explore areas as midwives talk about their experiences, whakaaro, etc.

Prompt Questions:

1. How do you practice in a way that integrates your Māori culture, identity, whakapapa?
2. Tell me about an experience of caring for a wāhine and her whānau?
3. Tell me about a midwifery experience that stands out in your mind?
4. Have you ever felt a conflict between being a midwife and being Māori?
5. If there was, how did you keep yourself safe?
6. Is there anything you do to keep yourself culturally safe in your midwifery practice?
7. Tell me about your support networks within your midwifery practice?
8. Do you identify yourself as a 'Māori midwife' or 'a midwife who is Māori'? And what does this mean to you?
9. Do you have any questions?

Thank the participant for her contribution. Explain when we will be in contact for a follow-up interview.

Give the koha to the participant for taking part in the research.

Approved by the Auckland University of Technology Ethics Committee on MM XXXX YYYY, AUTECH
Reference number XX/XX.

Appendix F: Confidentiality Agreement



Confidentiality Agreement

For transcribing data.

Project title: **He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.**

Project Supervisor: **Professor Denise Wilson**

Researcher: **Beatrice-Ann Materoa Leatham**

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

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Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on dd mmmm yyyy AUTEK Reference number XXXX.

Note: The Transcriber should retain a copy of this form.



Confidentiality Agreement

For typing data.

Project title: *He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.*

Project Supervisor: **Professor Denise Wilson**

Researcher: **Beatrice-Ann Materoa Leatham**

- ☐ I understand that all the material I will be asked to type is confidential.
- ☐ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature:

Typist's name:

Typist's Contact Details (if appropriate):

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Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on dd mmmm yyyy AUTEK Reference number XXXXX.

Note: The Typist should retain a copy of this form.



Confidentiality Agreement

For an interpreter.

Project title: *He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.*

Project Supervisor: **Professor Denise Wilson**

Researcher: **Beatrice-Ann Materoa Leatham**

- ☐ I understand that the interviews meetings or material I will be asked to translate is confidential.
- ☐ I understand that the content of the interviews meetings or material can only be discussed with the researchers.
- ☐ I will not keep any copies of the translations nor allow third parties access to them.

Translator's signature:

Translator's name:

Translator's Contact Details (if appropriate):

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Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on dd mmmm yyyy AUTEK Reference number XXXX.

Note: The Translator should retain a copy of this form.



Confidentiality Agreement

For research assistant.

Project title: **He Matatauihi i ngā Ururei Whēako hei Wāhine Pōkai: The experiences of being a Māori midwife.**

Project Supervisor: **Professor Denise Wilson**

Researcher: **Beatrice-Ann Materoa Leatham**

- ☐ I understand that all the material I will be asked to record is confidential.
- ☐ I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researchers.
- ☐ I will not keep any copies of the information nor allow third parties access to them.

Intermediary's signature:

Intermediary's name:

Intermediary's Contact Details (if appropriate):

.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....

Approved by the Auckland University of Technology Ethics Committee on dd mmmm yyyy AUTEK Reference number XXXX.

Note: The Intermediary should retain a copy of this form.

Appendix G: AUTECH Ethics Approval and Approval Memo



Auckland University of Technology Ethics Committee (AUTECH)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKĀU RAU

18 July 2018

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Ethics Application: 18/254 He Matatauihi I nga Ururei Wheako hei Wahine Pokai: The experience of being a Maori midwife

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTECH) approved your ethics application at their meeting on 16 July 2018, subject to the following conditions:

1. Clarification of the exclusion criteria in section C.3.4.1 of the application 'midwife under review' and make this definition clear in the recruitment material and Information Sheet;
2. Clarification of whether data has already been collected for this study given the statement in section D.2 where it is indicated that 'potential participants for this study have already contributed to this research';
3. Clarification of why there is a Consent and Release Form for Video Imaging. If videos and photographs are being used a protocol detailing this needs to be submitted as well advice of this in the Information Sheet;
4. Removal of the ACC statement in the Information Sheet.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTECH also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: bealeatham@hotmail.com; Liz Smythe

22 July 2018

Erin Moloney
Executive Officer
Research Ethics

Dear Erin,

Ethics Application: 18/254 He Matatauihi I nga Ururei Wheako hei Wahine Pokai: The experience of being a Maori midwife

Thank you for approving my ethics application subject to the following conditions outlined below. I have indicated below (in red) how I have addressed each point and attached corresponding forms.

1. Clarification of the exclusion criteria in section C.3.4.1 of the application 'midwife under review' and make this definition clear in the recruitment material and Information Sheet;
C.3.4.1 – Inserted:
"Any complaints received by the Midwifery Council of New Zealand about a midwife's conduct will be referred to the Health and Disability Commissioner, the Commissioner investigates the complaint to consider the ongoing process. A midwife that is going through any part of this process will be excluded from this research."
Recruitment/Information Sheets amended – see attached.
2. Clarification of whether data has already been collected for this study given the statement in section D.2 where it is indicated that 'potential participants for this study have already contributed to this research';
D.2 – Edited last para:
No participants have been recruited nor has any data been collected. However, Māori midwives who may be potential participants for this study have already contributed to this research by acknowledging the crucial need to give voice to their experiences, particularly amidst the current political environment. They have also endorsed the use of Kaupapa Māori, not only a methodology but way of being in the world.
3. Clarification of why there is a Consent and Release Form for Video Imaging. If videos and photographs are being used a protocol detailing this needs to be submitted as well advice of this in the Information Sheet;
'Consent and Release form' – removed.
4. Removal of the ACC statement in the Information Sheet.
ACC statement removed – see attached Information Sheet.

I look forward to hearing from you.

Nga mihi
Beatrice Leatham

Approved by the Auckland University of Technology Ethics Committee on MM XXXX YYYY, AUTEC
Reference number XX/XX.

Appendix H: CONSIDER Checklist

CONSIDER CHECKLIST

Checklist of items to include when reporting health research involving Indigenous Peoples

Governance

1. **Describe partnership agreements between the research institution and Indigenous-governing organization for the research, (e.g. Informal agreements through to MOU (Memorandum of Understanding) or MOA (Memorandum of Agreement)).**
 - This research project was undertaken as part of a Doctoral degree. Ethics approval was sought with the academic institution AUT. The research was governed by me (as the researcher) supported by Indigenous academic supervisor and Indigenous cultural supervisor.
2. **Describe accountability and review mechanisms within the partnership agreement that addresses harm minimization.**
 - Each step of the research process was supervised both academically and culturally. Indigenous participants were consulted with throughout the research process.
3. **Specify how the research partnership agreement includes protection of Indigenous intellectual property and knowledge arising from the research, including financial and intellectual benefits generated (e.g., development of traditional medicines for commercial purposes or supporting the Indigenous community to develop commercialization proposals generated from the research).**
 - The pūrākau shared by the Indigenous participants is currently the intellectual property held by this research. They have given consent for their stories to be shared and held by me. If further publications emerge, I will consult with the participants prior to publication.

Prioritization

4. **Explain how the research aims emerged from priorities identified by either Indigenous stakeholders, governing bodies, funders, non-government organization(s), stakeholders, consumers, and empirical evidence**
 - Repetitive negative Māori maternity evidence (Perinatal and Maternal Mortality Review Committee, 2017, 2018, 2022) (PMMRC) is compelling and undisputedly shows the importance of research that contributes to improving Māori maternity outcomes.

Relationships (Indigenous stakeholders/participants and Research team)

5. **Specify measures that adhere and honor Indigenous ethical guidelines, processes, and approvals for all relevant Indigenous stakeholders, recognizing that multiple Indigenous partners may be involved, e.g., Indigenous ethics committee approval, regional/national ethics approval processes.**
 - Consultation occurred first and foremost with Māori midwives, Nga Maia o Aotearoa regional committee, Indigenous maternity consumers, kaumatua and kuia of the Māori maternity sector.
 - AUT Ethics approval was obtained.
 - Code of Conduct for rangahau Māori was followed (Cram, 2001).
6. **Report how Indigenous stakeholders were involved in the research processes (i.e., research design, funding, implementation, analysis, dissemination/recruitment).**
 - Consultation occurred with Indigenous stakeholders i.e. Kahu Pōkai (Māori midwives) from the start to the completed research process. Kahu Pōkai gave input to recruitment and adopted methodology.
 - Research analysis has been developed in consultation with cultural supervisor and the mātauranga of Tohunga, Papa Hōhepa De La Mere.
 - No funding has been source for this research.
 - Initial dissemination of the findings has been presented to the participants at the Nga Maia Hui a Tau 2024.
7. **Describe the expertise of the research team in Indigenous health and research Methodologies**
 - Professor Denise Wilson is the expert Indigenous supervisor. She is a nurse and specialises in Māori health research at AUT.

8. **Describe the methodological approach of the research including a rationale of methods used and implication for Indigenous stakeholders, e.g., privacy and confidentiality (individual and collective)**
 - Kaupapa Māori and Mana Wahine were the methodologies used for this research. These theoretical foundations clearly prioritise Indigenous well-being and therefore, Indigenous health advancement. Kaupapa Māori and Mana Wahine provided the most relevant approach to ensure a safe, robust and rigorous process for all involved. These methodologies prioritize an Indigenous worldview allowing Māori ways of knowing to be forefront.
 - The method used incorporate a Māori epistemology and ontology, therefore a Māori way of being in the world. Participants lead how their pūrākau was gathered and contributed to the research process.
 - Only one participant wanted to be anonymous. The others were happy to be identified, however identifying information of others in their stories were taken out.
 - Implication for stakeholders include better support for Māori ways of being a midwife, improved maternal and perinatal outcomes. Influence of cultural practices, and cultural awareness of colleagues. Substantial contribution to Māori maternity discourse.
9. **Describe how the research methodology incorporated consideration of the physical, social, economic and cultural environment of the participants and prospective participants. (e.g., impacts of colonization, racism, and social justice). As well as Indigenous worldviews.**
 - As a Māori researcher and Māori midwife, consideration of these impacts is implicit. The research overtly recognises the impact of colonisation and racism. Kahu Pōkai move within prejudice environments hence experiences such as these influence their way of being a Kahu Pōkai. These notions are openly acknowledged in the research.

Participation

10. **Specify how individual and collective consent was sought to conduct future analysis on collected samples and data (e.g., additional secondary analyses; third-parties accessing samples (genetic, tissue, blood) for further analyses).**
 - Participation in this research is not ongoing. Kahu Pōkai are aware that their contribution is only for this research as part of my degree. Any future use of their knowledge or opportunity for their stories to be shared will only be done with their consent.
11. **Described how the resource demands (current and future) placed on Indigenous participants and communities involved in the research were identified and agreed upon including any resourcing for participation, knowledge, and expertise.**
 - There will be no resource demands placed upon the Indigenous participants.
 - The sharing of their knowledge and expertise was voluntary.
12. **Specify how biological tissue and other samples including data were stored, explaining the processes of removal from traditional lands, if done, and of disposal.**
 - No biological tissue or samples were used for this research.

Capacity

13. **Explain how the research supported the development and maintenance of Indigenous research capacity (e.g., specific funding of Indigenous researchers).**
 - This research was funded independently by me as the researcher and I was the only researcher.
14. **Discuss how the research team undertook professional development opportunities to develop the capacity to partner with Indigenous stakeholders?**
 - N/A

Analysis and interpretation

15. **Specify how the research analysis and reporting supported critical inquiry and a strength-based approach that was inclusive of Indigenous values.**
 - The analysis has used ancient mātauranga of Te Whare-wānanga (Melbourne, 2009). It takes the principles of traditional learning environments like the Whare-kōrero and has adapted them to reveal

mātauranga that acknowledged a Māori worldview. This method is immersed in Indigenous values, reo and tikanga. It re-ignites mātauranga in a way that has not been done within Māori midwifery research.

Dissemination

16. Describe the dissemination of the research findings to relevant Indigenous governing bodies and peoples.

- Dissemination of the research has commenced by way of presentation at the Nga Maia Hui a Tau 2024. Nga Maia is the national collective of Māori midwives. All the participants consented to the research being presented at this forum. Some of the participants were present and took part in the presentation.
- Potential forums to present the research include; Tairāwhiti Nga Maia Hui, NZCOM Conference 2025, Joan Donely Midwifery Research Forum 2025, ICM Midwifery Conference 2025.

17. Discuss the process for knowledge translation and implementation to support Indigenous advancement (e.g., research capacity, policy, investment)

- This research will contribute to narrative of Māori midwives in Aotearoa. This research is significant in that there is very little academia that has been produced by Māori midwives and specifically about Māori midwives.
- Particular interest may be sought to inform maternity policy and investment, especially with the current review maternity services. This research may provide key information, such as how Māori midwives provide maternity care.

Cram, F. (2001). Rangahau Maori: Tona tika, tona pono - validity and integrity of Maori research. In M. Tolich (Ed.), *Research ethics in Aotearoa New Zealand*. Pearson Education.

Melbourne, T. (2009). *Te Whare-Oohia: Traditional Maaori education for a contemporary world*. Massey University, Palmerston North.

Perinatal and Maternal Mortality Review Committee. (2017). *Eleventh annual report of the perinatal and maternal mortality review committee: Reporting mortality 2015*. <http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc>

Perinatal and Maternal Mortality Review Committee. (2018). *Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality and morbidity 2016*.

Perinatal and Maternal Mortality Review Committee. (2022). *Fifteenth Annual Report of the Perinatal and Maternal Mortality Review Committee*. Perinatal and Maternal Mortality Review Committee, Wellington.

***He Matatauihi I ngā Ururei Whēako hei Wāhine Pōkai:
The experience of being a Māori midwife***

Tēnā koe

Ko Ngāti Porou toku iwi, ko Te Whānau a Te Aopare toku hapū,
Ko Beatrice-Ann Materoa Leatham ahau.

I am a Doctorate of Health student at AUT University in Tamaki Makaurau. I have been a practising midwife since 2001 predominantly in the Auckland region. This year I commenced the research component of the degree.

I am interested in collecting the stories and experiences of Māori midwives, a research area that has yet to be explored.

If you are:

- **Māori whakapapa**
- **Practising midwife**
- **Have been a practising midwife in the past**

Please contact Beatrice Leatham for further information about participating by either:

Email: bealeatham@hotmail.com or Text/Ph: 021 836 567

Approved by the Auckland University of Technology Ethics Committee on XX MMMM YYYY, AUTC
Reference number XX/XX.