Rapua te Aronga-a-Hine

The Māori Midwifery Workforce in Aotearoa

A Literature Review - February 2020

Rapua te Aronga-a-Hine refers to a wāhine Māori world view that provides a platform for situating Māori midwives within the midwifery landscape and facilitates amplification of the experiences of Māori midwives and women who are served by the profession.

The cover page depicts Te Taiao as a metaphor for Māori midwifery and childbirth. Papatūānuku and her power extends from the shores and resides in the ocean floor. The surging tides symbolise the ebb and flow of contractions that bring our mokopuna closer to Te Ao Mārama. Tides create a current that embodies Māori midwives, influenced by external forces as they navigate the midwifery ocean. The whakairo in the sand epitomises the multiple pathways forward that will need traversing to achieve revolutionary change for Māori midwifery.

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'Pīngao ki te Tū, Tūturiwhatu ki te Tai'

'When the Pīngao is Healthy, the Dotterel will Nest'

(Tupara & Tahere, 2020).

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Author

Dr Hope Tupara and Megan Tahere
connect@tiekiconsultancy.co.nz

1. Executive Summary

Turbulence and change are key themes in the history of the maternity care system and the evolution of midwifery in Aotearoa New Zealand (Aotearoa) that is admired around the world. The midwifery profession has been heavily influenced by systems and structures that have pervaded Aotearoa society since the arrival of British migrants who were granted permission to live in harmony with Māori as a result of their signing of Te Tiriti o Waitangi (The Treaty of Waitangi [Te Tiriti; Tiriti]) in 1840. Despite the promises of self-determination that Māori chiefs understood Te Tiriti to stand for, Māori people soon became the minority and have since been subjected to assimilationist policies and structures that favour dominant cultural norms.

Today, the maternity sector, stands as an example of the results of colonisation that occur when one society dominates another. Midwives are the main providers of maternity care in Aotearoa, Pākehā midwives make up the majority of the midwifery workforce, and Māori women and babies are over-represented in health inequities and negative or sub-optimal maternity outcomes. In addition, Māori women and whānau continue to experience persistent inequities across socioeconomic determinants of health and risk factors that impact on their wellbeing throughout the maternity continuum.[1] Inequities for Māori women are also likely to be present amongst Māori midwives. Māori midwives are at risk of burnout and could leave the midwifery profession if it remains ill-equipped to properly support them.

Māori midwives are severely under-represented in the midwifery workforce across clinical, education and professional settings. Patterns of workforce movement by Māori midwives are different to non-Māori and there has been no research to identify the reasons for the differences. Overall, there is a general under-reporting of Māori midwifery workforce data.

Māori midwifery students are among the high attrition rates occurring in midwifery education and they are under-represented in completion rates. It was difficult to access current data about the progression of Māori midwifery students through the education pipeline and a variety of sources were accessed to enable some data to be presented in this literature review.

Research has identified an unexplained gap in completion rates between Māori and non-Māori bachelor level students across universities in Aotearoa. The researchers suggest the unexplained gap may be attributed to cultural-specific factors, which could be relevant to Māori midwifery students.

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[1] The maternity continuum includes pre-conception, pregnancy (antenatal period), labour and birth (intrapartum period), and six weeks following birth (postnatal period).

Rapua te Aronga-a-Hine has highlighted the need for centralised management of childbirth data to facilitate early decision making by policy makers, funders and clinicians regarding trends and interventions to improve inequities.

Māori working in the midwifery sector are exhausted from being under-resourced and subjected to bullying behaviour by both their Māori and Pākehā midwifery colleagues and other people in leadership, who use their positions of power to obstruct, side-line and drive out their Māori colleagues that challenge the status quo or speak up for change.

Māori research is undervalued and rarely used as evidence to inform policies, strategies or programmes in the midwifery sector. Māori childbirth knowledge is treated with scepticism and not held in high regard, with midwifery structures assuming control of Māori knowledge and the processes by which Māori midwives can apply it in their practice, such as rongoā.

Cultural competence is a legal requirement for regulated professions and midwives are no different. The resourcing, rigour and monitoring applied to cultural competence at the point of pre- and post-registration education and recertification of midwives in practice, compared to clinical competence, is not equal.

The midwifery profession and individual midwives must ensure that they are not contributing to or compounding the inequities faced by Māori. To safeguard Māori women, babies and whānau, change is necessary to enable Māori midwives to stand proud and thrive alongside their Tiriti partner. If the midwifery profession is prepared to commit to the true nature of partnership, a profession that is Tiriti-led, will open the door for revolutionary change.

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4. Introduction

The national midwifery workforce is under pressure and faces widespread shortages. Māori midwives are severely under-represented (Central Region Technical Advisory Services Limited, 2018) and the preventable mortality and morbidity of Māori women and babies persists. Māori as Tiriti partners have not been served well by the Health and Disability System that is suffering from systemic collapses (New Zealand Health and Disability System Review Hauora Manaaki ki Aotearoa Whānui, 2019).

Te Rau Ora[2] in partnership with Ngā Māia Trust (Ngā Māia) and Counties Manukau District Health Board (Counties Manukau Health) (the Partners) are working together to develop an evidence base to inform Māori workforce development priorities with a focus on Māori women, babies, children and whānau. The evidence base will help identify professional development needs, ensure a spotlight on indigenous health, and build a culturally appropriate professional Māori health workforce.

This literature review is the first step by the Partners to establish an evidence base that describes the current Māori midwifery landscape and the nuances of the workforce.

The aims of this literature review are to:

1. Characterise the midwifery profession in Aotearoa.
2. Describe the barriers to effective care for Māori women and their whānau.
3. Review midwifery education and professional development.
4. Discuss successful Māori midwifery workforce development initiatives.
5. Identify challenges and opportunities for future proofing the Māori midwifery workforce to ensure the needs of Māori birthing women and their whānau are met.

There is a wealth of Māori research that substantiates the need for change to achieve equitable health and wellbeing for Māori. The state of the midwifery sector and its effects on Māori midwives, midwifery students, women and their whānau is drawn together in Rapua te Aronga-a-Hine to identify opportunities to assist the aspirations of the Partners and a Māori midwifery revolution.

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[2] Te Rau Ora (formerly Te Rau Matatini) has a vision to improve Māori Health through leadership, education, research and evaluation, health workforce development and innovation, systemic transformation.

5. Te Tiriti o Waitangi (Te Tiriti)

Māori are the original inhabitants (indigenous peoples) of Aotearoa by virtue of their ancestral and historical connection to the land, and their cultural distinctiveness as recognised by the United Nations and the Government in Aotearoa (Martínez Cobo, 1987; Te Puni Kōkiri, 2019; United Nations, 2007).

Up until the 1800s Māori were the only peoples living in Aotearoa, they were self-governing, and had their own social institutions, legal, intellectual, ethical and moral systems that guided their day-to-day life.

Like British explorers, Māori were traversing the globe and they had experience of other societies, including British subjects. There is historical evidence that Māori visited other lands during the 1700 to 1800s, such as Sydney, London, New York, and Antarctica (O'Malley, 2017).

Following the arrival of British explorers to Aotearoa, growing numbers of their comrades began to arrive in the late 1830s. The British Government took steps to regulate their subjects and to secure commercial benefits for themselves by intercepting French interests in Aotearoa. He Whakaputanga o te Rangatiratanga o Nu Tīreni (the Declaration of Independence of the United Tribes of New Zealand [He Whakaputanga]) was written in English and Māori language versions. The Māori language version of He Whakaputanga was signed by 52 Māori chiefs between 1835 and 1839 (Ministry for Culture and Heritage Manatū Taonga, 2017a).

In time, He Whakaputanga was not considered a powerful enough mechanism for the British to assert complete control over the entire country. Total domination became the main driver for the drafting of a new agreement, Te Tiriti o Waitangi, that takes its name from the place where it was first signed. Te Tiriti then traversed the country, being signed by British representatives and 540 Māori chiefs (Ministry for Culture and Heritage Manatū Taonga, 2017b).

Both the Declaration and Te Tiriti were intended to provide for a mutually beneficial relationship between Māori and the British Government. Māori understood they were active participants in the governance of their own lands and they were equal members of society (Walker, 1989).

Following the signing of Te Tiriti, the Constitution Act 1852 made provision for a parliamentary system in Aotearoa that was based on the British Westminster model of governance. The first elections were held in 1853 and Parliament sat for the first time in 1854. The right to vote was based on the possession of individual property. Māori were collective land owners which excluded them from voting for Parliament (Ministry for Culture and Heritage Manatū Taonga, 2017c).

Te Tiriti provided the mechanism for the British to dominate Māori, who have been subjected to colonisation by imposed structures, processes and practices (Martínez Cobo, 1987; Smith, 2005; Wilmer, 1993). Colonisation is attributed with creating inequalities between Māori and other people living in Aotearoa. In the 180 years since the signing of Te Tiriti, Māori have managed to achieve:

- Māori representation in Parliament made up of seven seats determined by Māori electoral votes. In addition, Māori may also be members of Parliament via general electorate seats.
- Establishment of Te Rōpū Whakamana i te Tiriti o Waitangi (Waitangi Tribunal) that researches and makes legal decisions on historical and contemporary breaches of Te Tiriti by the Crown.[3] The Waitangi Tribunal is appointed and administered by the Ministry of Justice. Some Waitangi Tribunal settlements by iwi can also benefit the wider community. For example, the Manukau claim aimed to restore Auckland's western harbour from the effects of waste and sewage pollution.
- Establishment of Māori medium education and New Zealand Qualifications Authority (NZQA) accredited Māori tertiary institutions.
- Iwi have significant control of, and right to fishing.
- Te reo Māori, the Māori language, was made an official language of Aotearoa in 1987.
- Some radio frequencies are reserved for Māori.
- Te Māngai Pāho was established as a Māori broadcasting agency.
- A Māori television channel was established by Te Māngai Pāho.

Over time, the intention of Te Tiriti has been articulated as being represented by principles of partnership, participation and protection (Royal Commission on Social Policy, 1988). Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services. Protection involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices (Ministry of Health Manatū Hauora, 2014).

Te Tiriti, comprises three articles, agreed by Māori and the Government, to collectively recognise Māori as indigenous people and guarantee their sovereignty in Aotearoa (Waitangi Tribunal Te Rōpū Whakamana i te Tiriti o Waitangi, 2018).

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[3] The Governor-General of Aotearoa (New Zealand), currently Dame Patsy Reddy, is the viceregal representative of the Monarch of New Zealand, currently Queen Elizabeth II. The Crown refers collectively to the Monarch, the Governor-General as the Monarch's representative and Government Ministers. While most in Aotearoa recognise that Queen Elizabeth II does not herself run Aotearoa, a link can be drawn between the Crown and the Government by saying that while the Sovereign reigns the Government rules.

Article One: Involves sharing power and establishing structures and systems that ensure Te Tiriti partners have equal representation in decision-making. Representation by Māori on boards and committees occurs in many instances, but more often, Māori are the minority in decision contexts.

Article Two: Requires that Te Tiriti partners exercise their own self-determination and are in control of their individual and collective aspirations, facilitated by the removal of barriers to their success.

Article Three: Addresses the wider determinants of health and therefore it demands a close examination of the pledged commitments versus what is actually being done. Article three also assures Māori of access to the same rights as others including access to their own ethical and moral system (Berghan et al., 2017; Came, Cornes, & McCreanor, 2018; Came, Sullivan, & McCreanor, 2020).

There is discourse about a fourth Article of Te Tiriti, as explained by Te Puni Kōkiri (2001, pp. 40-41):

> *During the Waitangi signing of the Treaty, debate concerning ongoing respect for Māori customs and authority "became mixed with a dispute amongst the representatives of the missionary churches". The French Roman Catholic Bishop, Pompallier, was concerned that the predominance of the Anglican faith amongst the British representatives and missionaries would discourage Māori from adopting Catholicism. Pompallier intervened, asking the Governor to give the assembled chiefs a guarantee that their religious freedom would be protected. A declaration was accordingly drafted, accepted by Hobson, and read to those assembled, the text of which is recorded as:*
>
>> *E mea ana te Kāwana ko ngā whakapono katoa o Ingarani, o ngā Wēteriana, o Rōma, me te ritenga Māori hoki e tiakina ngātahitia e ia.*
>>
>> *The Governor says the several faiths of England, of the Wesleyans, of Rome, and also the Māori custom, shall be alike protected by him.*
>
> *The declaration was never added to the text of the Treaty, and so is not regarded as an official Article of the Treaty, but nonetheless it undoubtedly informed the views of Māori considering the Treaty at Waitangi. The "fourth Article" retains significance for many Māori today, who regard it as an important supplement to the promises made to them in Articles II and III of the Treaty, particularly that Māori customs and authority would be protected.*

In 2003, the Ministry of Health (MOH) produced a document (Ministry of Health Manatū Hauora, 2003) that made reference to a fourth Article of Te Tiriti, as if it were in addition to the three Articles commonly known to exist. The writing into history of a fourth Article was debated in Parliament (New Zealand Parliament Pāremata Aotearoa, 2003) and although reference to a fourth Article in the MOH document was removed, discussion about its existence and application continues.

There is much work to be done to strengthen alignments in the midwifery profession to Māori health policy and Crown obligations under Te Tiriti. To advance a Tiriti-led midwifery profession, all that is needed is a willingness by Te Tiriti partners to work together and make evidence-based decisions.

6. Political Reform

6.1. Whānau Ora

Whānau Ora was introduced as Government policy in 2010 as an innovative whānau-centred way of directing resources and support for Māori wellbeing and development because Government strategies were ineffective. The development and operational framework for Whānau Ora was articulated by the Taskforce on Whānau-Centred Initiatives that reported to Government in 2009. The implementation of Whānau Ora occurred in two phases:

Phase one of Whānau Ora (2010 to 2014) focused on building the capability of providers to deliver whānau-centred services. Te Puni Kōkiri worked with collectives of health and social service providers across the country to re-orientate the way they worked, placing whānau at the centre.

Phase two (2014 to present day) moved implementation by Government to three non-government Commissioning Agencies; which are, the Whānau Ora Commissioning Agency (formerly Te Pou Matakana), Te Pūtahitanga o Te Waipounamu and Pasifika Futures. The Commissioning Agencies are contracted to invest directly into their communities which includes individuals, whānau initiatives and Māori Health Providers (Te Puni Kōkiri, 2016).

The Whānau Ora Partnership Group (WOPG) is a Tiriti-based relationship established in 2015 with equal membership of six iwi Chairs (mandated by the National Iwi Chairs Forum) and Government Ministers. The Whānau Ora Outcomes Framework (the Framework) is the major agreed outcome of the Whānau Ora WOPG. It is based of seven over-riding outcomes:

- Whānau are self-managing and empowered leaders.
- Whānau are leading healthy lifestyles.
- Whānau and families are confidently participating in Te Ao Māori (the Māori World).
- Whānau are participating fully in society.
- Whānau and families are economically secure and successfully involved in wealth creation.
- Whānau are cohesive, resilient and nurturing.
- Whānau and families are responsible stewards of their living and natural environments.

(Te Puni Kōkiri, 2016; Whānau Ora Iwi Leaders Group, 2016).

The Framework recognises progressive and long-term change is often required for whānau to achieve their own aspirations. Unlike service provision where health, education and social services provided

to whānau are prescribed according to government determination of whānau priorities, Whānau Ora is self-determining. Individuals or collectives within a whānau identify their priorities for wellbeing according to their own context and circumstances. A priority for one person might be in getting their drivers licence so that they can apply for a job and get themselves to work. Another person might be a second chance learner interested in tertiary study, but they do not have the study skills required. Whānau Ora Commissioning Agencies work with a broad range of whānau needs and network with a wide range of organisations to ensure whānau goals are achievable. That said, the Framework outlines a set of short, medium and long-term outcomes achieved within five years, between five and 10 years, and 11 to 25 years respectively (Te Puni Kōkiri, 2016).

Whānau Ora Commissioning Agencies have reported remarkable transformations amongst whānau, including academic achievements, the establishment of whānau businesses, and planning for whānau housing initiatives, far exceeding success across government initiatives in terms of the volume of whānau achieving their goals within a short space of time (Whānau Ora Commissioning Agency, 2019).

The current Government promised further investment in Whānau Ora but it is yet to happen, and to ensure the gains so far continue to gather momentum, it is critically important that the Government does not ignore the overwhelming success that has occurred, in favour of its own investment that has already proven, over decades, to be ineffective.

6.2. New Zealand Health and Disability System Review

In 2018 the Minister of Health announced a major review of the Health and Disability System (the Review) with the final recommendations due to be delivered to Government in March 2020.

Heather Simpson was appointed to lead the Review with a panel of six experts and a Māori Expert Advisory Group. Panel members visited District Health Boards (DHBs; DHB), met with key stakeholder organisations, held workshops and wānanga around the country, and conducted an online submission process open to all. The panels interim report was released in September 2019 and aims to reflect the issues people and organisations described to them that are hampering achievement of better outcomes. The panel also checked whether the available evidence supports what they heard, and in their report, they signal their initial thoughts on where the biggest gains can be made to improve the performance of the Health and Disability System. The panel acknowledge the commitment and good intentions of most of those working in it, but the current system is not performing equally for all.

The report states:

> *When we project forward and consider the demographic, technological, societal, cultural, and environmental changes that are rapidly overtaking us, it is clear there are challenges ahead. Continuing with the current model of care, based largely on a Western medical model, employing more and more medically qualified staff focused on treating illness, rather than promoting wellness, will not only be ineffective in achieving the equitable outcomes we desire, it will not be sustainable. The numbers of staff required will not be available and the cost would be prohibitive.*

> (New Zealand Health and Disability System Review Hauora Manaaki ki Aotearoa Whānui, 2019, p. 4).

Unsurprisingly, from the wide variety of submissions the panel received, there is a degree of concurrence in the views that have been expressed, and agreed with, for decades. Yet the panel found the system changes have been only marginal.

There are no recommendations in the Health and Disability System Review interim report, but the panel has signalled that if the system is to be more equitable and more sustainable, significant change must happen.

A key part of the panel's findings relates to Māori. The panel asserts the significance for Māori of Te Tiriti that guaranteed Māori their full rights and benefits as citizens. Yet more than 80 years after the establishment of our public health system, the health and wellbeing outcomes for Māori are still significantly poorer than for non-Māori in Aotearoa. The panel points out the Health and Disability System has not properly recognised different world views, different knowledge bases, or different cultural norms (New Zealand Health and Disability System Review Hauora Manaaki ki Aotearoa Whānui, 2019).

The Health and Disability System is the landscape in which midwifery operates, it is where Māori midwives work, and where Māori women receive services from midwives. Based on the panel's work so far, the tenor of the interim report bodes well for Māori aspirations.

6.3. Living Standards Framework (LSF)

The Living Standards Framework (LSF) informs the Government's long-term strategic direction including the five priorities for its 2019 Wellbeing Budget which are:

1. Taking mental health seriously.
2. Improving child wellbeing.
3. Supporting Māori and Pasifika aspirations.
4. Building a productive nation.
5. Transforming the economy.

(New Zealand Government Te Kāwanatanga o Aotearoa, 2019b).

The primary focus of the LSF is to raise living standards for all. The Treasury, the Government's economic and financial advisor, developed the LSF as a practical policy advice tool for applying the Government's wellbeing approach more systematically across its work with other Government agencies. The LSF is informed by 12 domains that reflect current evidence about factors that contribute to wellbeing outcomes and four types of capital; including, natural, human, social, financial and physical as shown in Figure 1.

Figure 1: LSF 2019

(The Treasury Te Tai Ōhanga, 2019b).

The Treasury is intending to refresh the LSF in 2021 to reflect Māori and Pasifika worldviews and the different ways that culture contributes to wellbeing. A discussion plan will be released during 2020 when the Treasury intends to work closely with Māori and Pasifika communities to inform the refresh of the LSF. Until the refresh process, the LSF Dashboard provides indicators the Treasury believes are important in advising cross-government wellbeing budget priorities (The Treasury Te Tai Ōhanga, 2019a).

The LSF Dashboard, centralises data inputs from across Government and is the measurement tool which informs the Treasury's advice to Ministers on improving priorities for wellbeing. For example, wellbeing of people is understood from a single data source, the New Zealand General Social Survey (GSS) that looks at wellbeing across multiple domains in the LSF. The GSS provides a link to the LSF for understanding and tracking wellbeing according to those LSF domains and comparisons between different populations groups (The Treasury Te Tai Ōhanga, 2019a). Māori will be awaiting participation in the refresh process to ensure the LSF measurement is relevant and effective for their communities.

6.4. Tertiary Education

The workforce in Aotearoa is ageing and Māori entering the workforce is growing. Experimentation with new models of tertiary education is critical to meet future needs of Māori (Tertiary Education Commission Te Amorangi Mātauranga Matua, 2019). In 2016 the Productivity Commission commenced a review of the education system in Aotearoa and in 2019 the Minister of Education announced reforms to the tertiary sector, effective from 1 April 2020. The seven key changes for vocational education are:

1. Creation of workforce development councils.
2. Establishment of regional skills leadership groups.
3. Establishment of Te Taumata Aronui, to help ensure vocational reforms reflects the Government's commitment to Māori Crown partnerships.
4. Creation of a New Zealand Institute of Skills and Technology. All 16 polytechnics and institutes will become part of the Institute.
5. Shift the role of supporting workplace learning from Industry Training Organisations (ITOs) to providers.
6. The establishment of Centres of Vocational Excellence (CoVEs).
7. Unify the vocational education funding system.

(Tertiary Education Commission Te Amorangi Mātauranga Matua, 2019).

Each year the Government invests around $2.8 billion in tertiary education and its Tertiary Education Strategy guides all funding decisions to ensure institutions are supported to achieve the Government's priorities for tertiary education (Tertiary Education Commission Te Amorangi Matauranga Matua, 2017).

The reforms are intended to deliver to the unique needs of underserved populations, such as Māori, that has a younger population structure compared to other ethnicities, which means they will form a major part of the labour workforce in the future. The Labour Government proposes the changes will bring an opportunity to set up a new system that prioritises Māori success and works with Māori to shift to more culturally responsive teaching and learning, where learners know they are valued. It is also a chance to make sure there is a much stronger voice for Māori businesses and iwi development (Tertiary Education Commission Te Amorangi Mātauranga Matua, 2019).

The reforms exclude degree qualifications such as the undergraduate midwifery programme and appear not to directly impact midwifery education. But the underlying motivation for the reforms by the Minister of Education to 'join the dots' between education and employment, is relevant for all Māori workforce development, signalling the intentions of Government to promote success for Māori across the workforce spectrum.

It is too early to predict the long-term benefits of the reforms. With priority being given to vocational education there could be some negative impacts on midwifery education as tertiary institutions reconfigure their priorities. For example, some midwifery students begin their tertiary journey into midwifery education by a stepped approach, enrolling in pre-degree or bridging courses first.

7. Midwifery in Aotearoa

7.1. Role of the Midwife

Midwives have a significant role in Aotearoa as primary maternity care providers. The midwifery profession offers multiple career pathways; including, self-employed case loading claiming payment directly from the MOH for Lead Maternity Care (LMC), employed roles within DHBs often referred to as a Core Midwife, or other service providers and organisations where they may work in clinical, leadership, education, research, policy or advisory roles, and employed roles within tertiary education. Midwives have numerous opportunities to represent the profession on various committees, leadership groups and governance boards, and professional, regulatory and disciplinary bodies across the country.

Pregnant women engaging with health care will encounter a midwife at some point throughout the maternity continuum, whether they are having their baby at home, a primary maternity facility or birthing centre, or a secondary or tertiary hospital. Maternity care is free to eligible women, unless they choose to have their care provided by an obstetrician LMC. To access maternity care, women register with an LMC. The majority of women choose a self-employed midwife LMC, with the remainder choosing an obstetrician or general practitioner (GP) LMC who has a diploma in obstetrics (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020c).

Table 1: Comparison of LMC types between 2003 and 2017

Lead Maternity Carer (LMC) Type	2003		2017	
	Number	**Percentage**	**Number**	**Percentage**
Registered with LMC	42,906	77.7	55,076	92.3
Midwife	33,531	60.7	51,854	86.9
Obstetrician	3,342	6.1	3,064	5.1
General practitioner	3,376	6.1	112	0.2
Other/unknown	2,657	4.8	46	0.1
Not registered with LMC	12,306	22.3	4,585	7.7
Total	**55,212**	**100.0**	**59,661**	**100.0**
(Ministry of Health Manatū Hauora, 2019k).				

Māori women were likely (92%) to register with an LMC during their pregnancy but this was less likely to occur in the first trimester (55.2%). Māori women are the second highest users of LMC services behind women in the European or Other ethnic group.

All LMCs are contractually obliged to provide continuity-of-care to the woman and her baby, taking responsibility for assessing their needs, negotiating a care plan and facilitating any additional care that may be required (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020c).

Self-employed midwife LMCs generally work with a partner or within a team or practice of midwives to provide primary maternity continuity-of-care. Midwives employed in hospital settings are involved in the care of women that are either unable to access a self-employed midwife LMC, or have a GP or obstetrician LMC, have more complex needs, or have had their care handed over to a secondary or tertiary provider by their LMC because their health and wellbeing is compromised for one reason or another. In such cases, midwives work within a multidisciplinary team environment to provide co-ordinated care.

The Aotearoa LMC model of primary maternity care is unique in the world and is the cornerstone of the country's maternity service. Evidence shows that when women and babies are provided continuity-of-care, maternity outcomes are improved (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020c).

Midwives can provide maternity care in a variety of settings to meet the needs of individual women and their birth plans. Antenatal care is usually provided in a clinic setting, with some midwives providing home visits. Labour and birth care can occur at home, or in a primary, secondary or tertiary facility. Women have the option to choose where they would like to birth. Postnatal care is provided in the home.

Settings that midwives provide care in includes:

1. Primary - Home: Midwives can provide antenatal, labour and birth, and postnatal care in the woman's home (or similar, such as the home of a family member or their marae). Home birth is a safe option for well women, expecting to have a normal birth.

2. Primary Facility - Primary Unit or Birth Centre: Usually community based where care is provided by midwives for women who are at low risk of complication and are expecting to birth normally. If complications arise, transfer to a secondary or tertiary facility is required

to access secondary care services such as epidural analgesia, ventouse, forceps or operative birth (caesarean section) (Ministry of Health Manatū Hauora, 2019k).

3. Secondary Facility: A hospital that provides care for normal births, complicated pregnancies and births including operative births. They have an obstetrician rostered onsite during working hours and on call after hours. Access to support from an anaesthetist and paediatrician, and radiological, laboratory and neonatal services are available.

4. Tertiary Facility: A hospital that provides care by specialised multidisciplinary teams for women with high-risk, complex pregnancies. An obstetric specialist or registrar is available onsite 24 hours a day and has level three neonatal care services (Ministry of Health Manatū Hauora, 2019k).

The provision of midwifery care is expected to be safe, informed by evidence and based upon the partnership model where informed choice is integral (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015).

The midwifery Scope of Practice states:

The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.

The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.

Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.

(New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015, p. 4).

7.2. Midwifery Infrastructure

Midwifery is a separate profession from nursing in Aotearoa. Midwives are autonomous health professionals who are recognised as experts in normal childbirth with well women and babies. The midwifery profession is operationalised by separate but interconnected entities with respective functions. In Aotearoa, the regulatory body is the Midwifery Council of New Zealand (the Midwifery Council) and the New Zealand College of Midwives (NZCOM) is the professional body.

7.2.1. Ministry of Health (MOH)

The MOH leads the public health and disability system in Aotearoa on behalf of the Government. The MOH has overall responsibility for the management and development of that system, which includes setting the country's health strategy, funding and monitoring of the Health and Disability System and the collection of health workforce data.

The MOH is the budget holder of Vote Health monies to fund DHBs to provide maternity services in their respective regions. The MOH also funds the Primary Maternity Service Notice 2007 which is a Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88) to enable self-employed LMCs to claim payment for services by defining primary maternity services and associated funding schedules (New Zealand Government Te Kāwanatanga o Aotearoa, 2007).

The NZCOM, on behalf of its membership took legal action against the MOH on the grounds of gender-based pay inequity for self-employed LMC midwives. In 2017, after 21 months of discussion NZCOM reached a landmark agreement with the MOH to co-design a funding model that pays self-employed LMC midwives equitably for the services they provide. The co-design was intended to address the structural barriers that deny self-employed LMC midwives pay equity and threaten the sustainability of the LMC midwife model of care. The breakthrough is that NZCOM now has a legally binding agreement with the MOH to reach the equity goal midwives have sought for a very long time (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2017). To date the co-design outcome between the MOH and NZCOM has not been finalised.

The MOHs (2019a) Equity Work Programme focuses on facilitating equity across the health system's operational landscape and promotes the cultural shift required to affect the system change that achieves equity in health outcomes. Co-leadership and governance arrangements have been established to advance the Equity Work Programme, and the MOH lead is the Deputy Director-General Māori Health and the DHB lead is the Waitematā DHB CEO. Maternity care and midwifery is one of the five listed priority areas to be addressed (Ministry of Health Manatū Hauora, 2019a).

Signed-off by the Director-General of Health in March 2019, the MOHs definition of equity is:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

(Ministry of Health Manatū Hauora, 2019a).

7.2.2. Midwifery Council of New Zealand (MCNZ)

The Health Practitioners Competence Assurance Act 2003 (the HPCA Act) (New Zealand Government Te Kāwanatanga o Aotearoa, 2019a) makes provision for the regulation of health practitioners in Aotearoa in order to protect the public. The Midwifery Council is responsible for the regulation of midwives (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2020). The functions of the Midwifery Council within the HPCA Act are:

(a) *to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes.*

(b) *to authorise the registration of health practitioners under this Act, and to maintain registers.*

(c) *to consider applications for annual practising certificate.*

(d) *to review and promote the competence of health practitioners.*

(e) *to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners.*

(f) *to receive information from any person about the practice, conduct, or competence of health practitioners and, if it is appropriate to do so, act on that information.*

(g) *to notify employers, the Accident Compensation Corporation, the Director-General of Health, and the Health and Disability Commissioner that the practice of a health practitioner may pose a risk of harm to the public.*

(h) *to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession.*

(i) *to set standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession.*

(j) *to liaise with other authorities appointed under this Act about matters of common interest.*

(ja) *to promote and facilitate inter-disciplinary collaboration and co-operation in the delivery of health services.*

(k) *to promote education and training in the profession.*

(l) *to promote public awareness of the responsibilities of the authority.*

(m) *to exercise and perform any other functions, powers, and duties that are conferred or imposed on it by or under this Act or any other enactment.*

(New Zealand Government Te Kāwanatanga o Aotearoa, 2019a, Section 118).

The Midwifery Council is comprised of qualified midwives and lay members, with all members appointed by the Minister of Health for a term of one to three years and they may be re-appointed when their term is complete.

The Midwifery Council must collect information about the profession for the Director-General of Health; including, the name of the midwife, their date of birth, ethnicity, gender, employer, place or places of work, and the average weekly number of hours worked by the health practitioner at each place of work. The midwifery Annual Practising Certificate (APC) renewal process serves as the mechanism for collecting the information required.

Upon completion of an accredited midwifery degree, the graduate applies to the Midwifery Council for entry to the Register of Midwives. To practice as a midwife, all midwives must meet the Midwifery Council's prescribed requirements to demonstrate that they have the required qualifications, are fit for registration, and have the competence to practice within the midwifery Scope of Practice. There are four Competencies for Entry to Register of Midwives, each contains a competence statement, explanation and set of performance criteria. The Competencies for Entry to the Register of Midwives are:

1. *The midwife works in partnership with the woman/wahine throughout the maternity experience.*

2. *The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.*

3. *The midwife promotes practices that enhance the health of the woman/wahine and her family/whanau [sic] and which encourage their participation in her health care.*

4. *The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care.*

(Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2007, pp. 1-5).

7.2.3. Midwifery Tertiary Education Providers

The Midwifery pre-registration education programmes are delivered by four midwifery schools at Te Ara Institute of Canterbury (ARA), Auckland University of Technology (AUT), Otago Polytechnic and Waikato Institute of Technology (Wintec). Massey University (MU) discontinued delivering midwifery education in 2012. Victoria University of Wellington (VUW) has for a long time provided postgraduate midwifery education, and in 2019 it was approved to deliver an undergraduate programme beginning in 2020, bringing the total number of midwifery schools to five.

The schools deliver the four-year (480 credit) programme over three extended academic years of 45 weeks per year, in contrast to the traditional university year of around 32 weeks. Midwifery students complete a Bachelor of Midwifery or a Bachelor of Health Science (Midwifery) degree.

The Bachelor of Midwifery or a Bachelor of Health Science (Midwifery) is listed on the New Zealand Qualifications Framework (NZQF), which is the heart of the education system in Aotearoa for all qualifications, both secondary and tertiary. The NZQF is divided into 10 levels. Each level is based on how complex the learning is, and it starts from level one and goes through to level 10. The National Certificate of Education Achievement (NCEA) is the main secondary school qualification in Aotearoa, which is made up of three certificates awarded at levels one, two and three on the NZQF. Completion of the Bachelor of Midwifery or a Bachelor of Health Science (Midwifery) degree is at level seven on the NZQF.

Table 2: NZQA framework

Level	Qualification
10	Doctorate Degree
9	Master's Degree
8	Postgraduate Diplomas and Certificates Bachelors Honours Degree
7	Bachelor's Degree Graduate Diplomas and Certificates
6	Diplomas
5	
4	Certificates
3	
2	
1	
(New Zealand Qualifications Authority Mana Tohu Mātauranga o Aotearoa, 2020).	

7.2.4. New Zealand College of Midwives (NZCOM)

Established in 1989, the NZCOM is recognised as the professional organisation and 'voice' for midwives and student midwives in Aotearoa. The NZCOM represents midwifery and women's health interests, both nationally and internationally, playing an active role worldwide through its work with the International Confederation of Midwives (ICM).

The NZCOM works in partnership with maternity consumer groups such as the Royal New Zealand Plunket Trust (Plunket), Parents Centre New Zealand, the New Zealand Homebirth Association and La Leche League (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020a). In addition, the NZCOM works alongside associated professional groups; including, the College of Obstetricians and Gynaecologists, the New Zealand Society of Anaesthetists, the Royal College of GPs, and the Paediatric Society. The NZCOM also works with DHBs and other agencies who have an interest in maternity services, in order to implement Government strategies that will further improve maternity and midwifery services for women and their babies in Aotearoa (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020a).

As a professional organisation, the NZCOM represents more than 90% of all practising midwives, providing indemnity insurance, professional advocacy, ongoing education, the Midwives First Year of Practice (MFYP) programme and provides the Resolution Committee for consumers are all significant work done by the NZCOM (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020a).

The NZCOM is organised into 10 geographic regions and a further five sub-regions. Each regional group of the NZCOM functions autonomously in alignment with the national NZCOM constitution. The Chairperson from each of the NZCOM regional groups sits on the NZCOM National Board of elected representatives to govern the organisation. The National Board also includes students, consumers, Māori and Pasifika midwives, an education advisor, and the NZCOM Kuia, Elder, Chief Executive Officer (CEO), President and Midwifery Advisors (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020d).

The NZCOM has developed the midwifery Philosophy, Code of Ethics, Practice Guidelines and Consensus Statements, and the Standards of Midwifery Practice (the Standards) for Aotearoa. The Standards define the benchmark for the midwife's practice and identify a series of actions that are essential to the development and maintenance of the midwifery partnership with women (New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015).

The NZCOM Standards of Midwifery Practice are:

1. *The midwife works in partnership with the woman.*
2. *The midwife upholds each woman's right to free and informed choice.*
3. *The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.*
4. *The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.*
5. *Midwifery care is planned with the woman.*
6. *Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.*
7. *The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.*
8. *The midwife evaluates her practice.*
9. *The midwife negotiates the completion of the midwifery partnership with the woman.*
10. *The midwife develops and shares midwifery knowledge and initiates and promotes research.*

(New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2020e).

Membership of the NZCOM includes registered midwives, students, other health professionals and organisations, and consumers. As of the 28th January 2020 Māori made up 10.9% of the total NZCOM membership, as shown by the following table:

Table 3: NZCOM membership 2019

NZCOM Membership Type	Number	Also, a Ngā Māia Member[4]
Total	3,572	120
Identify as Māori	391 (10.9%)	120 (30.7%)
Māori Midwife	296 (8.3%)	111 (37.5%)
(Eddy, 2020).		

The NZCOM has a history with Māori midwives that started 30 years ago. With the passing of the Nurses Amendment Act in 1990 Helen Clark advised the NZCOM to apply for a Workforce Development Grant from the Department of Health. The NZCOM was granted a total of $76,900 for

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[4] At the time of NZCOM membership registration, midwives have the option to self-identify as being a member of Ngā Māia.

three initiatives made up of $50,000 for an educator. An educator was paid $20,000 to run a series of seminars around the country to educate health professionals about the midwifery model of care and the implications of the Nurses Amendment Act 1990, and the rest was used for travel expenses, secretarial services and the establishment of an office base. Some monies from the $50,000 grant NZCOM received were accrued to ensure their continuing ability to employ the educator the following year (Pairman, 2005).

The second grant NZCOM received was for $14,200 to undertake research into midwifery education needs for midwives practicing under the Nurses Amendment Act 1990. The third lot of funding given to the NZCOM was a $12,700 bicultural grant to increase Māori and Pasifika women's awareness of midwifery as a profession and promote culturally safe practice amongst the midwives of Aotearoa (Pairman, 2005).

The NZCOM National Committee (now known as the National Board) had no Māori members and was unsure how to proceed with seeking Māori representation, let alone how to properly use the bicultural grant. The NZCOM National Committee sought advice from Irihapeti Ramsden,[5] on how to establish a Māori consultation process and she advised them to contact the National Council of Māori Nurses and the Ministry of Māori Affairs for representation. The Ministry of Māori Affairs declined to be involved, but the National Council of Māori Nurses agreed to nominate one of their members onto the NZCOM National committee, Mina Timutimu, who was a nurse and a midwife.

In 1992, Mina Timutimu attended her first NZCOM National Committee meeting and she was introduced to the meeting as 'Kuia'. The role Mina Timutimu held with the NZCOM evolved into officially being the Kuia for the organisation and she remained the Kuia until her death in 2016. Irihapeti Ramsden later became an honorary member of the NZCOM for her work on cultural safety and her input into midwifery's understandings of partnership with Māori (Pairman, 2005).

A Memorandum of Understanding (MOU) between NZCOM and Ngā Māia was signed in 2006. The MOU between NZCOM and Ngā Māia lapsed many years ago and discussions had in 2016 concerning the reinstatement of it have not come to fruition.

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[5] Dr Irihapeti Merenia Ramsden later received her Doctorate in 2002 from Victoria University of Wellington. The title of her Doctoral Thesis is *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*.

Ngā Māia is recognised as the national professional organisation representing Māori midwives and the interests of Māori birthing women and whānau.

During the period that the NZCOM was discussing Māori representation on its National Committee, Māori midwives and midwifery students across Aotearoa were having hui and discussing identified gaps in midwifery education and the racism they were exposed to in the health system and midwifery education. The experiences of Māori midwives and midwifery students became the impetus for the formation of the Māori midwifery collective, Ngā Māia o Aotearoa me te Waipounamu[6] (Ngā Māia). The first Ngā Māia hui was held in 1994 in Waikato where foundation members of Ngā Maia were tutors in the Tihei Mauri Ora[7] Programme at Waikato Polytechnic (now Waikato Institute of Technology or Wintec).

In 1997 during a Ngā Māia hui at Waitara, the NZCOM National Committee that attended agreed to pass over the $12,700 bicultural grant it was holding, to Ngā Māia which Ngā Māia then used to establish their structure (Pairman, 2005).

At a Ngā Māia hui in 1999, again at Waikato Polytechnic, attendees approved the first Deed (the first Deed) for Ngā Māia o Aotearoa me Te Waipounamu Trust (the Trust). The following year the Trust became a legal entity. The inaugural Trustees of the Trust were: George Wynyard Cherrington, Te Rahipere Cherrington, Jamisena Faith Kett, Sarah Hera McGhee, Moana Shortland, Miriama Mahuri, Anne Kupe-Wharehoka, Estelle Anne Marment, Karen Leslie Peters, Rangimarie Faith Hohaia and Patricia Crete Cherrington. The main purpose of the Trust was to promote, maintain and protect traditional Māori birthing (Ngā Māia Trust, 2014).

In 2014, the Trustees of the Trust at the time approved major changes to the Deed, to enable the rōpū to apply for funding independently rather than relying on other groups like the NZCOM to support their objectives (Ngā Māia Trust Trustee 2014, 2019).[8] A new Deed was created and the legal name of

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[6] Ngā Māia o Aotearoa me te Waipounamu was later renamed, Ngā Māia Trust.
[7] Tihei Mauri Ora arose in 1989 when the late Becky Fox joined the late Rewi Panapa as a Māori nursing educator at Waikato Polytechnic. By 1990 Becky Fox, Rewi Panapa and Rose McEldowney, the Head of the Department of Nursing and Health Studies worked together to establish a parallel working environment for Māori nursing students to address retention and achievement rates and create a safe learning environment that offered a unique body of knowledge that was explicitly Māori. The late Dr Hare Puke, gave the programme its name and it was the first Māori support programme for nursing and midwifery students. The programme provided dedicated kaiāwhina, tutorials run by Māori staff, a whānau room for students, Māori student forum, support to use te reo Māori, support to attend annual hui and iwi clinical placements for Māori students (Ngā Manukura o Āpōpō, 2014).
[8] The identity of the former Trustee who shared this information for clarity of Ngā Māia Trust history purposes, has been kept confidential.

the rōpū was shortened to Ngā Māia Trust (Ngā Māia), for reason of conciseness (Ngā Māia Trust Trustee 2014, 2020), and the original purpose of the Trust was widened to include provision of facilities and financial assistance to promote traditional Māori birth, and the delivery of training programmes for workforce development (Ngā Māia Trust, 2014).

Ngā Māia is organised into 10 rohe, which the Ngā Māia Trust Deed defines as being Te Tai Tokerau, Tāmaki Makaurau, Waikato, Wairoa/Gisborne, Rotorua/Whakatane, Hawkes Bay, Dannevirke, Taranaki, Wellington and Te Waipounamu (Ngā Māia Trust, 2014). Another public source provides differing information, stating that Ngā Māia is organised into five rohe (Te Huia, 2019).

Membership fees are set, received and retained by each rohe to finance their rōpū (Te Huia, 2019). The Ngā Māia Trustees are required to administer and maintain a register of members, known as the Ngā Māia Register (Ngā Māia Trust, 2014). As of 2019, Ngā Māia had 275 members, consisting of Māori midwives and midwifery students, whānau and kaumātua who self-identified as having Māori whakapapa links (Te Huia, 2019).

Ngā Māia is governed by five Trustees, with three or more required to be practising midwives and a General Manager, or similar role by another title, may be appointed to manage day-to-day administration and implementation of the Trusts planning, reporting and monitoring obligations (Ngā Māia Trust, 2014). Currently, Ngā Māia has a volunteer CEO in place.

Ngā Māia is represented on various professional bodies across the health sector which contributes to building capacity and capability. Low numbers and under-representation of Māori midwives at all levels of the midwifery profession is indicative of a colonised infrastructure perpetuated by both Māori and Pākehā that oppresses and subjugates Māori and is compounded by subjective and prejudicial appointment processes. The same Māori midwifery voices are given airtime, resulting in a misuse of power, narrow superficial consultation, and exclusion of the views of most Māori midwives. Conditions are set for disharmony among Māori midwives, distrust in leadership and decision-making processes, and concerns about transparency of information, funding, activity, and direction.

The 2006 MOU between NZCOM and Ngā Māia signalled the beginning of a partnership to improve the quality and appropriateness of NZCOMs relationship with Māori midwives, and services for Māori midwives and birthing whānau.

In 2006, led by Henare and Tungāne Kani, Ngā Māia published Tūranga Kaupapa which is a set of principles providing cultural guidelines on Māori values to inform midwifery practice. The aim of Tūranga Kaupapa is to assist in ensuring cultural requirements are met for Māori women and their

whānau throughout the maternity continuum (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2011; H. Tupara & Tahere, 2018). The ten principles of Tūranga Kaupapa are:

1. Whakapapa.
2. Karakia.
3. Whanaungatanga.
4. Te Reo Māori.
5. Mana.
6. Hau Ora.
7. Tikanga Whenua.
8. Te Whare Tangata.
9. Mokopuna.
10. Manaakitanga.

(Ngā Māia Trust, 2017).

In 2007 the NZCOM and Midwifery Council integrated Tūranga Kaupapa into the Midwifery Standards for Practice and the Competencies for Entry to the Register of Midwives, as a way to give life and meaning to their recognition of Māori as tangata whenua of Aotearoa and obligations under Te Tiriti (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2011; New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015; H. Tupara & Tahere, 2018).

Aotearoa is the first country in the world to recognise indigenous concepts within professional and regulatory midwifery frameworks. Tūranga Kaupapa represents a significant advance for Māori women. However, an evaluation of the application of Tūranga Kaupapa to midwifery education and practice and the subsequent impacts on positive childbirth outcomes for Māori, is yet to happen due to lack of resourcing. It is important that Tūranga Kaupapa is valued, and that the space it holds within midwifery in Aotearoa is nurtured by Te Tiriti partners to ensure its purpose is upheld into the future.

In 2009 the MOU partners engaged in a joint venture to report on 2005 midwifery activities and outcomes for Māori birthing whānau using data extracted from the Midwifery and Maternity Providers Organisation (MMPO) database of midwives practice outcomes. Key recommendations from the report were:

- *Evaluate/audit reliability of MMPO Māori ethnicity data.*
- *Increase the number of Māori midwives registered with MMPO.*

- *Improve access to Māori midwives in regions where Māori whānau are mainly birthing.*

- *Ensure midwives who are not working with Māori whānau have training in cultural safety.*

- *Develop resources and professional development pathways which focus on the particular needs of wāhine rapou,[9] eg [sic] increased risk of obstetric intervention.*

- *Celebrate the generally lower rates of obstetric intervention among Māori māmā.*

- *Continue to monitor and explore how use of obstetric intervention techniques may influence maternal/infant birth outcomes such as post-partum blood loss, perineal trauma, Apgar scores and the likelihood of breastfeeding.*

- *Actively support strategies which aim to promote, improve and sustain Māori rates of breastfeeding.*

- *Improve the quality of Māori MMPO data on DHB region of birth, planned place of birth, obstetric and medical history, use of TCAM[10] and infant deaths.*

- *Continue to report on the Māori MMPO dataset with opportunities for aggregation of data (over several years), identification/monitoring of trends, comparison with non-Māori data and strengthening capacity to inform practice.*

- *Obtain funding to compile an aggregated report on Māori MMPO data for the 2006-2009 period.*

(Tumana Research, 2005).

The recommendations arising from the Ngā Māia and NZCOM joint venture report alluded to some research and workforce themes. Ngā Māia was hopeful the information would lead to the development of resources for women and for midwives working with Māori women, babies, and whānau (Tumana Research, 2005).

Despite unsuccessful attempts by Ngā Māia to forge a Tiriti-led partnership with NZCOM, Ngā Māia remains optimistic about having the opportunity to be better placed to advocate for Māori women, babies and whānau and to be included alongside NZCOM in negotiations with the MOH to co-design the self-employed LMC midwives funding model (Te Huia, 2020).

7.2.6. Midwifery and Maternity Providers Organisation (MMPO)

The MMPO was set up in 1995 and provides a practice management system for LMC midwives with a caseload of women for whom they provide continuity-of-care. The MMPO provides a mechanism for

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[9] Wāhine rapou (rapoi) is a term applied to a woman during her first pregnancy (Williams, 1985).
[10] As per source glossary, Complementary and Alternative Medicines or Therapies (TCAM)

midwives to access payment from the MOH under Section 88. The MMPO's practice management system is centred on a standardised set of notes that, as well as offering a professional record of maternity care for the midwife and the woman, provides a national data collection tool for analysing maternity outcomes (New Zealand College of Midwives Te Kāreti o Ngā Kaiwhakawhānau o Aotearoa, 2020b).

There are also other practice management systems available to midwives in Aotearoa, such as those provided by Mothers and Midwives Associated (MAMA) Maternity Information Services and Expect.

7.2.7. Midwifery Employee Representation and Advisory Service (MERAS)

Established in 2002, the MERAS is the only union dedicated to representing midwives and approximately 90% of midwives employed by DHBs belong to MERAS. MERAS members, which also includes midwives employed by non-DHB maternity hospitals and units, provide a strong collective voice on workforce issues. The MERAS negotiates the national employee collective agreement specific to midwifery with DHBs and represents midwives with individual employment issues (Midwifery Employee Representation and Advisory Service, 2020; New Zealand College of Midwives Te Kāreti o Ngā Kaiwhakawhānau o Aotearoa, 2020b).

The NZCOM, MMPO and MERAS are associated as a professional structure, but are all governed and operated separately from each other, thereby preventing the fragmentation of midwifery into other organisations who may not hold the interests of midwives as central (New Zealand College of Midwives Te Kāreti o Ngā Kaiwhakawhānau o Aotearoa, 2020b).

7.2.8. New Zealand Nurses Organisation (NZNO)

NZNO is the leading professional organisation for nurses in Aotearoa, representing the largest number of nurses and health workers. Some midwives for one reason or another choose to be a member of NZNO instead of NZCOM; an example of this is midwives who hold dual registration as a nurse and midwife and wish to avoid splitting their membership between two separate organisations.

7.3. Midwifery Workforce

7.3.1. The Midwifery Workforce

Almost 8.5% of the entire workforce in Aotearoa is employed within the health sector, and midwives make up approximately 1.5% of the health workforce (New Zealand Health and Disability System Review Hauora Manaaki ki Aotearoa Whānui, 2019). When midwives in Aotearoa apply for an APC, they complete a survey as part of the Midwifery Council renewal process with the compliance rate reported as high as 90% (Jo, 2020).

Of all midwives in 2019, 1,827 (56.6%) reported having a degree in midwifery from Aotearoa as their first qualification that enabled them entry to the Register of Midwives, an increase of 10% since 2015. All other midwives first qualification was post nursing or a midwifery degree from overseas (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019a).

In 2019 there were 3,226 midwives in Aotearoa with an APC as shown in Table 4 (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019a).

Table 4: Midwives with an APC in Aotearoa 2015-2019

Year	Midwives with an APC
2019	3,226
2018	3,106
2017	3,122
2016	3,023
2015	3,033
(Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).	

The average age of a practising midwife in 2019 was 46.5 years, compared to 47 years old in 2018. In 2017 the average age of a midwife was 47.1 years, and in 2016 and 2015 it was 47.7 and 47.8 years respectively. During 2015 to 2019, the average time a midwife stayed in the midwifery workforce was 15.3 years (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019a).

For the purposes of this literature review, questions from the survey have been selected to present recent midwifery workforce information collected by the Midwifery Council. When midwives were asked by the Midwifery Council survey in 2019 to choose an option that best describes the work they do, 1,168 (36.2%) reported case loading as their main work and of those 977 (83.7%) were self-employed LMC midwives, and the remaining 191 (16.3%) were case loading midwives within a DHB or another organisation. Core midwives (employed by a DHB) made up 56.6% (1,631) of the midwifery workforce. The majority of midwives were practising in the larger centres; for example, Auckland, Christchurch, Wellington, Waikato and Tauranga (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).

Table 5 shows the answers given for primary employer type when midwives were asked by the Midwifery Council survey from 2015 to 2019 what employer type best describes their employment setting as a midwife (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019a).

Table 5: Midwives primary employer type 2015-2019

Employer Type	2019	2018	2017	2016	2015
DHB	1,813	1,745	1,682	1,591	1,607
Private Maternity/Trust	146	140	136	127	124
Midwifery Agency	14	13	4	7	13
Self-employed/LMC	1,009	999	998	951	950
Māori Service Provider	5	8	10	14	10
Pasifika Service Provider	8	1	4	4	2
Subcontracted to LMC	24	22	36	23	32
Educational Institution	86	82	75	70	61
Government Agency	22	8	5	5	7
Other	99	84	51	28	9
Not Stated	-	4	121	203	218
Grand Total	3,226	3,106	3,122	3,023	3,033
(Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).					

7.3.2. The Māori Midwifery Workforce

The number of Māori midwives with an APC has been reasonably static over the last five years. One of the survey questions that is part of the Midwifery Council APC renewal process relates to ethnicity where the midwife is asked to choose a primary ethnic group they identify with, and a second or third ethnicity, if relevant. Table 6 provides a breakdown of Māori ethnicity data collected for the years 2015 to 2019.

Table 6: Māori midwives in Aotearoa 2015-2019

Year	1st Ethnicity	2nd Ethnicity	3rd Ethnicity	Total Māori Midwives	All Midwives
2019	197 (6.11%)	119	1	317 (9.83%)	3,226
2018	185 (5.9%)	106	3	294 (9.47%)	3,106
2017	179 (5.7%)	101	1	281 (9.0%)	3,122
2016	184 (6.1%)	98	3	285 (9.4%)	3,023
2015	174 (5.7%)	103	1	278 (9.2%)	3,033
(Calvert, 2020; Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).					

A 0.4% increase in midwives who identify as Māori for their first ethnicity and a 0.6% increase in the total number of Māori midwives (includes those that identified Māori as either their first, second or

third ethnicity) was observed in Aotearoa over the five-year period from 2015 to 2019. Midwives who identify with two ethnicities including Māori, may choose to relegate their Māori identity as secondary because they are unfamiliar with it, or to avoid experiencing discrimination from Pākehā, and from Māori if they perceive themselves to fall short of a set of acceptability criteria (Te Huia, 2015). Further research is needed to better understand the demographic of Māori midwives and their needs to enhance their wellbeing in the profession.

Table 7 shows the different settings Māori midwives work in.

Table 7: Māori midwives work settings 2019-2015

Work Setting	2019	2018	2017	2016	2015
Administration - DHB	11	10	3	5	2
Administration - Other	1	2	2	1	3
Case Load - DHB	7	5	10	7	10
Case Load - Other	11	12	6	12	10
Case load/ Self-employed LMC	121	119	121	116	125
Core - Primary	27	15	22	27	22
Core - Secondary	61	58	44	51	48
Core - Secondary/Tertiary	54	47	49	43	40
Education - DHB	2	4	2	4	
Education - Tertiary	5	3	4	3	5
Maternity Leave, Returning	3	3	3	4	
Other Midwifery	6	13	3	6	6
Other Not in Employment	2	2	4	4	4
Other Paid Employment	3		1	1	2
Undertaking Research	2			1	
Nursing	1		1		1
Working Overseas		1	1		
Study Leave, Returning			1		
Professional Advice, Policy			2		
Not Stated			2		
	317	294	281	285	278
(Calvert, 2020; Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).					

Māori midwives are geographically dispersed throughout Aotearoa with main areas of concentration being Auckland, Christchurch, Far North, Gisborne, Hamilton, Hastings, Manukau, Rotorua, Tauranga and Waikato as shown in Figure 2 (Calvert, 2020; Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019a).

Figure 2: Geographic location of Māori midwives in Aotearoa 2019
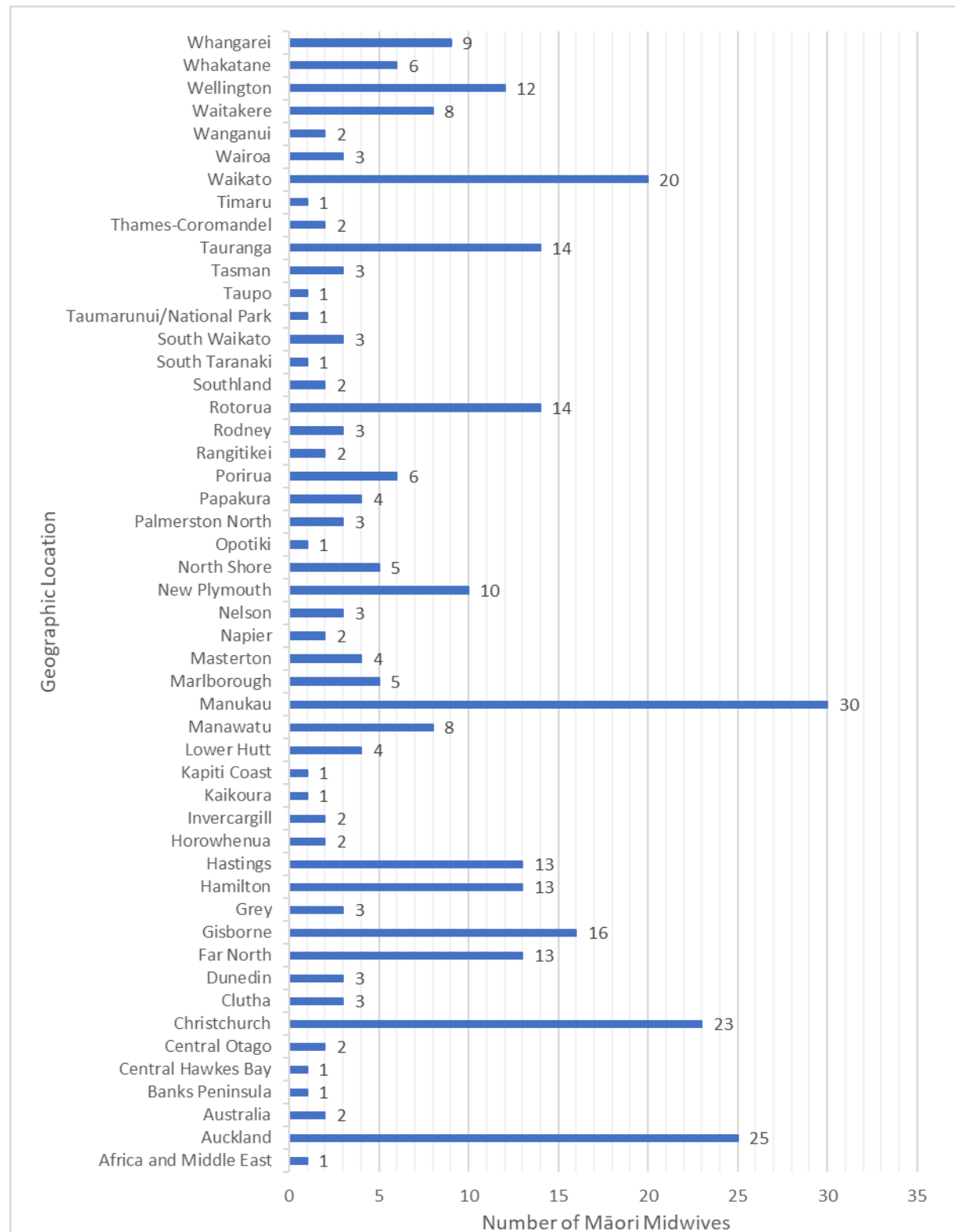
Māori midwives tend to be younger than the average age for all midwives. For the years 2015 to 2019 the average age of a Māori midwife was 43 years compared to the average age for all midwives at 47 years for the same period (Calvert, 2020).

The average time that Māori midwives spent in practice between 2015 to 2019 was 12 years, which is 3 years less than the average time spent in the midwifery workforce by all midwives during the same period of time (Calvert, 2020).

The Health Workforce New Zealand (HWNZ) Directorate in the MOH has worked on analysing 'big data' pertaining to the midwifery workforce and maternity service utilisation to reveal patterns, trends and associations, especially relating to human behavior and interactions. HWNZ uses data supplied by the Midwifery Council as a result of their APC renewal process and data that captures the demand for maternity services, such as hospitalisation data with Diagnostic Related Groups (DRG) case-weights[11] by age, gender, ethnicity and DHB (Jo, 2018).

Midwives applying for an APC in Aotearoa have their participation in the workforce tracked by way of their registration number, year-by-year, which allows for any new midwife entering the profession to be identified for statistical purposes. The midwifery workforce can be separated into three streams, these are:

1. Existing: Midwives whose registration number is already in the tracking system.
2. New-Entry: Midwives who it is their first time having an APC approved in Aotearoa.
3. Re-Entry: Midwives returning to the profession, and their first APC was more than one year ago.

(Jo, 2018).

Figures 3 to 5 show Māori entering and exiting the midwifery workforce with the average age distribution calculated across three years (2017, 2018 and 2019).

In 2013 there were 32 new-entry Māori midwives to the profession, a number which has not been matched since. Between 2013 and 2019, 70% of new-entry Māori midwives were under the age of 35 years, contributing to the younger age structure of the Māori midwifery workforce.

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[11] Data is in the form of counts and weight is the number of occurrences, providing a value for each observation within a dataset. Case-weighting is a data correction technique that refers to statistical adjustments made to data after it has been collected in order to correct for over or under representation of certain characteristics in a sample and improve the accuracy of estimates.

Figure 3: Māori midwives new-entry patterns 2013-2019

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
2013 (n=32)	3	7	5	7	5	4	0	0	1	0	0	0
2014 (n=21)	0	11	3	3	3	0	0	0	1	0	0	0
2015 (n=23)	2	5	4	7	4	1	0	0	0	0	0	0
2016 (n=23)	4	5	5	3	1	4	0	0	1	0	0	0
2017 (n=20)	0	9	4	4	2	1	0	0	0	0	0	0
2018 (n=25)	8	5	5	3	1	2	1	0	0	0	0	0
2019 (n=25)	4	4	9	3	1	1	2	0	0	0	0	0
Av. age dist.	17%	27%	26%	14%	6%	6%	4%	0%	0%	0%	0%	0%

(Jo, 2019c).
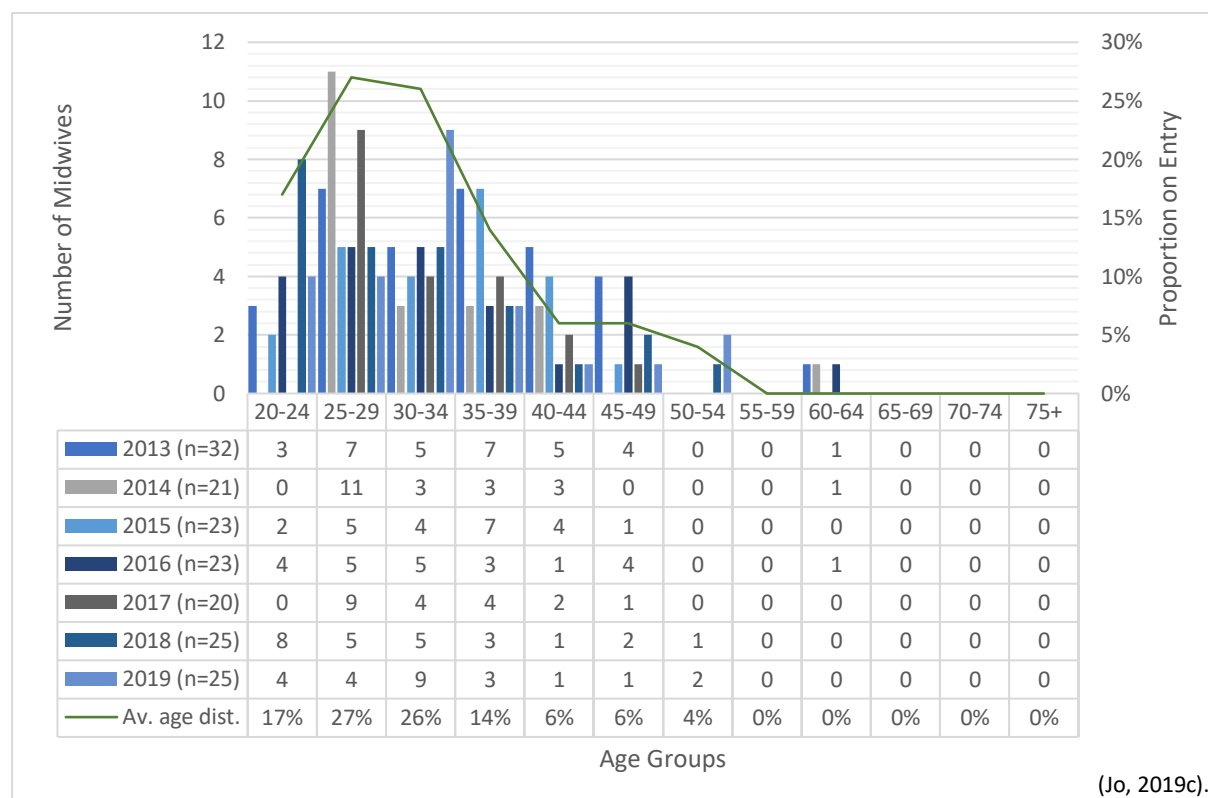
Figure 4: Māori midwives re-entry patterns 2013-2019

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
2013 (n=11)	0	1	1	2	2	0	3	0	1	1	0	0
2014 (n=29)	0	2	2	4	11	4	4	1	1	0	0	0
2015 (n=8)	0	1	0	5	0	0	0	1	1	0	0	0
2016 (n=18)	0	1	0	4	4	5	2	2	0	0	0	0
2017 (n=11)	0	3	0	0	1	1	3	2	1	0	0	0
2018 (n=6)	0	0	3	1	1	0	1	0	0	0	0	0
2019 (n=17)	0	0	6	1	2	1	2	4	1	0	0	0
Av. age dist.	0%	9%	26%	6%	12%	6%	18%	18%	6%	0%	0%	0%

(Jo, 2019c).
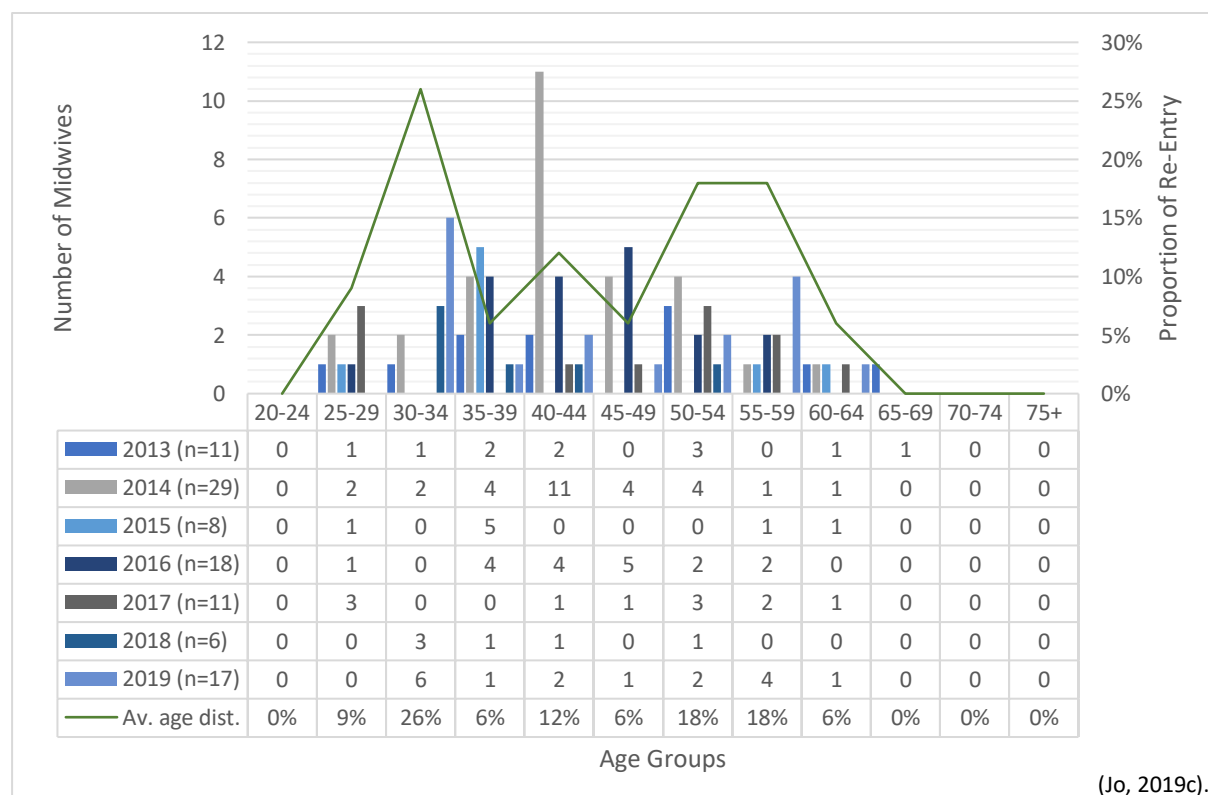
Based on average age distribution Figure 4 shows that the highest proportion of Māori midwives re-entering the workforce were 30 to 34 years old which is a re-entry characteristic that is mirrored in other health professions (Jo, 2020). Returning from parental leave was a consistent reason reported for re-entering the midwifery workforce (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2013, 2014, 2015, 2016, 2017, 2018, 2019a). The re-entry of 11 Māori midwives in the 40 to 44-year age group in 2014, and the re-entry of 25 Māori midwives aged 50 to 59 years old between 2013 and 2019, is worthy of further investigation.

Figure 5: Māori midwives exit patterns 2012-2018

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
2012 (n=43)	3	1	4	10	9	6	5	3	1	0	1	0
2013 (n=21)	0	1	4	4	3	1	3	2	2	1	0	0
2014 (n=22)	0	2	0	4	5	7	1	1	2	0	0	0
2015 (n=22)	0	5	2	2	1	3	4	1	3	0	0	1
2016 (n=18)	0	0	2	4	2	3	3	3	1	0	0	0
2017 (n=25)	0	4	3	1	4	1	3	4	3	1	1	0
2018 (n=19)	1	2	3	2	1	5	4	0	0	1	0	0
Av. age dist.	6%	7%	7%	6%	4%	6%	9%	6%	7%	13%	17%	0%

Age Groups

(Jo, 2019c).
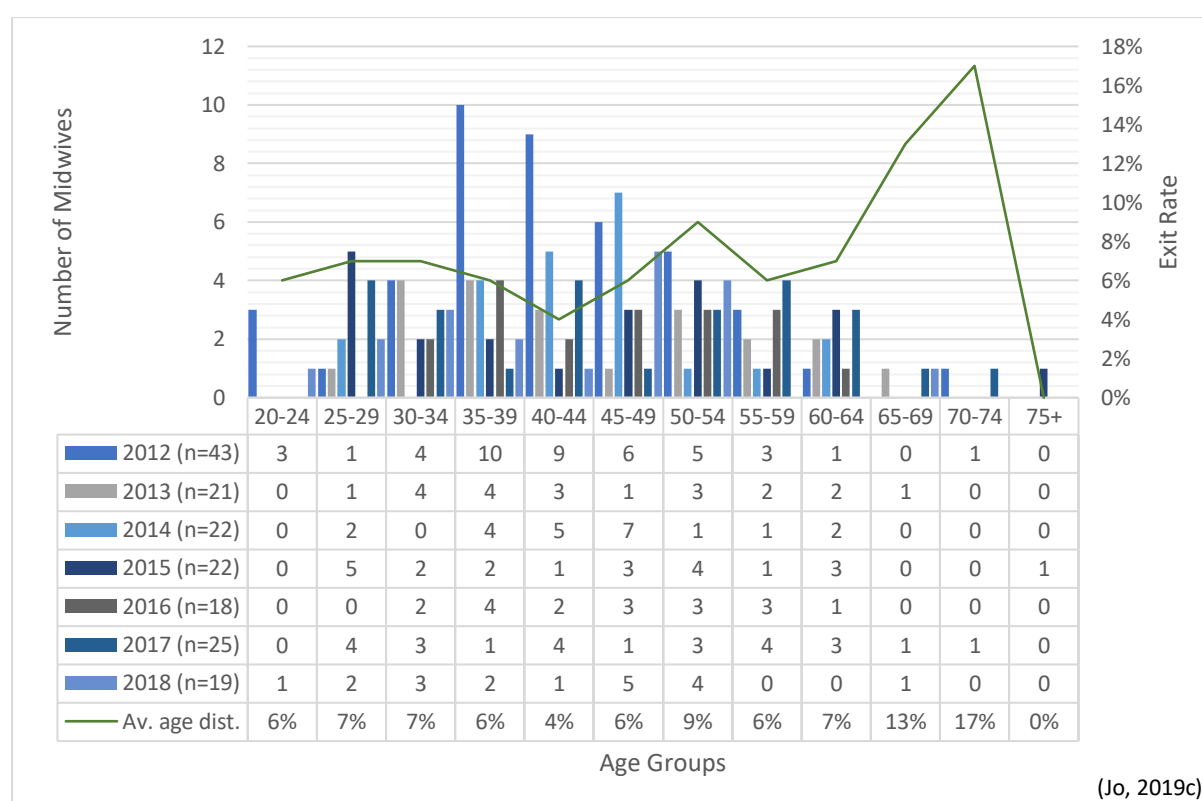
Figure 5 highlights a significant exit of 19 Māori midwives aged between 35 and 44 in 2012, and 43 Māori midwives in total exiting the profession in this same year which is almost double the exit rate of any year. There is no research that specifically identifies reasons for Māori midwives leaving the midwifery profession. However, from 2015 to 2019 reasons given by Māori midwives for not currently practising included, living overseas, inadequate remuneration, bullying culture, racism and undervalued workforce (Calvert, 2020). In addition, research conducted overseas identifies that working in a busy practice environment where the midwife feels unable to provide quality woman-centred care increases stress (Fenwick et al., 2012) which is a common reason for midwives wanting to leave the profession (Kirkham & Morgan, 2006; Kirkham, Morgan, & Davies, 2006; Sullivan, Lock, & Homer, 2011). Moreover, research conducted in Aotearoa cites a lack of workplace management

support as a key contributor to midwives leaving the profession (Dixon et al., 2017). Workplace conditions influence mental health and wellbeing and it would be worthwhile identifying what constitutes healthy working conditions and how they can be achieved (Seidler et al., 2014). Te Rau Ora has a history of providing education and training to Māori midwives to work effectively with Māori women and their whānau who experience mental illness (Tupara & Ihimaera, 2004). The mental health needs of Māori health professionals such as midwives, to be able to serve others, is a different matter, and worthy of exploration.

Figure 6: Māori midwives after entry and exit in 2012-2019 and 2019 FTE distribution by age

Age Group	2012	2013	2014	2015	2016	2017	2018	2019	2019 FTE Dist.
20-24	9	6	2	3	5	3	9	10	7.8
25-29	10	20	32	31	26	29	26	24	22.5
30-34	19	21	21	23	30	40	48	58	48.1
35-39	48	39	38	45	44	39	38	37	31.4
40-44	48	45	54	54	61	53	47	50	48.4
45-49	39	41	48	40	44	56	58	58	54.5
50-54	40	42	45	46	36	36	38	44	41.5
55-59	30	24	22	28	41	38	38	42	43.3
60-64	5	9	15	16	15	21	18	17	15.2
65-69	2	4	3	2	5	5	5	9	8.7
70-74	2	0	0	1	2	2	2	2	1.4
75+	0	1	1	1	0	0	1	0	0.0
Total	252	252	281	290	309	322	328	**351**	**322.7**
(Jo, 2018).									

Difference is noted between the Māori midwifery workforce numbers reported by HWNZ (Jo, 2018) and the Midwifery Council (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2014, 2015, 2016, 2017, 2018, 2019a), the reason for this is unknown, but could be due to the timing that data is received, analysed and reported by each organisation.

Māori midwives within the three streams will exit the profession for various reasons. HWNZ (Jo, 2018) has used theoretical data modelling to estimate the probability of exit from the profession, for example by age, and in turn workforce movements can be simulated to forecast the future workforce. The following figures provide a picture of Māori midwifery workforce forecasting into 2029.

2019 Total:
351

2019 Workforce FTE:
322.7

2029 Projected Total:
428

2029 Projected
Workforce FTE:
391.4

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
■ New-Entries Since 2019 as at 2029	11	32	43	38	24	13	9	5	1	0	0	0
■ Re-Entries Since 2019 as at 2029	0	3	12	14	10	8	9	13	11	4	0	0
■ 2019 workforce as at 2029	0	0	5	12	32	22	27	27	21	17	5	1
■ National Workforce as at 2019	10	24	58	37	50	58	44	42	17	9	2	0

Age Groups

(Jo, 2019a).

Figure 8: Māori midwives 2029 projection (with increase in student enrolment from 2021)

2019 Total:
351

2019 Workforce FTE:
322.7

2029 Projected Total:
589

2029 Projected
Workforce FTE:
533.2

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
■ New-Entries Since 2019 as at 2029	29	69	85	68	39	23	17	7	1	0	0	0
■ Re-Entries Since 2019 as at 2029	0	3	12	14	10	8	9	13	11	4	0	0
■ 2019 workforce as at 2029	0	0	5	12	32	22	27	27	21	17	5	1
■ National Workforce as at 2019	10	24	58	37	50	58	44	42	17	9	2	0

Age Groups

(Jo, 2019b).

In 2029 the total midwifery workforce in Aotearoa is projected to reach 3,489 with a projected FTE of 3,052.9, that equates to a projected increase of 263 midwives and 227.1 FTE from 2019. Projections

for the 2029 midwifery workforce sees a more consistent age distribution of 30 to 59-year-old midwives in comparison to 2019 which represented an ageing workforce.

The MOH has an interest in seeing the number of Māori midwives increase in proportion to the Māori population of Aotearoa (Jo, 2020). Based on the projection of Māori making up 17% of the estimated total population in Aotearoa in 2029, HWNZ has set a comparable Māori midwifery workforce aim (Jo, 2019c, 2020). To reach the 17% (593) goal of the total number of projected midwives in 2029 (3489), an additional 37 Māori midwifery students per year will need to complete undergraduate midwifery training from 2021, on top of the approximate 20 to 25 each year that currently complete their studies (Jo, 2019c, 2020).

Figure 8 projects that the Māori midwifery workforce will increase from 351 in 2019 to 589 in 2029 if there is an additional intake of Maori midwifery students per year commencing from 2021. The increase in the Māori midwifery workforce will predominantly be seen in the 25 to 44-year age band which will contribute to sustaining the Māori midwifery workforce into the future.

All midwives in Aotearoa often move between employed and self-employed work, depending on personal and family needs and general life circumstances (Dixon et al., 2017; Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2015, 2016, 2017, 2018, 2019a).

Table 8: Māori midwives in the DHB workforce versus Māori women 15-49 years 2010-2017

	2017	2016	2015	2014	2013	2012	2011	2010
% Māori DHB midwives	7.2%	6.3%	6.4%	5.9%	5.8%	4.9%	5.0%	5.4%
% difference	-9.3%	-10.2%	-10.1%	-10.6%	-10.7%	-11.6%	-11.3%	-10.8%
(Central Region Technical Advisory Services Limited, 2018).								

Clinical outcomes can be improved when the ethnicity and worldview of the clinician is matched with that of the patient, with the match being further enhanced when the clinician has a high level of ethnic and cultural identity and acculturation (Durie, 2001; Gurung & Mehta, 2001; Huriwai, Sellman, Sullivan, & Potiki, 1998; Marie, Fergusson, & Boden, 2008). Table 8 indicates a lack of capacity for DHB service providers to meet the needs of Māori childbearing aged women, with the shortfall in capacity calculated by deducting the percentage of Māori midwives working in a DHB from the percentage of Māori women that make up the total number of women of childbearing age in Aotearoa.

Figure 9: DHB core staff Māori midwives in 2018 and projected to 2028

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
New-Entries Since 2018 as at 2028	7	13	9	9	7	5	3	1	0	0	0	0
Re-Entries Since 2018 as at 2028	0	5	14	16	16	15	15	15	9	2	0	0
2018 workforce as at 2028	0	0	0	1	3	3	2	3	3	3	1	0
National Workforce as at 2018	6	14	26	22	20	25	19	21	7	3	1	0

2019 Total: 164

2019 Workforce FTE: 111.2

2028 Projected Total: 180

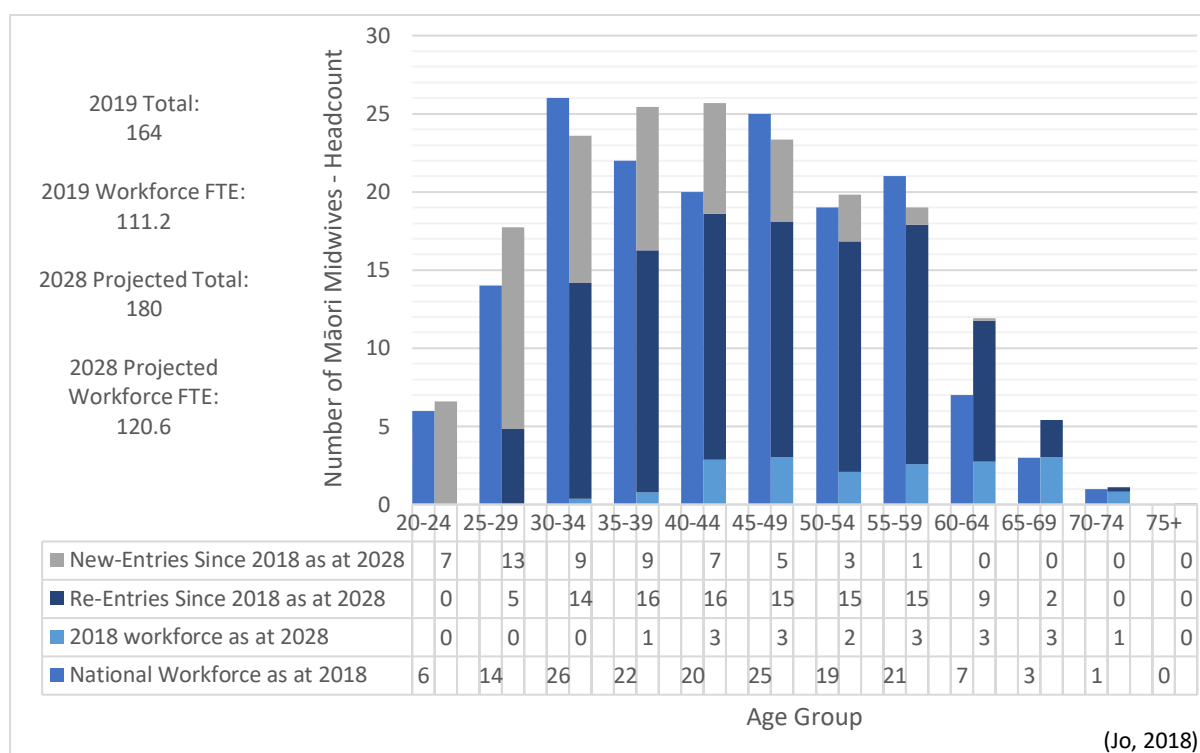2028 Projected Workforce FTE: 120.6

(Jo, 2018).

Figure 9 projects an increase of 16 DHB employed Māori midwives (Core Staff) from 2018 to 2028, and an increase of 9.4 FTE over the same time period. Midwives who are employed by DHBs (56.2% of midwives listed a DHB as their primary employer type in 2019) work fewer hours (median 32 hours) than midwives who were self-employed or both employed and self-employed (median 40 hours and 36 hours respectively) (Dixon et al., 2017). The bulk of Core Staff Māori midwives will remain to be aged between 30 to 49 years.

Older midwives may begin to work lesser hours and therefore decreases their presence in the workforce and capacity to provide support and mentoring. The DHB midwifery workforce has the lowest Mean FTE (0.70) of any DHB workforce. DHB employed midwives largely work part-time and are paid on average for 28.9 hours per week. Analysis of mean hours paid per midwife per week by DHB, suggests that workforce utilisation varies between DHBs. Midwives shifting between DHB employment and self-employment reflects the professions flexible working options, contributing to the part-time availability of midwives to work within the DHB (Central Regions Technical Advisory Services Limited, 2018).

Since 2010 the Mean FTE of the DHB midwifery workforce has not exceeded 0.70, with Hawke's Bay DHB having the lowest Mean FTE (0.63) and South Canterbury having the highest (0.81) in 2017. Nine DHBs (45%) had a Mean FTE lower than the national average of 0.70.

DHBs are carrying high numbers of midwifery vacancies, with an overall lack of supply nationally and significant problems recruiting midwives. Of all DHBs in 2017, 75% reported having midwifery vacancies which equated to a national vacancy FTE of 102.6 and vacancy rate of 9.8% (Central Regions Technical Advisory Services Limited, 2018).

Figure 10 below, shows a small projected increase in LMC Māori midwives aged between 20 to 39 years in 2028, and a noticeable decrease in the 40 to 49-year age group. There is a noticeable increase among Māori midwives aged 50 to 54 years old. There are a number of possible reasons for the Māori midwifery workforce age trend which peaks and troughs, but it is likely to be attributed to family related reasons such as a change in family circumstances, parental leave or parental responsibilities (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2013, 2014, 2015, 2016, 2017, 2018, 2019a)

Figure 10: Self-employed LMC Māori midwives in 2018 and projected to 2028

	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
New-Entries Since 2018 as at 2028	5	16	19	10	6	7	4	1	1	0	0	0
Re-Entries Since 2018 as at 2028	0	3	3	6	10	14	14	12	8	2	0	0
2018 workforce as at 2028	0	0	1	1	1	3	7	6	2	1	0	0
National Workforce as at 2018	3	16	21	16	26	31	17	18	9	3	0	0

2019 Total: 160

2019 Workforce FTE: 166.5

2028 Projected Total: 164

2028 Projected Workforce FTE: 169.4

(Jo, 2018).
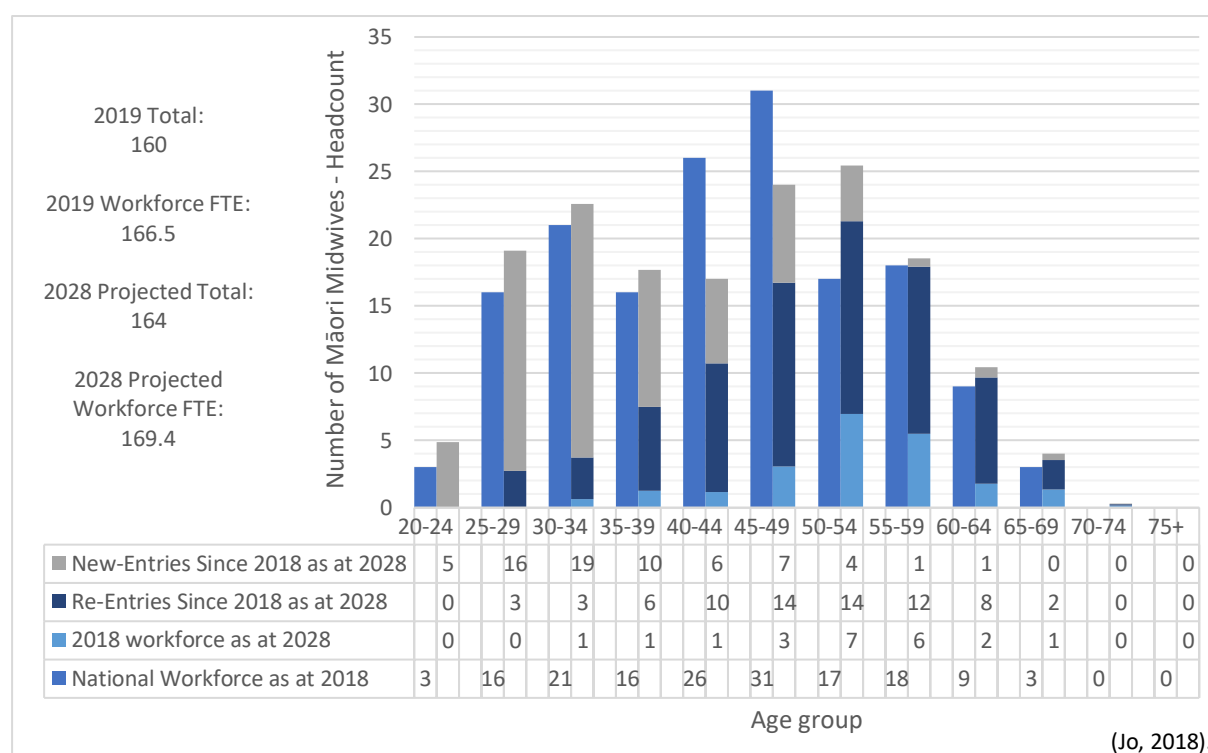
Although midwives in Aotearoa who are employed by a DHB work fewer hours, a study revealed that self-employed midwives providing case loading continuity-of-care, whether that was combined with some employed work or not, had better emotional health and higher levels of empowerment than those who were DHB employed (Dixon et al., 2017). Findings around the emotional wellbeing of midwives in Aotearoa provides evidence that working as a case loading midwife with the support of midwifery partners, and having flexibility and autonomy has the potential to be protective of the workforce (Dixon et al., 2017).

7.4. Maternity Service Utilisation Data

7.4.1. Māori Women

Of the 59,661 women who were recorded as giving birth in 2017 in Aotearoa, 14,892 (25%) were Māori. The birth rate for all women was 61.7 births per 1000 females of reproductive age (15 to 44 years), which is the lowest since 2008. Most notably between 2008 and 2017, the birth rate for women aged under 20 years has fallen by half. Birth rates were highest for Māori and were significantly higher (1.2 to 1.8 times the rate) for each DHB region. The proportion of Māori women giving birth for the first time was 32.4% (Ministry of Health Manatū Hauora, 2019k).

The demographic of the Māori population has been changing over the past decades. From 2012 to 2014 approximately 25% of births where the child is identified as Māori had a non-Māori mother but a Māori father (Stats NZ Tatauranga Aotearoa, 2015).

Figure 11 charts the number of Māori, Pasifika, Indian, Asian (excluding Indian), Other and European woman who gave birth in 2017.

Figure 11: Women who gave birth in Aotearoa by ethnicity 2017

(Ministry of Health Manatū Hauora, 2019k).
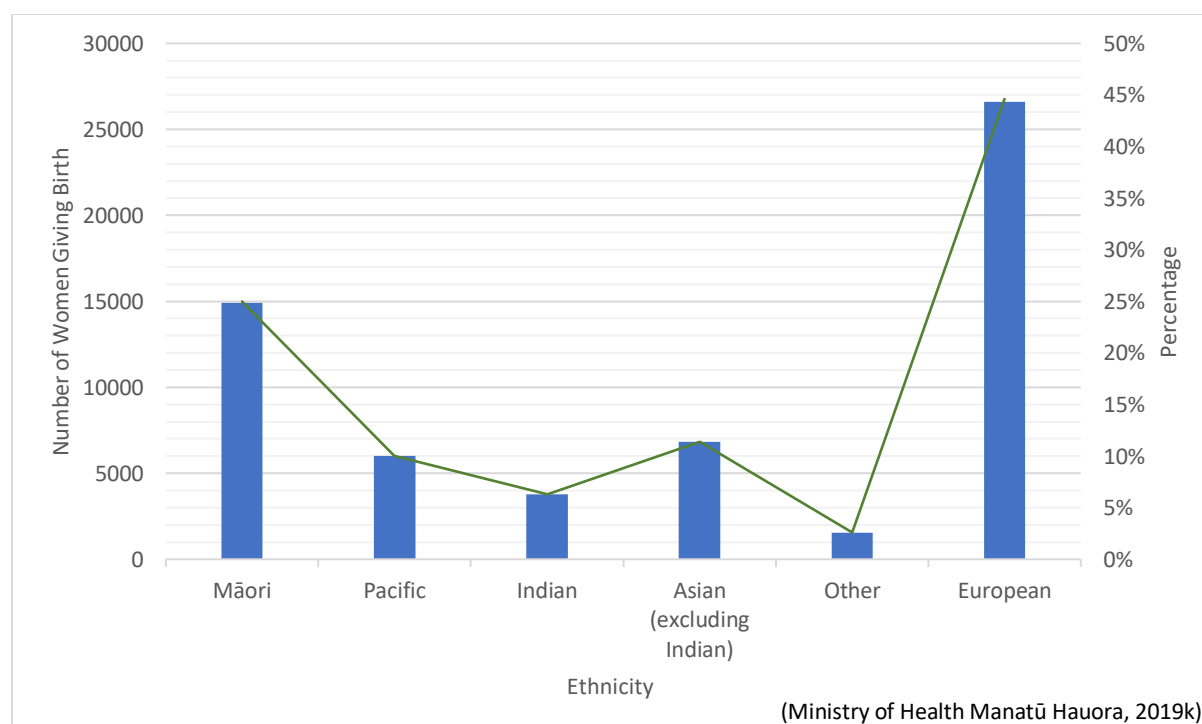
The median age of women giving birth in Aotearoa in 2017 was 30 years. Māori, Pasifika and Indian women gave birth at a younger age, with median ages at birth of 26 years, 28 years and 30 years, respectively. Of all women under the age of 20 years who gave birth in 2017, Māori feature highly. (Ministry of Health Manatū Hauora, 2019k).

Figure 12 provides detail about the total number and percentage of women giving birth in Aotearoa, by DHB of residence and place of birth; including home, within or outside of their DHB of residence.

Figure 12: Women giving birth, by DHB of residence and place of birth in Aotearoa 2017

| DHB of Residence | Home Birth | | Maternity Facility | | | | Unknown | Total |
| | | | In DHB[12] | | Outside DHB[13] | | | |
	No.	%[14]	No.	%[12]	No.	%[12]	No.	No.
Northland	172	7.7	1,948	87.6	105	4.7	15	2,240
Waitematā	239	3.1	6,319	82.5	1,105	14.4	52	7,715
Auckland	88	1.6	4,673	83.6	831	14.9	41	5,633
Counties Manukau	93	1.1	6,815	83.0	1,306	15.9	62	8,276
Waikato	194	3.7	4,874	92.8	185	3.5	67	5,320
Lakes	55	3.6	1,401	90.6	91	5.9	9	1,556
Bay of Plenty	84	2.7	2,830	92.2	155	5.1	31	3,100
Tairāwhiti	19	2.7	650	93.7	25	3.6	9	703
Hawke's Bay	79	3.7	1,981	93.7	55	2.6	19	2,134
Taranaki	49	3.5	1,302	93.2	46	3.3	4	1,401
MidCentral	77	3.6	1,917	90.4	127	6.0	14	2,135
Whanganui	22	2.6	722	86.2	94	11.2	7	845
Capital & Coast	85	2.4	3,281	94.3	115	3.3	9	3,490
Hutt Valley	47	2.4	1,729	89.3	161	8.3	10	1,947
Wairarapa	30	5.6	463	87.2	38	7.2	5	536
Nelson Marlborough	80	5.7	1,304	92.3	29	2.1	9	1,422
West Coast	37	10.5	270	76.3	47	13.3	2	356
Canterbury	294	4.6	6,031	94.6	47	0.7	28	6,400
South Canterbury	16	2.5	583	92.7	30	4.8	2	631
Southern	106	3.1	3,277	96.2	24	0.7	31	3,438
Unknown	128	–	0	–	43	–	212	383
Total	**1,994**	**3.4**	**52,370**	**88.7**	**4,659**	**7.9**	**638**	**59,661**
Source: National Maternity Collection (Ministry of Health Manatū Hauora, 2019k).								

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[12] Women giving birth at a facility located within the DHB of residence.
[13] Women giving birth at a facility located outside the DHB of residence.
[14] The denominator used for calculating the percentage excludes women with unknown place of birth (638 women).

The shaded red areas on the map of Aotearoa in Figure 13 represent the concentration of Māori birth events (live and still births) in each DHB region.

Figure 13: Aotearoa map of birth events, by DHB region 2017
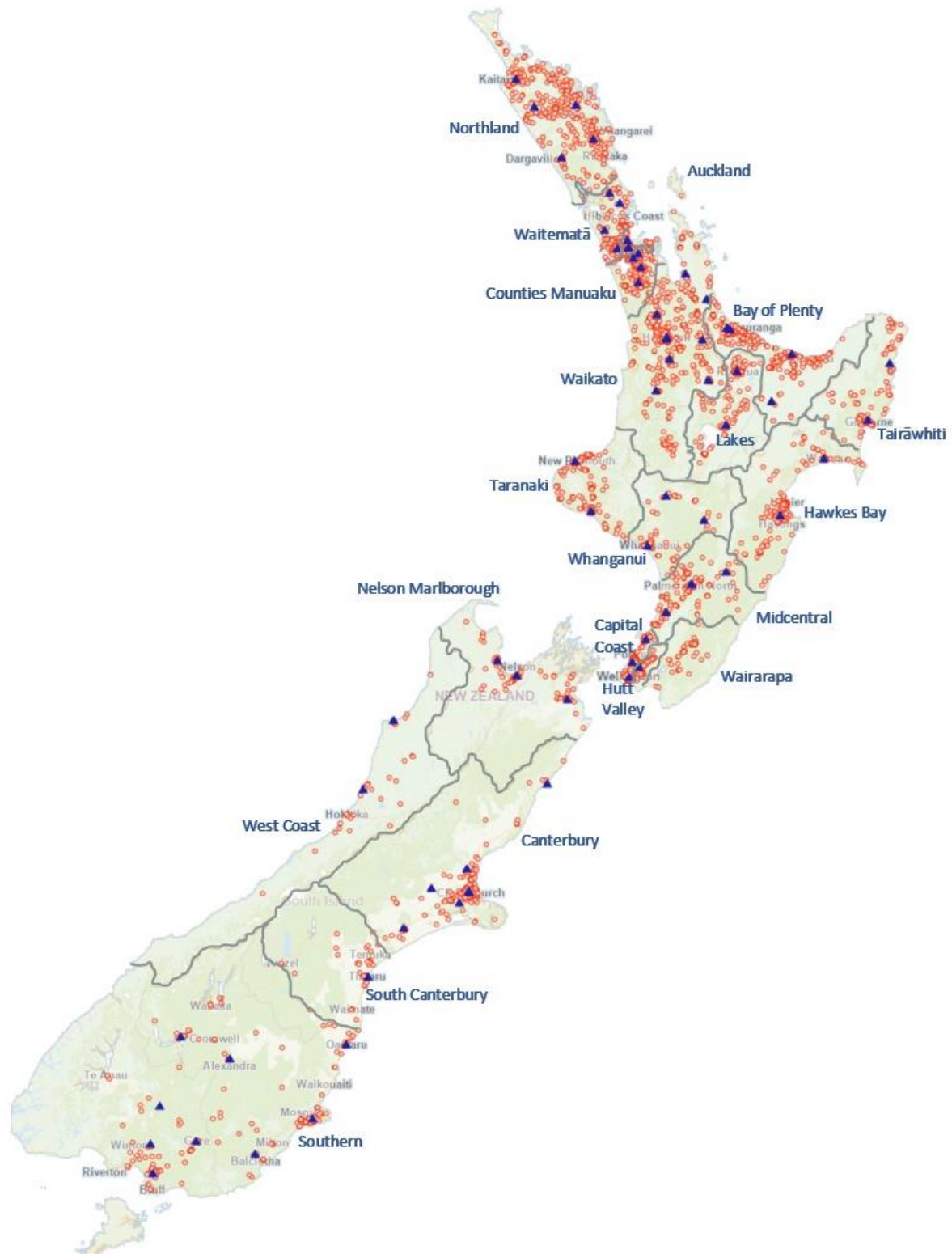
(Jo, 2020).

The Canterbury DHB region had the highest number of home births in 2017 (294), followed by Waitematā DHB (239), Waikato DHB (194) and Northland DHB (172). The West Coast DHB region had the highest proportion of home births, 10.5% in comparison to 3.4% nationally. Home births were more common (3.9%) among Māori women.

The majority (88.7%) of women in 2017 birthed in either a primary, secondary or tertiary DHB maternity facility. The proportion of women giving birth at a tertiary facility increased slightly between 2008 and 2017, from 42.8 % to 45.6%, with women being more likely to give birth at a secondary or tertiary facility than at a primary facility in 2017. The proportion of Māori women giving birth at a primary facility was almost double that of non-Māori women (15.9% and 8.5% respectively). Birthing at a primary facility was more common among younger women and women living in quintile five (most deprived) areas.

One-third of women in 2017 experienced a normal birth (33.1%: 19,773). Māori women had the highest proportion of normal births (42.4%), while Indian women had the lowest proportion (16.9%). Place of birth influences birth outcome, with outcome's for low-risk women who birthed at home or in a primary maternity facility being better than the outcomes for low-risk women birthing in high technology facilities (Davis et al., 2011; Farry, McAra-Couper, Weldon, & Clemons, 2019).

Almost 30% of birthing women in 2017 resided in the most deprived neighborhood's in the country. Māori women were more likely to reside in more deprived areas, and this trend was more evident for Māori birthing women, with 48.5% residing in quintile five areas (most deprived), whereas 5.5% resided in quintile one areas (Ministry of Health Manatū Hauora, 2019k).

Women living in the most deprived areas were less likely to have an induction of labour (27.4% of women in quintile one compared with 24.8% of women in quintile five). Induction of labour was least common among Māori women (21.1%) (Ministry of Health Manatū Hauora, 2019k).

The proportion of augmentation among women giving birth decreased with maternal age and was least common for Māori (22%) in comparison to Asian (excluding Indian) and Pasifika women (27.3% and 24.7% respectively) (Ministry of Health Manatū Hauora, 2019k).

The proportion of epidurals was fairly consistent across age groups, and was most common among Indian women (42.3%) and least common among Māori (18%) and Pasifika (21.8%) women (Ministry of Health Manatū Hauora, 2019k).

The proportion of Māori women who had an episiotomy was at least four times lower than for Indian and Asian women (36.9% and 30.8% of Asian). Women who lived in the least deprived neighbourhoods were almost twice as likely (20.9%) to have an episiotomy in comparison to women in the most deprived neighbourhoods (11.4%). Women giving birth for the first time had five times the proportion of episiotomies compared to women who had given birth at least once before (Ministry of Health Manatū Hauora, 2019k).

Reporting of caesarean sections in 2017 showed a national caesarean section rate of 27.1%, with Māori women having the lowest number of caesarean sections of all ethnic groups. The specific number of caesarean sections for Māori women was not identified in the MOH report (Ministry of Health Manatū Hauora, 2019k).

The majority of women giving birth in 2017 (98.7%) gave birth to one baby[15], and only 1.3% (773 women) gave birth to two or more babies.[16] The proportion of twin[17] or multiple[18] births has not changed much over the last decade, ranging from 1.3% to 1.6% of all women giving birth. Specific numbers pertaining to plurality (twin or multiple births) for Māori women was not reported in the MOH report (Ministry of Health Manatū Hauora, 2019k).

The Report on Maternity 2017 (Ministry of Health Manatū Hauora, 2019k) highlights areas for improvement in maternity outcome data reporting and critical analysis pertaining to Māori women. A comprehensive understanding of the links between maternity data and socioeconomic factors, the indications for intervention, and the implication of intervention on Māori women and their health, wellbeing and quality of life, is needed to inform innovative planning and funding of women's health services to meet the needs of Māori women.

7.4.2. Māori Babies

There were more male babies (51.2%) than female babies (48.8%) born in Aotearoa in 2017. The majority of babies were born to women aged between 20 to 39 years (92.0%). Over one-quarter of babies in 2017 were Māori (28.6%). Non-Māori babies were predominantly in the European or Other ethnic group (43.2%). Half of live-born babies were from the more deprived neighbourhoods (22.2% in quintile 4 and 28.6% in quintile 5) (Ministry of Health Manatū Hauora, 2019k).

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[15] Being pregnant with one baby is referred to as a singleton pregnancy.
[16] Plurality was unknown for 407 women (0.7%).
[17] Twin pregnancy refers to being pregnant with two babies.
[18] Multiple pregnancy refers to being pregnant with three or more babies.

Figure 14 presents the percentage of babies born in Aotearoa in 2017, by sex, maternal age group, baby ethnic group and baby neighbourhood deprivation quintile.

(Ministry of Health Manatū Hauora, 2019k).
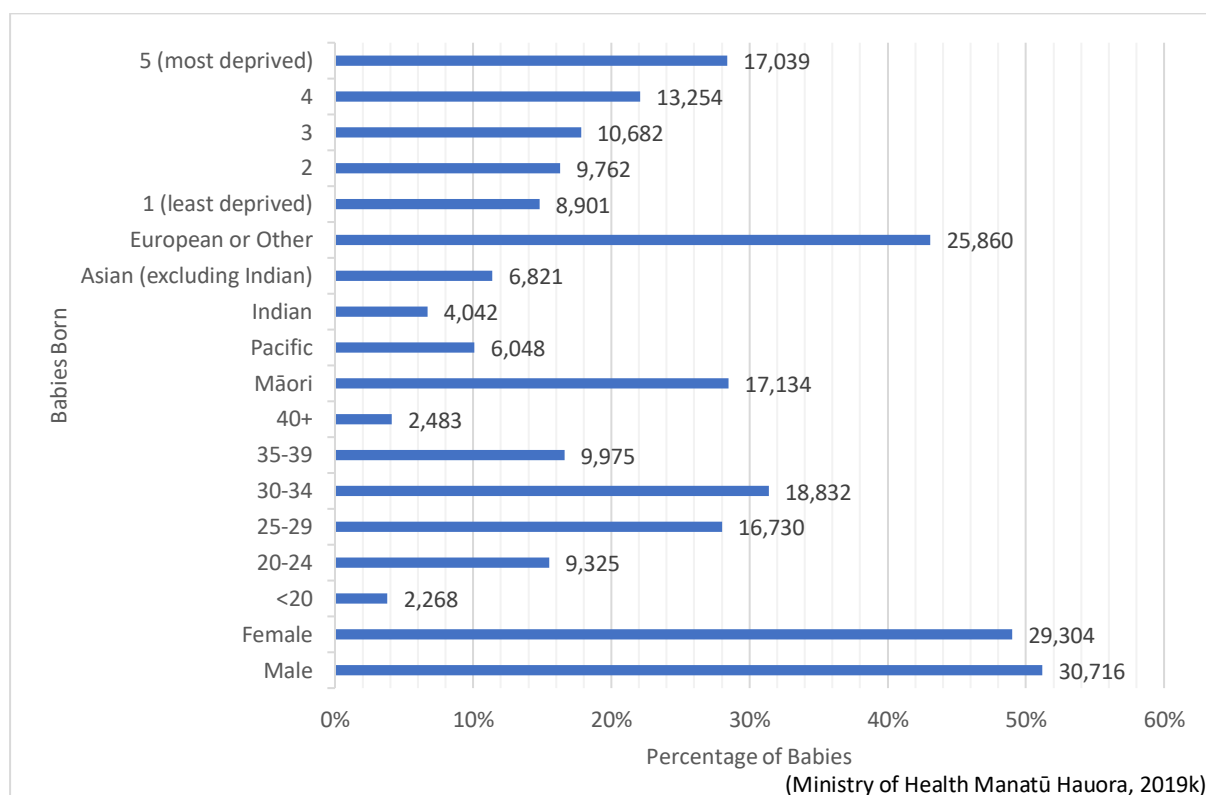
In 2019 low birthweight was more common among babies born to women who were over 40 years old and under 20 years old (7.7% and 6.9%, respectively), Indian and Māori babies (9.3% and 6.4%, respectively), and babies in the more deprived neighbourhoods (6.7% of babies residing in quintile five). Furthermore, preterm[20] birth was more common among Māori babies (8%) in comparison to other ethnic groups.

Of babies with known breastfeeding status in 2017, the majority were breastfed, either exclusively[21] (69.3%), fully[22] (8.5%) or partially[23] (15.3%) at two weeks after birth. Babies born to women aged

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[19] NZDep is an area-based index providing a measure of neighbourhood deprivation by looking at nine socioeconomic variables in one area and assigning them a decile score from one (least deprived) to ten (most deprived) (Ministry of Health Manatū Hauora, 2019l).

[20] Refers to babies born before 37 weeks of gestation (Ministry of Health Manatū Hauora, 2019k).

[21] The baby has never had any water, formula or other liquid or solid food. Only breast milk (from the breast or expressed) and prescribed medicines (defined in the Medicines Act 1981) have been given to the baby from birth (Ministry of Health Manatū Hauora, 2019k).

[22] The baby has taken breast milk only, and no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours (Ministry of Health Manatū Hauora, 2019k).

[23] The baby has taken some breast milk and some infant formula or other solid food in the past 48 hours (Ministry of Health Manatū Hauora, 2019k).

under 20 years were less likely to be breastfed at two weeks after birth, with 69.3% exclusively or fully breastfed, 16.4% partially breastfed and 14.3% fed artificially. The proportion of babies receiving breast milk was lowest for Māori, with 76.5% of Māori babies being exclusively or fully breastfed at two weeks after birth, and a further 13.1% were partially breastfed. Breastfeeding was more common for babies from less deprived neighbourhoods than for babies from more deprived neighbourhoods (95.7% of babies in quintile 1 compared with 90.5% of babies in quintile 5) (Ministry of Health Manatū Hauora, 2019k).

Babies whose mothers identified as Māori made up 26.3% of the perinatal related deaths[24] in Aotearoa between 2013 and 2017, this is a perinatal mortality rate of 10.59 in comparison to rates for Pasifika (12.65), Asian (10.37), Middle Eastern, Latin American or African (9.38) and European (9.18) women. Of the perinatal related deaths between 2013 and 2017, over one-quarter were babies of Māori ethnicity (28.6%) (Perinatal and Maternal Mortality Review Committee Komiti Arotake Mate Pēpi Mate Whaea Hoki, 2019).

Figure 15: Perinatal related mortality by maternal prioritised ethnic group 2013-2017

(Perinatal and Maternal Mortality Review Committee Komiti Arotake Mate Pēpi Mate Whaea Hoki, 2019).

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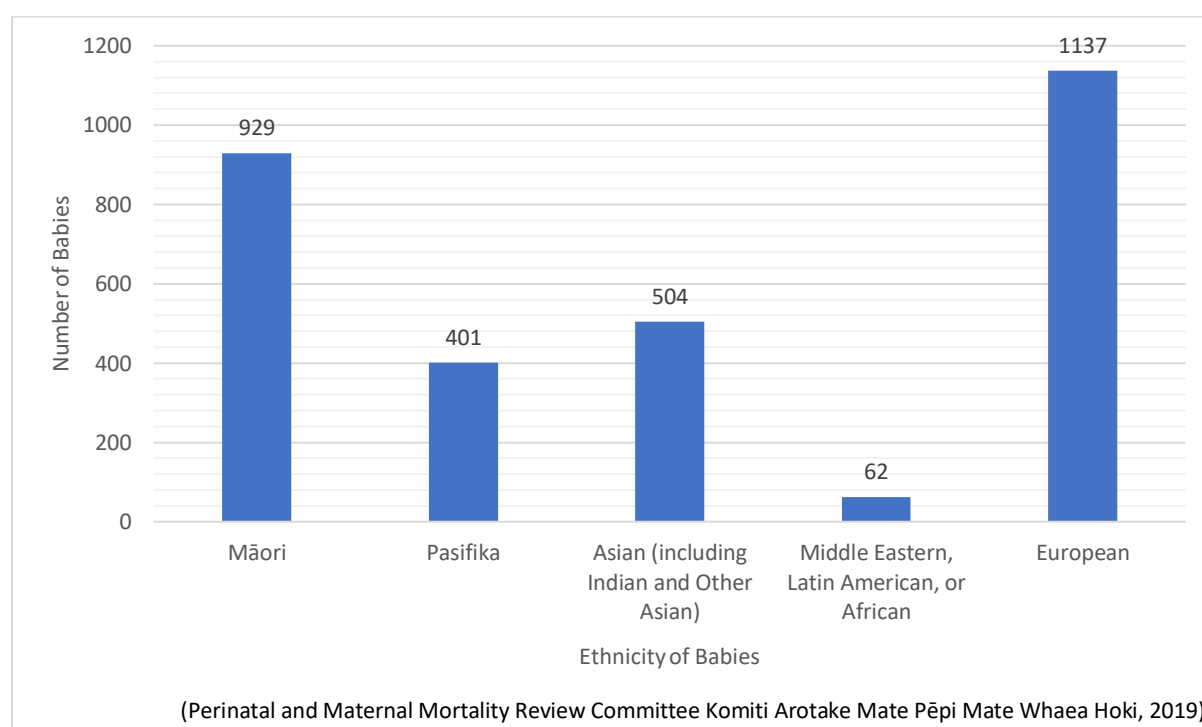
[24] Fetal deaths (including terminations of pregnancy and stillbirths) and neonatal deaths (up to midnight of the 27th day of life) per 1,000 total babies born at 20 weeks' gestation or beyond, and weighing at least 400g if gestation was unknown (Perinatal and Maternal Mortality Review Committee Komiti Arotake Mate Pēpi Mate Whaea Hoki, 2019).

From 2006 to 2016, Sudden Unexpected Death in Infancy (SUDI)[25] rates for Māori babies were significantly higher in comparison to all other ethnic groups. SUDI rates for babies of women under 25 years old was significantly higher than for those in all other age groups. The SUDI rate for babies born in the most deprived areas (quintile 5) was significantly higher than the rate for all other deprivation quintiles (Ministry of Health Manatū Hauora, 2018a, 2019j).

Figure 16: SUDI in babies aged < 1 year old 2006-2016

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Māori	29	34	46	41	39	41	19	20	30	20	27
Pasifika	5	10	8	7	6	3	5	8	6	14	6
Asian	1	1	1	1	2	0	0	1	2	2	1
European or Other	14	19	11	17	13	10	13	12	7	8	8

(Ministry of Health Manatū Hauora, 2018a, 2019j).
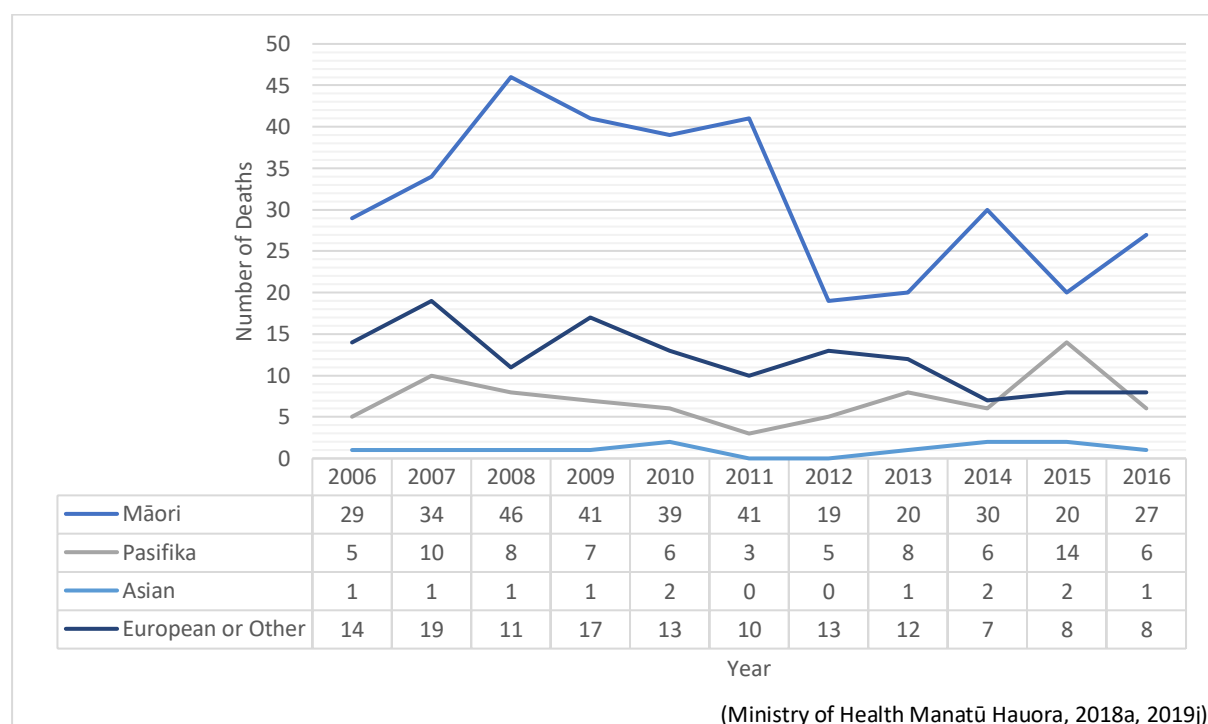
"Deaths in infancy are a sensitive indicator of social and economic conditions and the adequacy of health services" (National Advisory Committee on Health and Disability [National Health Committee], 1998, p. 11).

7.4.3. Māori Women and Babies at Handover of Care

Between four to six weeks after birth the LMC must discharge the woman from LMC services, notify their GP and transfer the baby's care to a Well Child Tamariki Ora (WCTO) provider. Women can decline to have a GP and WCTO provider referral made. Of data sourced in 2017 from LMC claim forms, 95.5% of women were referred to their GP upon discharge from their LMC and 97.6% of babies were transferred to a WCTO provider. The proportion of referral for women and their babies has been consistent at over 95% for the period 2008 to 2017 (Ministry of Health Manatū Hauora, 2019k). At the

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[25] SUDI includes deaths recoreded as: sudden infant death syndrome, other sudden death, cause unknown, unattended death, other ill-defined and unspecified causes of mortality, accidental suffocation and strangulation in bed, inhalation of gastric contents, and inhalation and ingestion of food causing obstruction of respiratory tract (Ministry of Health Manatū Hauora, 2018a, 2019j).

2019 WCTO Review Symposium in Dunedin, 2017 and 2018 data showed that 12% of new Māori babies to their services receive no contact with WCTO nurses and only 57% of Māori babies had contact with one of their nurses by 28 days old.

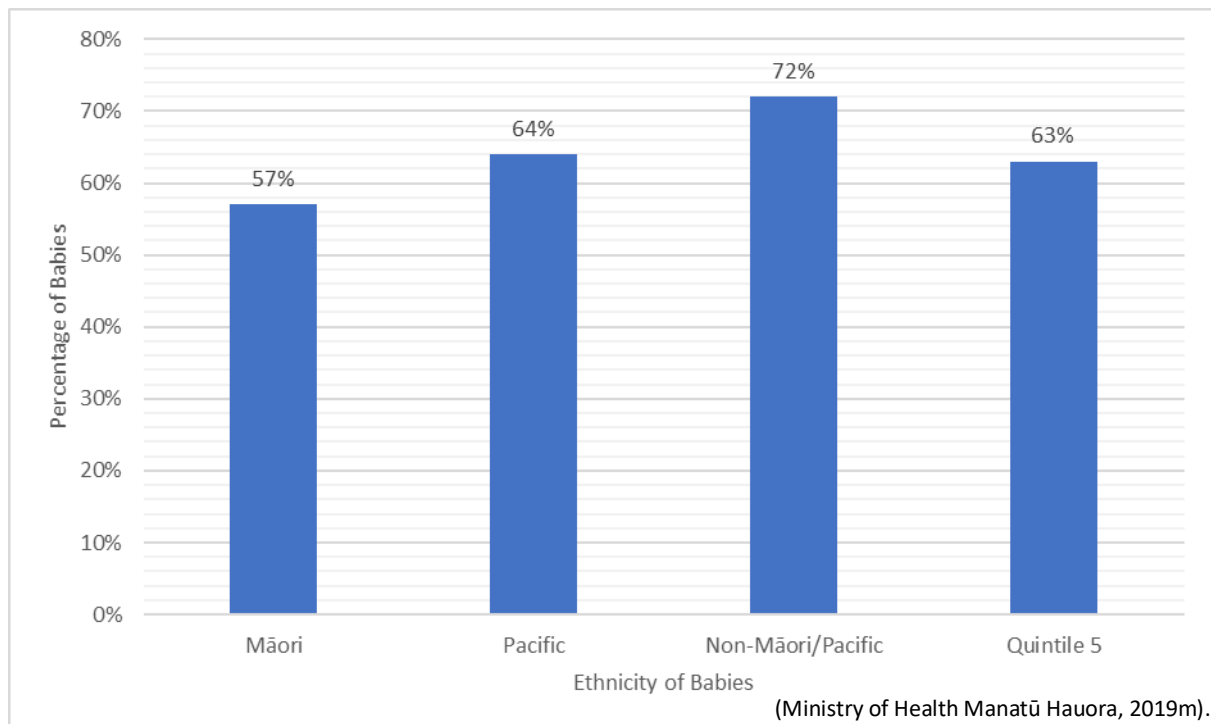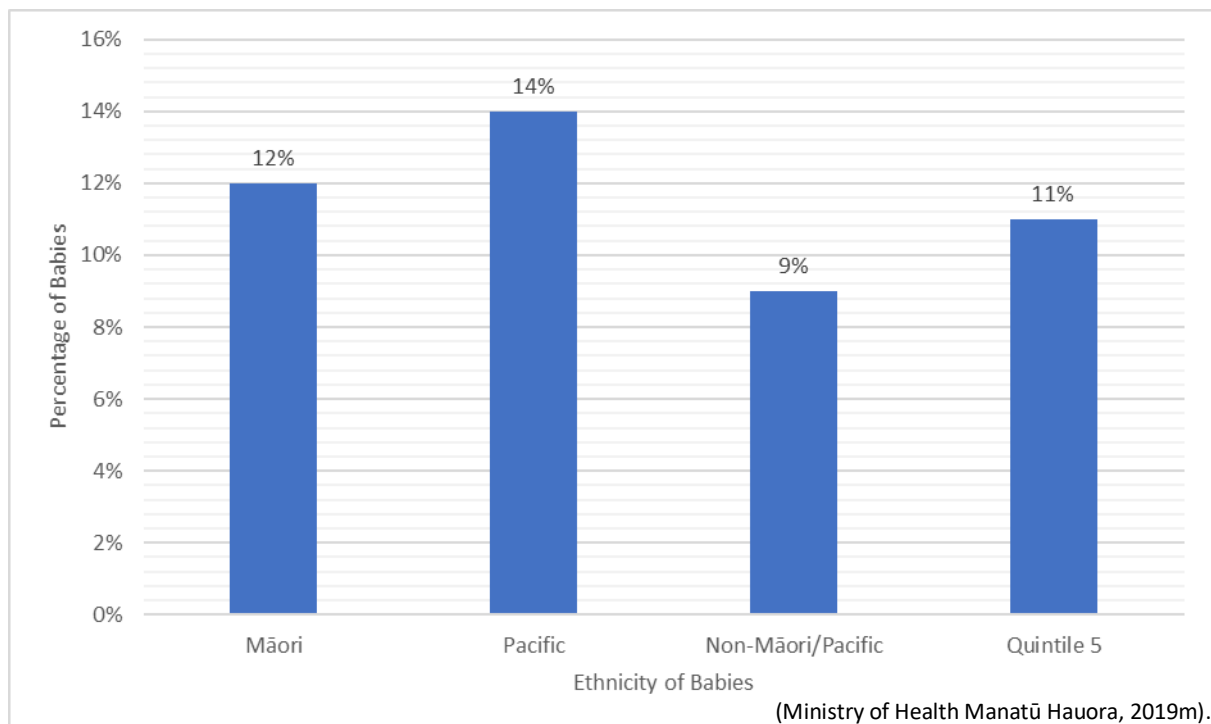Figure 17: Percentage of babies referred to WCTO by 28 days 2017-2018

(Ministry of Health Manatū Hauora, 2019m).

Figure 18: Percentage of babies not receiving any WCTO contacts by 28 days old 2017-2018

(Ministry of Health Manatū Hauora, 2019m).

Figures 17 and 18 indicate that between referral and contact data, only 45% of Māori babies are being seen by a WCTO nurse by 28 days old.

Overarching issues highlighted by the MOHs WCTO presentation include inequality and inequity in outcomes, coverage, access, funding and resources that affect the most disadvantaged communities and need for better cross-agency alignment (Ministry of Health Manatū Hauora, 2019m).

7.5. Socioeconomic Determinants of Health for Māori

Although there has been an improvement in the health status of Māori over the past four decades, there remains significant avoidable and premature morbidity and mortality among Māori.

Social, cultural and economic factors are the most important determinants of good health. In order to improve Māori health status and reduce inequities, the effect of socioeconomic conditions on health needs to be understood. Socioeconomic inequities in health are reducible and acting on socioeconomic determinants of health to reduce health inequities is important (National Advisory Committee on Health and Disability [National Health Committee], 1998). Socioeconomic factors largely lay outside the control of health professionals and women. However, health practitioners can contribute to closing gaps in health inequities for Māori women and whānau by facilitating response to individual circumstances; for example, thorough assessment of not only medical and obstetric history but, social and cultural factors, and the actioning of appropriate and timely referrals. To address health inequities, a whole of Government approach is required.

7.5.1. Māori Women's Health

Māori women are among the highest and lowest socioeconomic indicators. Therefore, health professionals need to be mindful of stereotyping as not all Māori are homogenous.

The average income for Māori is 20% less than for non-Māori, and there is no sign of gap reduction (The Salvation Army Social Policy and Parliamentary Unit, 2020). Low income households spend a large percentage of their weekly income on accommodation (Claus, Leggett, & Wang, 2009). Nationwide rent continues to outstrip income, with housing related debt levels continuing to rise relevant to household income (The Salvation Army Social Policy and Parliamentary Unit, 2020).

Using data from the 2006 to 2007 Household Economic Survey (HES) by Stats NZ, it was calculated that a low-income household receiving an average weekly income of $704 a week spends a minimum of $147 (21%) of the household weekly income for a single child under the age of 12, and 40% for two children, 54% for three children and 68% for four children (Claus et al., 2009). Results showed that as household incomes rise, so does child expenditure, with high income households spending more than

twice as much on a child compared to low income households (Claus et al., 2009). Regardless of the measure used, Māori children featured highly in low-income households between 2013 and 2018 (Perry, 2019).

Participation by Māori in the labour force is 69.7% (men and women combined). Māori representation in skilled occupations has risen and about 43.6% of Māori employed in Aotearoa were in skilled occupations and 17% were in low-skilled occupations. Māori make up the highest proportion of lower skilled occupations and in industries that are vulnerable to changes in technology (Ministry for Women Minitatanga mō ngā Wāhine, 2019).

The unemployment rate for Māori women was 12.1% in 2017, a decrease from 13.8% in 2015 and 4.3% higher than Māori men and 7.5% higher than the average unemployment rate for all people in Aotearoa. In the labour market Māori women are paid at a lower rate than European women (New Zealand Human Rights Commission Te Kāhui Tika Tangata, 2018).

Employment rates for Māori have increased at all qualification levels, particularly for those with no school qualifications and postgraduate degrees. The highest rates of employment for Māori are in the lower North Island and upper South Island. The lowest rates of employment are in Northland. In 2017 Māori with a postgraduate degree or higher qualifications had the highest employment rates at 89.7 per cent compared with other ethnic groups (Ministry of Business Innovation and Employment Hīkina Whakatutuki, 2017).

Māori women in business play an important role in creating opportunities for their whānau. Self-employed LMC midwives are not only clinical practitioners, but they are business owners. The self-employed income for these women in business exceeds the minimum wage. Of Māori women who work in a business, 3% own the business with ownership higher in the 45 to 60-year age range. More Māori women own businesses in rural and provincial areas and the main business types are agriculture, forestry, fishing, professional, scientific and technical services, and health care and social assistance (Ministry for Women Minitatanga mō ngā Wāhine, 2019).

Māori women in business are employers, for example six in ten construction businesses that Māori women are involved in, employ others and nearly 20% of these businesses employ five or more people. Of the 28% of Māori women in business who have qualifications at degree level or above, the majority are aged 20 to 34 years old and nearly all Māori women in this age range with a child have a child under 15 years of age. Māori women in businesses are balancing their work and childcare responsibilities (Ministry for Women Minitatanga mō ngā Wāhine, 2019).

Figure 19 shows that in 2013 Māori women were more disadvantaged than non-Māori women across all socioeconomic indicators; for example education, employment, income, housing and accommodation, and access to utilities and transport (telecommunications and motor vehicle) (Ministry of Health Manatū Hauora, 2019l).

Figure 19: Socioeconomic indicators by gender, Māori and non-Māori 2013

Indicator	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
School completion (Level 2 Certificate or higher), 15+ years	42.1	47.8	45.1	65.2	63.4	64.3
Unemployed, 15+ years	9.8	10.9	10.4	3.9	4.1	4.0
Total personal income less than $10,000, 15+ years	23.0	25.0	24.1	14.8	21.7	18.4
Receiving income support, 15+ years	23.1	36.7	30.4	10.9	16.4	13.8
Living in household without any telecommunications,[1] all age groups	3.1	2.9	3.0	1.0	0.8	0.9
Living in household with internet access, all age groups	69.4	68.6	69.0	84.3	83.2	83.8
Living in household without motor vehicle access, all age groups	8.1	9.3	8.7	3.7	5.0	4.4
Living in rented accommodation, all age groups	48.3	50.5	49.5	27.7	27.3	27.5
Household crowding,[2] all age groups	18.3	18.8	18.6	7.8	7.6	7.7

Notes:

1 Telecommunications include telephone, cell/mobile phone, facsimile and internet.

2 Based on the Canadian National Crowding Index. A required number of bedrooms is calculated for each household (based on the age, sex and number of people living in the dwelling), which is compared with the actual number of bedrooms. A household is considered crowded when there are fewer bedrooms than required.

Source: Stats NZ

(Ministry of Health Manatū Hauora, 2019l).

Figure 20 shows that higher proportions of Māori lived in neighbourhoods with the most deprived NZDep scores.

Figure 20: Population by NZDep, gender, Māori and non-Māori, 2001, 2006 and 2013

| NZDep decile	2001		2006		2013	
	Māori	**Non-Māori**	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
1 (least deprived)	16,629 (3%)	338,700 (11%)	19,215 (3%)	386,277 (12%)	22,845 (4%)	396,504 (12%)
2	21,027 (4%)	329,952 (10%)	24,603 (4%)	374,643 (11%)	28,773 (5%)	395,583 (12%)
3	26,508 (5%)	347,385 (11%)	29,361 (5%)	367,875 (11%)	32,004 (5%)	381,726 (11%)
4	30,552 (6%)	324,507 (10%)	33,678 (6%)	355,188 (11%)	37,173 (6%)	365,547 (11%)
5	41,478 (8%)	326,130 (10%)	40,191 (7%)	343,464 (10%)	44,706 (7%)	355,488 (10%)
6	48,591 (9%)	317,841 (10%)	50,184 (9%)	333,948 (10%)	52,848 (9%)	342,387 (10%)
7	53,148 (10%)	306,519 (10%)	58,908 (10%)	319,884 (10%)	61,827 (10%)	329,565 (10%)
8	66,216 (13%)	294,441 (9%)	73,692 (13%)	300,948 (9%)	76,434 (13%)	312,522 (9%)
9	85,191 (16%)	268,932 (8%)	98,838 (17%)	278,652 (8%)	100,728 (17%)	287,640 (8%)
10 (most deprived)	121,227 (23%)	225,408 (7%)	136,452 (24%)	229,626 (7%)	140,886 (24%)	232,779 (7%)
Unknown	15,669 (3%)	130,218 (4%)	213 (0%)	4,329 (0%)	381 (0%)	13,068 (0%)
Total	**526,236 (100%)**	**3,210,033 (100%)**	**565,326 (100%)**	**3,294,834 (100%)**	**598,604 (100%)**	**3,412,809 (100%)**
Notes: Due to rounding, individual figures in this table do not add to give the stated totals. 'Unknown' refers to the population for whom an NZDep score was not ascertained for that year. Source: 2001 – Stats NZ, 2006 – Salmond et al., 2007, 2013 – Atkinson et al., 2014.						
(Ministry of Health Manatū Hauora, 2019l).						

7.5.2. Māori Women's Health Behaviours and Risk Factors

Persistent disparities in behaviours and risk factors that impact on health and wellbeing exist for Māori women in comparison to non-Māori women (Ministry of Health Manatū Hauora, 2019l).

Tobacco smoking data from 1999 to 2015 shows that smoking for Māori girls is four times higher than for non-Māori girls. Disparities between Māori and non-Māori smoking (current and daily) is more pronounced for Māori women (Ministry of Health Manatū Hauora, 2019l). In 2017, tobacco smoking at time of registration with a primary maternity care provider and at two weeks postnatal was more common among Māori women (68%), women aged 40 and above (73.4%), and women residing in the most deprived neighbourhoods (67.4%). The highest proportions of smokers giving birth in 2017 were women in the Tairāwhiti and Northland DHB regions (Ministry of Health Manatū Hauora, 2019k).

Māori are more likely to live in communities saturated with alcohol outlets. In 2017 to 2018, there were large differences in the prevalence of hazardous drinking[26] of alcohol between Māori and non-Māori. Māori women were 2.04 times more likely to be classified as hazardous drinkers. In comparison to other ethnic groups, Māori women suffered more adverse effects as a consequence of other people's alcohol consumption (ActionPoint, 2020).

Figure 21: Hazardous drinking by ethnicity and gender 2017-2018

(ActionPoint, 2020).

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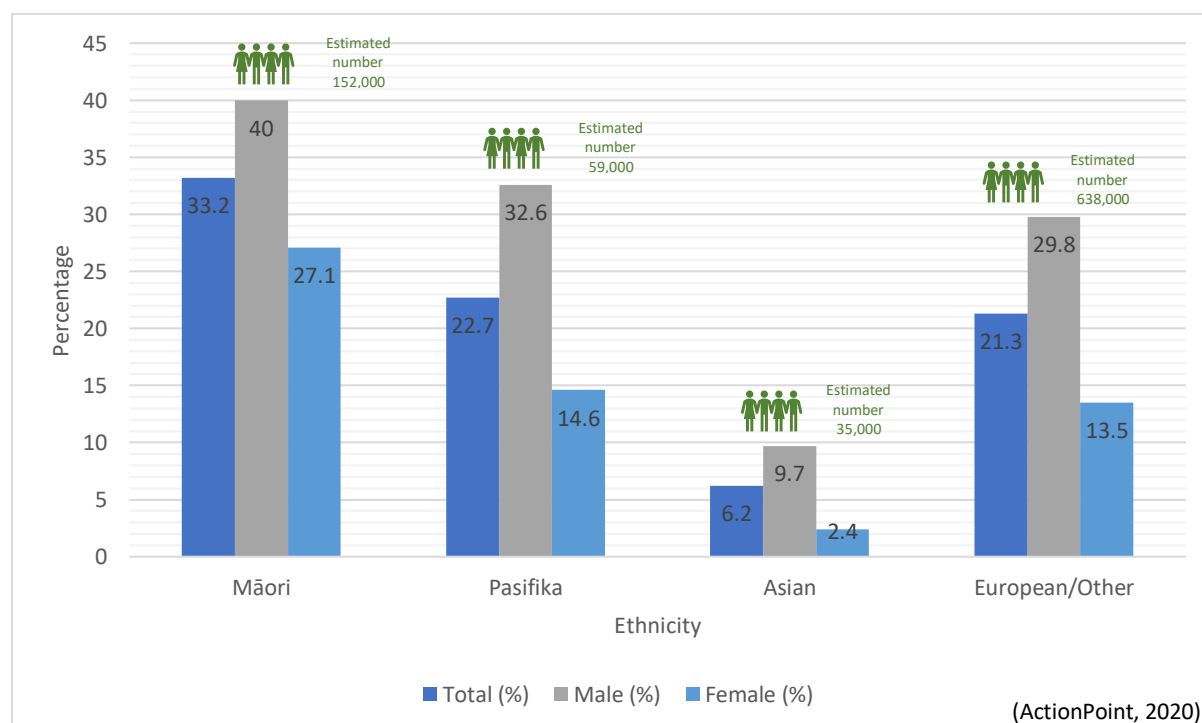
[26] Hazardous drinking is measured using the ten question Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization that covers three aspects of alcohol use: consumption, dependence and adverse consequences (Ministry of Health Manatū Hauora, 2019l).

Māori females in Aotearoa experience much higher rates of assault and hospitalisations as a result of assault or attempted homicide in comparison to non-Māori females, with little change observed over time (Ministry of Health Manatū Hauora, 2019l). Māori women experience almost three times more intimate partner violence (IPV) than the national average. Of all IPV victims, 77% are women between 15 and 29 years old, and women 40 to 49 years old experience more violent incidents (Ministry of Justice, 2018).

Of all women who accessed Women's Refuge services in Aotearoa in 2014 and 2015, 42% were Māori in comparison to Pākehā (41%), Pasifika (6%), European (6%), Asian (3%), and Other (2%) women. Furthermore, 50% of children who accessed Women's Refuge services in the same time period were Māori compared to Pākehā (33%), Pasifika (8.5%), European (4%), Asian (2%) and Other (2.5%) children (Women's Refuge, 2015). From 2018 to 2019 Māori women made up 38.6% of referrals to the Women's Refuge, an increase from 32% between 2017 and 2018. Data shows a steady incline in the use of Women's Refuge services by Māori women over the past five years. The way that Women's Refuge data was reported from 2017 to 2019 differed from previous years, with the ethnicity of referred children not available (National Collective of Independent Women's Refuge Inc Ngā Whare Whakaruruhau o Aotearoa, 2018, 2019).

Between 2007 and 2016 there were 686 people killed by homicide in Aotearoa; for example, murder and manslaughter offences. Māori make up approximately one third of all homicide victims. Of all family-linked homicide victims, 40% were male and 60% were female. Around one in five homicides was committed by a current or ex-partner and 75% of these victims were female (New Zealand Police Nga Pirihimana o Aotearoa, 2018).

Being Māori, female, younger, and having a lower socioeconomic position, are all associated with an increased prevalence of mental disorder. Māori women experience greater severity of serious and common mental disorders than non-Māori women (Oakley Browne, Wells, & Scott, 2006). Women with a history of mental disorder are significantly more likely to have a recurrence during the first few weeks of the postnatal period with Māori women at higher risk of experiencing postnatal depression (Oakley Browne et al., 2006; Webster, Thompson, Mitchell, & Werry, 1994).

The MOH continually undertakes the New Zealand Health Survey and in 2018 to 2019 it showed that 17.5% of Māori women experienced psychological distress in the last four weeks in comparison to 10.4% of women overall in Aotearoa for this time period (Ministry of Health Manatū Hauora, 2019e). The New Zealand Health Survey in 2018 to 2019 also reported that the prevalence of a diagnosed mood and/or anxiety disorder was 22.9% for Māori women (Ministry of Health Manatū Hauora, 2019f)

and that 24.4% of Māori women were diagnosed with depression (Ministry of Health Manatū Hauora, 2019i).

Between 2006 and 2019 there were 116 maternal deaths[27] in Aotearoa and of these 45 (38.8%) were Māori women. Suicide is the single largest cause of maternal death in Aotearoa, with Māori women making up 60% (18) of the 30 deaths by suicide during this time. Māori women were 3.41 times more likely to die by suicide than European women between 2006 and 2019. Māori women are a high-risk group for maternal suicide which warrants routine screening. Although the Edinburgh Postnatal Depression Scale is widely used it has never specifically been validated for Māori. Suicide prevention and mental wellbeing are topical currently, however, there has not been any budget provided by the Government to specifically reduce maternal suicide deaths. There is an urgent need for investment in the areas of prevention, developing appropriate screening tools and treatment for Māori women (Perinatal and Maternal Mortality Review Committee Komiti Arotake Mate Pēpi Mate Whaea Hoki, 2019).

The 2018 to 2019 New Zealand Health Survey shows that of Māori women aged over 15 years, 42.2% visited a dental health care worker in past 12 months (Ministry of Health Manatū Hauora, 2019g). As a result of decay, an abscess, infection or gum disease 10.9% of Māori women had one or more teeth removed in past 12 months, and were nearly twice as likely to have such extractions compared to non-Māori women (Ministry of Health Manatū Hauora, 2019h).

Maternal periodontal disease has been associated with other systemic diseases, such as diabetes and cardiovascular disease (American Academy of Periodontology, 2015). There is also a significant association between periodontal disease and pre-eclampsia in pregnancy (Jahromi, Adibi, Adibi, & Salarian, 2014). Several studies also suggest that women with periodontal disease may be more likely to birth prematurely or have infants with low-birth weight than mothers with healthy gums (American Academy of Periodontology, 2015).

Excess weight is a leading contributor to numerous health conditions; such as, type 2 diabetes, cardiovascular diseases, many types of cancer, osteoarthritis, gout, sleep apnoea, some reproductive disorders and gallstones. The 2018 to 2019 New Zealand Health Survey shows that 47.8% of Māori

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[27] "Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy (miscarriage, termination, or birth), irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Perinatal and Maternal Mortality Review Committee Komiti Arotake Mate Pēpi Mate Whaea Hoki, 2019).

women were obese[28] (Ministry of Health Manatū Hauora, 2019d). Māori women formed 38.9% of obese women giving birth in Aotearoa in 2017 (Ministry of Health Manatū Hauora, 2019k).

In 2018 to 2019, of the women in Aotearoa who declared the use of illicit drugs, 25.4% of Māori women used cannabis and 2.4% used amphetamines in the last 12 months compared to European (0.6%), Pasifika (0.1%) and Asian (0.1%) (Ministry of Health Manatū Hauora, 2019b, 2019c). Māori women were 1.16 times more likely than non-Māori women to use amphetamines (Ministry of Health Manatū Hauora, 2019b).

Māori are significantly over-represented at all stages of the criminal justice system in Aotearoa (Gluckman, 2018) which is reflective of a major Government policy and programmes failure (George et al., 2014; Gluckman, 2018). Across the three women's correctional facilities in Aotearoa (Arohata Prison, Auckland Region Women's Corrections Facility and Christchurch Women's Prison) there were 1,332 women prisoners as of 31 December 2019, making up 6.8% of the total prison population (Department of Corrections Ara Poutama Aotearoa, 2019). Data for the number of Māori women in prison in 2019 was not available, however, in 2017 they made up 63% of the female prison population (Department of Corrections Ara Poutama Aotearoa, 2017; Stats NZ Tatauranga Aotearoa, 2012). Extensive research on the incarceration of prisoners in Aotearoa (particularly of indigenous peoples) has been undertaken, finding many common threads including 'the state as a parent' morphing into 'the state as a prison warden'. Most women in prison are likely to be served by DHB maternity care services.

7.5.3. Māori Child Health

Unfortunately, Māori babies and children are not immune from the inequities experienced by Māori. An increasing number of babies and children in Aotearoa are being placed in the care of Oranga Tamariki Ministry for Children (the Ministry for Children). A recent case involving a Māori baby taken into Ministry for Children care from a maternity unit and a stand-off between midwives, hospital staff, Police and the Ministry for Children has highlighted the controversial issue for Māori.

Approximately 25% of all children in Aotearoa are Māori. In June 2019, Māori children made up 4,424 (69%) of all children and young people in the care of the Ministry for Children; down 1% from 2018 but a 42% increase from 2013. Figures released by the Children's Commissioner shows that a high proportion of Māori children three months old and under are taken into care. Iwi-based and kaupapa Māori services are calling for a meaningful partnership with the Ministry for Children and a greater

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[28] Obesity is defined as a person having a body mass index (BMI) of 30 or more (or equivalent for those younger than 18 years).

role in supporting Māori children and whānau (The Salvation Army Social Policy and Parliamentary Unit, 2020).

From July 2018 to June 2019 there were 464 children who had 707 findings of harm (emotional, physical, sexual and neglect) recorded for them, which represents 5.65% of all children in the care of the Ministry for Children during this same time period. Of the 464 children with findings of harm during this time period, 70% (325) were Māori (Oranga Tamariki Ministry for Children, 2019).

Unintentional injury is the leading cause of death for children aged one to 14 years of age and the leading cause of unintentional injury hospitalisation for children aged five to 14 years (Safekids Aotearoa, 2020). Between 2010 and 2012 Māori children under 14 years old had a significantly higher unintentional injury hospitalisation rate than that of non-Māori children (14.9 per 100,000) and had an unintentional injury mortality rate 3.5 times that of non-Māori children. The top three unintentional mortality categories for children under 14 year-olds in Aotearoa between 2010 and 2012 were, suffocation or accidental threats to breathing, motor vehicle accidents, accidental drowning and submersion (Ministry of Health Manatū Hauora, 2018b).

During the period 2009 to 2015, there were 56 child abuse and neglect (CAN) deaths in Aotearoa and Māori children accounted for 28 of these deaths, with 27 being aged under four years old. Māori children under four years old were four times more likely to be killed by CAN than non-Māori children. Of all CAN deaths in Aotearoa between 2009 and 2015, 80% involved children under five years of age with two-thirds (66%) of CAN deaths occurring by fatal physical abuse and/or grossly negligent treatment (Family Violence Death Review Committee, 2017).

Violence against Māori women, babies and children is not part of traditional Māori culture, but is reflective of the patriarchal norms of the colonising culture as well as trauma from the widespread fragmentation of Māori social structures that were enforced during and after colonisation. Death caused by family violence demonstrates how multiple forms of oppression based on race, gender and class (colonial, structural, institutional and interpersonal) intersect and shape how violence is experienced. People who live with the most harmful levels of family violence are also often experiencing multiple forms of disadvantage and discrimination and a socioeconomic gradient is visible for all family violence deaths during 2009 to 2015, which is pronounced for Māori. The distributions of Māori who have died or are the offenders in family violence cases are weighted towards high deprivation levels, with much larger proportions residing in the most deprived neighbourhoods compared with non-Māori who have died or are the offenders (Family Violence Death Review Committee, 2017).

The Child Poverty Monitor 2018 highlights that Māori whānau are at least twice as likely to have children facing food deprivation, with about 30% of Māori children facing food deprivation in comparison to 15% of Pākehā children (Duncanson, Richardson, Oben, Wicken, & Adams, 2019).

7.5.4. Māori Cultural Health and Wellbeing

The 2013 Stats NZ survey on Māori wellbeing showed that 48.4% of Māori women said it was very important for them to be engaged in Māori culture, 56% said spirituality was very important, with 49.4% saying that religion was not at all important. When Māori women were asked if they know their iwi, 90.2% knew and 88.7% had been to their ancestral marae at some time, and 68.1% felt very strongly connected to their marae as tūrangawaewae. When asked about cultural practices, 83.2% said they used Māori greetings, 60.2% sang a Māori song, haka, gave a mihi, or took part in Māori performing arts and crafts, 63.2% discussed or explored whakapapa, and 49% taught or shared te reo Māori with others (Stats NZ Tatauranga Aotearoa, 2013).

When asked about whānau measures, 69.8% of Māori women said their whānau was doing well. Whānau composition was between six and ten for 29.2% of Māori women with 94.9% including their parents, partner, children, brothers and sisters as whānau. Accessing support in times of need was reportedly very easy for 48.6% of Māori women and 26% said they felt lonely a little of the time and 5.3% said they felt lonely all of the time in the last four weeks (Stats NZ Tatauranga Aotearoa, 2013).

When asked about te reo Māori proficiency, 41.5% of Māori women knew no more than a few words or phrases in comparison to 5.6% of Māori women who reported being able to speak te reo Māori very well, with only 8.3% saying that te reo Māori was their first language learned and still understood (Stats NZ Tatauranga Aotearoa, 2013). Overall, when asked about te reo Māori, 257,500 (55%) of Māori adults reported being able to speak more than a few words or phrases in te reo Māori, which is an increase from 153,500 (42%) in 2001. Of Māori adults 50,000 (11%) said they could speak well enough in te reo Māori to conversate about almost anything (Stats NZ Tatauranga Aotearoa, 2013). In 2013 Females and older people were more likely than males and younger people to speak te reo Māori, with the majority of speakers (44.2%) aged 75 years and older, in comparison to 20% of 15 to 24 year olds (Ministry of Social Development Te Manatū Whakahiato Ora, 2016).

Understanding the use of te reo Māori is important to informing public health promotion approaches that reach the diversity of Māori. For example, the use of te reo Māori translated pamphlets, while important, should be done within the context of a wider implementation strategy that is authentically committed to understanding and supporting the use of te reo Māori and is relative to the issue being targeted and the community being served.

8. Health Research to Inform Midwifery Practice

Research helps to fill knowledge gaps or identify answers to questions about health services and therefore, it is fundamental to improving and developing the health system. Research is sometimes not used, and often, research by Māori, is disregarded as not valid or scientific (Smith, 2008).

Dawson et al., (2019) developed a conceptual model to represent six factors that underpin maternal health inequity in Aotearoa and especially for Māori. The boundaries between each is blurred and the connections are complex. Due to the specificity of the six factors to Aotearoa, as shown in Figure 22, localised solutions are important to achieve equity (Dawson et al., 2019).

Figure 22: Six factors that underpin maternal health inequity in Aotearoa
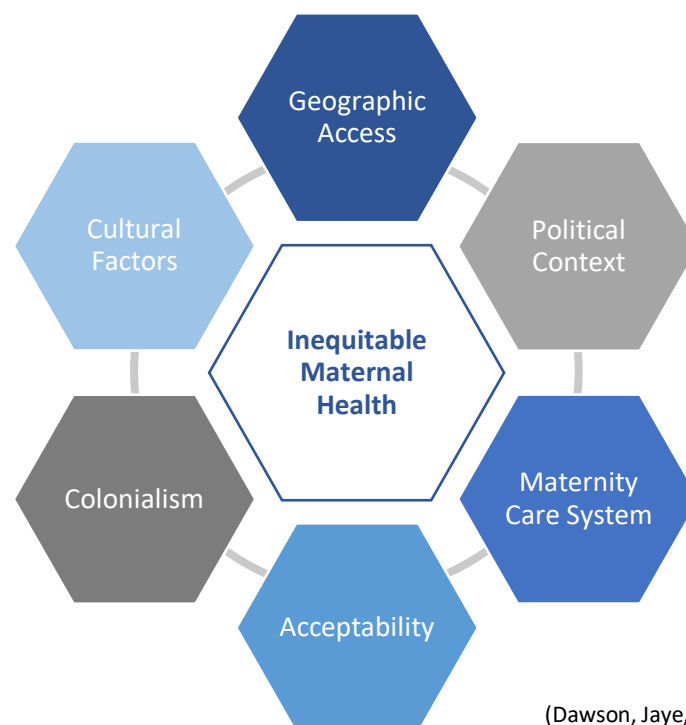
(Dawson, Jaye, Gauld, & Hay-Smith, 2019).

The World Health Organisation (WHO) (2020) summarises a human rights-based approach (HRBA) to health as a collection of solutions-based strategies and actions that will eliminate inequities in health. The goal of 'health for all' will be achieved by standards and principles that ensure:

1. Availability: Sufficient quantity of functioning public health and health care facilities, goods, services, and programmes.

2. Accessibility: Health facilities, goods, and services are accessible (physically accessible, affordable, and accessible information) to everyone without discrimination.

3. Acceptability: Health facilities, goods, and services are respectful of medical ethics, culturally appropriate, sensitive to gender and age, respectful of confidentiality, and improve health

status. The social and cultural distance between health systems and their users determine acceptability.

4. Quality: Health facilities, goods, and services are scientifically and medically approved and of good quality.

The WHO (2020) HRBA approach to health is used to organise the summaries of selected research findings.

8.1. Availability of Care

The Growing Up in New Zealand longitudinal study recruited a diverse sample of 6822 pregnant women during 2009 and 2010 to describe the timeliness of LMC engagement and identify the factors associated with timely engagement. Early engagement by women with antenatal care improves maternal health, reduces perinatal mortality and enables early infant enrolment with health care services. Researchers completed a face-to-face interview with each pregnant woman using a questionnaire that included six questions about LMCs. Of the sample, over 80% engaged an LMC in a timely manner (Bartholomew, Morton, Atatoa Carr, Bandara, & Grant, 2015).

Timeliness of LMC engagement was found to be poorer for Māori, younger women, women having their first pregnancy, and women living in socioeconomically deprived areas. Further research is needed to understand the barriers and enablers to Māori women accessing antenatal care for whom access to care is inequitable (Bartholomew et al., 2015).

A study of 10 women aged between 30 and 69 years with gestational diabetes mellitus (GDM) was undertaken in rural Northland in 2015. Research identified common emotional discourse about the burden of diabetic pregnancies they observed in women while they were undertaking a larger study to understand the complexities of living with diabetes. The researchers recruited a subset of women and they aimed to explore the phenomenon of GDM among Māori women in a rural context marked by high area-deprivation with participants were recruited from the local primary care clinic (Reid, Anderson, Cormack, Reid, & Harwood, 2018).

The research found intergenerational experiences informed their perceptions that GDM was an inevitable heritable illness that 'just runs in the family'. The cumulative effects of deprivation and living with GDM compounded the complexities of participant' lives including perceptions of powerlessness and mental health deterioration. Māori women living with Type 2 Diabetes Mellitus (T2DM) were clear that health providers had failed to intervene in ways that would have potentially slowed or prevented progression of GDM to T2DM (Reid et al., 2018) .

Positive relationships with healthcare providers facilitated management of GDM and helped women engage with self-management. Participants revealed missed opportunities for health services to detect and manage diabetes with ongoing negative health consequences for women and their children. Poor collaboration between health and social services meant psychosocial issues were rarely addressed and the cycle of intergenerational poverty and disadvantage prevailed. The findings highlight the opportunities for extended case management to include whānau engagement, input from social services, and evidence-based medicine and/or long-term management and prevention of T2DM (Reid et al., 2018).

A study undertaken by Hunter et al., (2011) reported a high association between planned and actual place of birth, with 82.68% of women who planned to birth at home actually doing so and 90.23% of women who planned to birth in a primary maternity unit actually doing so. Overall, 9.36% of women in the study birthed at home and 16.25% in a primary maternity unit; 74.36% of women in the study birthed in a secondary or tertiary facility.

Māori women were more likely to choose a primary birthing unit as their planned place of birth (23%), in comparison to Aotearoa European (18%), Pasifika (14%) and Asian (10%) women. Among Māori women 9% planned homebirth which is significantly decreased in comparison to Aotearoa European women (13%), but slightly higher in comparison to Pasifika (7%) and Asian (4%) women (Hunter et al., 2011).

Research in Counties Manukau reiterates the reported increase in planned homebirth amongst Māori women described by Hunter et al., (2011). A greater proportion of Māori women planned to birth at home (17.4 %) or in a primary birthing unit (27.2 %) and were more likely to present to the primary birthing unit. Results also indicated that primary birthing units offer low-risk women and babies of low risk women a level of protection from adverse outcomes (Farry, 2015).

Outcomes for low-risk women birthing in high technology facilities are shown to be less favourable than for those low-risk women who birthed at home or in a primary maternity facility (Davis et al., 2011). Farry's (2015) findings echo the work of Davis et al., (2011) by concluding, if low-risk women of Counties Manukau present to a freestanding primary midwifery led birthing unit in labour they are significantly more likely to have a normal vaginal birth and healthy baby.

To decrease the cost and long-term impact of unnecessary birth interventions the maintenance and increase of primary maternity units in Aotearoa needs to be a priority to ensure the needs of all women are met (Hunter et al., 2011). Furthermore, women need to be informed of the increasing

body of evidence that shows the increased risk of unnecessary intervention for low risk women who commence their labour in a secondary or tertiary facility.

Further research is required to conclude whether Māori women prefer to birth in primary birthing units and uncover how the historical development of midwifery in Aotearoa has influenced birth place preferences of Māori women. Statistics indicate that over a 40 year period a return to birthing away from hospital among Māori women increased from 5% in 1967 (Simmonds, 2011) to 9% by 2007 (Hunter et al., 2011). Birthing at home with skilled Māori birth attendants was the norm up to the 1930s (Tupara, 2020).

8.2. Accessibility of Care

In a 1999 review of maternity services in Aotearoa (National Health Committee, 1999), Māori women frequently encountered problems in securing their preferred LMC. Some twenty years later Māori women are still facing the same issues.

Access to quality information and healthcare during the perinatal period is important and can affect both the mother's and the baby's health outcomes (World Health Organization, 2017). Although maternity care in Aotearoa is free, many Māori women experience other access barriers. For example, Corbett, Chelimo and Okesene-Gafa (2014) identified that the odds of late booking for antenatal care are six times more likely amongst Māori women compared to Aotearoa European and other ethnic groups.

There are often barriers for Māori and rural populations to accessing care during or following pregnancy. Technology can help reduce these barriers by making health information more accessible. Researchers explored the use of technology with nine participants using Kaupapa Māori methodology. They concluded that health technology is effective and responsive to Māori; however, values such as whānau (extended family structures) and kanohi ki te kanohi (face-to-face interactions) need to be incorporated and respected (Gasteiger, Anderson, & Day, 2019).

Socioeconomic inequalities in birth outcomes are pervasive (Blumenshine, Egerter, Barclay, Cubbin, & Braveman, 2010), with Māori birthing women having greater levels of deprivation than other ethnic groups and women living in deprived areas most at risk of poor health (Ministry of Health Manatū Hauora, 2019k; Salmond, Crampton, & Atkinson, 2007). The pregnancies of Māori women have a higher likelihood of being classified as high risk due to being complicated by other maternal health problems such as diabetes and hypertension (National Health Committee, 1999; Reid et al., 2018),

requiring specialised medical or obstetric advice. Despite higher maternity care needs, Māori women access and use antenatal services less than other women (Health Funding Authority, 2000).

Research by Makowharemahihi et al., (2014) explored the lived realities of pregnant Māori women under 20 years of age, to identify barriers to, and facilitators of, access to maternity care. They used a Kaupapa Māori research paradigm to analyse interviews of 44 pregnant or recently pregnant Māori women under the age of 20 years of age, who were recruited in two case study sites during different stages of pregnancy and motherhood.

Makowharemahihi et al., (2014) concluded that contrary to published literature young Maori women are engaging early with health services (GP services, school and community based youth health services) to confirm their pregnancy and for maternity care. However, system barriers from this first health contact lead to avoidable delays in young Māori women accessing a seamless maternity care pathway and a LMC midwife. They cited a lack of sufficient and appropriate information and support for this young population group who have limited resources and experience to navigate through health services. Makowharemahihi et al., (2014) suggest that identified inequities in access to maternity care could be reduced through an integrated model of care.

Māori women are less likely to receive antenatal education classes and have fewer cumulative antenatal visits than non-Māori women. Māori women have reported lower levels of satisfaction with their antenatal, labour, and birth care and inequities in access to obstetric care as well. Certain key barriers to adequate antenatal care and/or care during labour and birth have been identified among Māori women, including access to information to make informed choices, insufficient numbers of independent practicing Māori midwives, inadequate access to culturally responsive care including whānau-centred services, and cost barriers (Ratima & Crengle, 2013).

8.3. Acceptability of Care

It is important that Māori women are viewed within their wider social context and that midwives work in partnership with Māori women (Tupara, 2010). Māori women seek a maternity service where provision of care recognises and respects their culture (Hunter et al., 2011). Findings of the Maternity Consumer Survey 2014 reiterates the maternity care needs of women in Aotearoa have not changed over time and having a maternity care provider that respects their culture, values, beliefs and background influences their choice of LMC (Buchanan & Magill, 2015).

Māori have a preference for self-employed Māori midwife LMCs and they want to be confident that their care provided by an LMC is culturally responsive to their needs (Abel, Finau, Tipene-Leach, Lennan, & Park, 2003; Ratima, Ratima, Durie, & Potaka, 1994).

Dissatisfaction expressed by Māori women regarding maternity services has included, finding culturally appropriate maternity care which acknowledges the diversity of Māori; and cultural issues of rudeness, ignorance and insensitivity. It was identified by Māori women that an appropriate maternity service would be one that met their cultural needs; including culturally responsive care in venues which were inclusive of whānau and elders shared experiences, focusing on normal birth whilst integrating Māori birthing practices provided by Māori midwives (Ratima & Crengle, 2013).

Interpersonal discrimination experience has been associated with adverse birth outcomes with limited research to evaluate this relationship within multicultural contexts outside the United States where the nature and salience of discrimination experiences may differ (Thayer, Bécares, & Atatoa Carr, 2019). Thayer et al., (2019) evaluated the relationship between perceived discrimination, as measured in pregnancy, with birth weight and gestation length among a total of 1,653 Māori, Pasifika, and Asian women from Aotearoa.

Of the sample of women in the study by Thayer et al., (2019), 30% reported some type of unfair treatment that they attributed to their ethnicity. Discrimination experience was a strong predictor of low birth weight and shorter gestation among Māori women only. For Māori women, unfair treatment at work and in acquiring housing, was associated with lower birth weight, and an ethnically motivated physical attack, and unfair treatment in the workplace, criminal justice system, or in the banking sector, were associated with significantly shorter gestation. It was concluded that further research is needed to better understand the risk and protective factors that may moderate the relationship between discrimination experience and adverse birth outcomes among women from different ethnic groups (Thayer et al., 2019).

Newtown Union Health Service (NUHS) has provided very-low-cost primary health care services for low-income, high-needs people for 20 years in Wellington, Aotearoa. A study of 11 women receiving midwifery care from NUHS investigated the feasibility of using focus groups and interviews with women, to gauge their satisfaction of maternity care, and to explore their perceptions of the NUHS model of a midwifery-led service embedded in primary care (Pullon, Gray, Steinmetz, & Molineux, 2014).

Overall, the women in the NUHS study were extremely positive about the model of care. The women reported that cultural competence was excellent in many aspects of care but needing attention in

others, indicating that further work is needed for more complex aspects of cultural competency. It was noted that the need for interpreters, translation services and social services coordination are difficult within the current funding model (Pullon et al., 2014). Although none of the participants in this study were Māori women, the findings of complex challenges for the ethnic groups of women in their care illuminates some of the same issues that have long been described by Māori researchers as integral to improving care for Māori women.

Māori women, when compared with non-Māori women, report barriers to breastfeeding, including a lack of professional support, culturally irrelevant information, feeling pressured by health providers, conflicting advice, and cultural insensitivity (Glover, Manaena-Biddle, & Waldon, 2007; Glover, Waldon, Manaena-Biddle, Holdaway, & Cunningham, 2009).

8.4. Quality of Care

Māori consistently show higher fertility rates compared to other ethnic groups in Aotearoa. After accounting for age, socioeconomic status and religion, research concluded that cultural or other ethnic factors differentially influence fertility for Māori in comparison to other ethnic groups, and that further research is needed to understand contributing factors to high fertility rates (Urale, O'Brien, & Fouché, 2018).

International studies indicate that multiple maternal risk factors, even when considered in combination, do not explain the extent of disparities in birth outcomes for Māori. The implication is that poor access to antenatal and intrapartum care may only be one of a number of important factors that contribute to inequalities in birth outcomes for Māori. There is strong evidence that birth outcomes, such as low birthweight, affect a baby's health outcomes in later life. Further research is needed to understand more fully the inequalities in birth outcomes for Māori; for example, optimal antenatal care for Māori from a life course perspective (Ratima & Crengle, 2013).

Drewniak, Krones and Wild (2017) reviewed research results from 47 studies across 12 countries and identified six potential barriers to health care that may be related to the attitudes and behaviours of health professionals'. The attitudes and behaviours identified included biases, stereotypes and prejudices; language and communication barriers; cultural misunderstandings; gate-keeping and statistical discrimination. They concluded that data on health professionals' attitudes or behaviours are both limited and inconsistent, and more empirical data is needed (Drewniak et al., 2017).

Preliminary findings of a literature review by Drewniak et al., (2017) are consistent with international research evidence that health care professionals exhibit the same levels of implicit bias as the wider

population (FitzGerald & Hurst, 2017). It is suggested by FitzGerald and Hurst (2017) that the interactions between health professional and multiple patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. Evidence indicates that biases are likely to influence diagnosis, treatment decisions, and levels of care in some circumstances and need to be further investigated (FitzGerald & Hurst, 2017).

On the basis of FitzGerald and Hurst's (2017) research, there could be distinctive issues that arise in the Aotearoa context for women who belong to multiple identity characteristics that are associated with inequities. Characteristics such as, being Māori, a woman, young, a smoker and living in a low decile are characteristics that give rise to implicit biases which involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender (FitzGerald & Hurst, 2017).

Research of Implicit bias amongst health professionals was also examined in a study of health professional's communication with 37 pregnant women in Vietnam who are among the minority ethnic groups experiencing economic, social and health inequalities. The women in the study reported that health professionals deliver information in a one-way didactic style and do not account for the women's own personal circumstances (Mckinn, Duong, Foster, & McCaffery, 2017).

Experiences of interpersonal racial discrimination and the link to health professionals behaviour, attitudes and interactions with minority groups and quality care has been identified in research in Aotearoa pertaining to Māori, and is consistent with findings in international studies (Harris et al., 2006).

Research to investigate implicit bias among medical students in Aotearoa found that students' negative attitudes, feelings and beliefs about an individual because of the ethnic group they belong to, do influence their behaviour, leading to discrimination. As a result, ethnic bias can affect health professional decision-making and the quality of interactions with patients (e.g. poorer communication with patients and poorer patient perceptions of encounters), both of which have implications for future engagement with patients receiving care (Cormack et al., 2018).

The researchers (Cormack et al., 2018) say the findings from their study were not surprising given that medical students are exposed to negative stereotypes about Māori in wider society and in their training institutions; which is relevant to midwifery education contexts. The good news is that there are remedial strategies available because although ethnic biases can be fairly entrenched, emerging research also shows that they can be changed. The first step in making change is for educators and

students to examine their own ethnic bias, including assumptions and beliefs about ethnic groups and how this may impact care (Cormack et al., 2018).

Glover et al., (2013) describes how knowledge of indigenous people's practices and principles can be combined with proven effective smoking cessation support into an appropriate cessation intervention for indigenous people. The cultural principles and practices that could be used to increase salience, and what competition elements could have an impact on efficacy of smoking cessation were identified. It was found that having social support, given by family, friends and co-workers, has a positive influence on smoking cessation in general and that group cessation approaches align with Māori whānau centred values and practices and increase the number of smokers assisted at a time (Glover et al., 2013).

Walker et al.'s (2019), research involved a literature search between 2000 and 2018 of qualitative studies related to smoking amongst indigenous women in pregnancy. The prevalence of smoking during pregnancy among Māori women approaches 50% and is associated with pregnancy loss, preterm birth, low birth weight, anatomical deformity and SUDI. Seven studies from Aotearoa and Australia involving 250 indigenous women were used from the literature search (Walker et al., 2019). Three themes were identified in Walker et al.'s (2019) research, these were:

1. Realising wellbeing and creating agency included giving the baby an optimal start to life, pride in being a healthy mother, female role models, and family support.
2. Understanding the drivers for smoking included understanding the impact of stress and chaos that hindered prioritisation of self-care, the social acceptability of smoking, guilt and feeling judged, and inadequate information about the risks of smoking.
3. Appreciating culturally responsive approaches included valuing Māori programmes, improving accessibility to programmes, and having something to replace smoking.

It was concluded by Walker et al., (2019) that future interventions and smoking cessation programmes might be more effective and acceptable to Māori women and their whānau when they harness self-agency and the desire for a healthy baby, recognise the high value of Māori peer involvement, and embed a social focus in place of smoking as a way to maintain community support and relationships. The researchers assert that development and evaluation of smoking cessation programmes for pregnant Māori women and their whānau is warranted (Walker et al., 2019).

It makes sense to identify whether evidence is being put to good use in the development of health services and programmes that will facilitate improved outcomes for Māori women and whānau.

9. Midwifery Pre-registration Education Pipeline

Ara, AUT, Otago and Wintec (providers) were operating an academic year for students doing a midwifery pre-registration education programme (midwifery programme) in 2019 and were contacted to provide information about their programmes for this literature review. Only one school, Ara, provided information about their programme, from the past three years as follows:

From 2017 to 2019 Māori made up 16% of all midwifery students at Ara and for the same period Māori were 14% of the midwifery graduates. Attrition rates for Māori are no different to other students with the highest attrition occurring in the first year and mostly for family, personal or financial reasons. From 2017 to 2019, 15 students left the programme at Ara in the first year and of these students, five were Māori (three indicated they want to return at a later date) (Kensington, 2020).
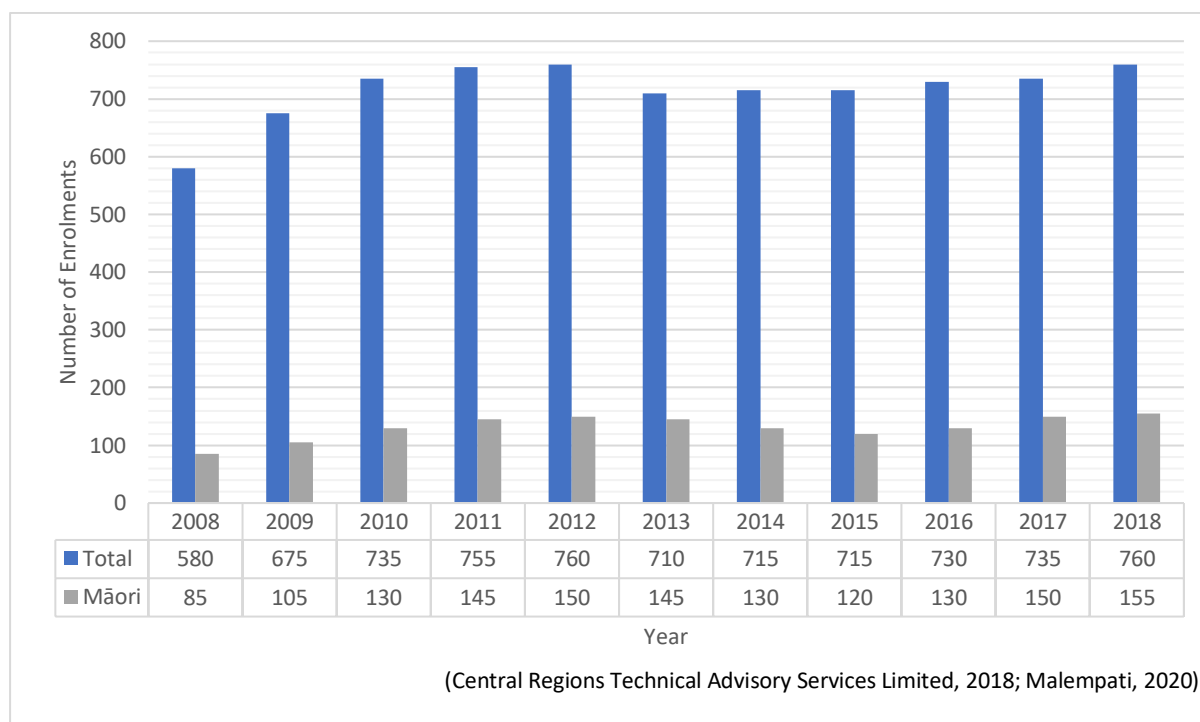
Ara has 11 midwifery lecturers who share 7.8 FTE with one of the midwifery lectures being Māori and working a tenured 0.8 FTE. Ara groups Māori and Pasifika students in the first year of the programme and provides them with support from the Māori kaiako. In 2019 Ara commenced student hui for Māori and Pasifika students with Ara staff and midwives from the community to provide the opportunity for whakawhanaungatanga and to foster support for midwifery students. Ara is exploring options to formalise the Tuakana Teina Programme and they have existing relationships with Rōpū Te Waipounamu, Ngā Māia and Kia Ora Hauora (Kensington, 2020).

Remaining information about Māori participation in midwifery programmes is accessed from other sources collected by Government agencies or for technical reports. The data provided includes further information about Ara. It is important to note that MU discontinued as a midwifery tertiary education provider in 2012.

Annual midwifery programme enrolment numbers across all years of study have increased since 2008. From 2008 to 2018, all four providers have higher annual enrolment numbers for midwifery programmes with the most significant increase seen in AUTs enrolment numbers, which is 73% higher in 2018 than in 2008.
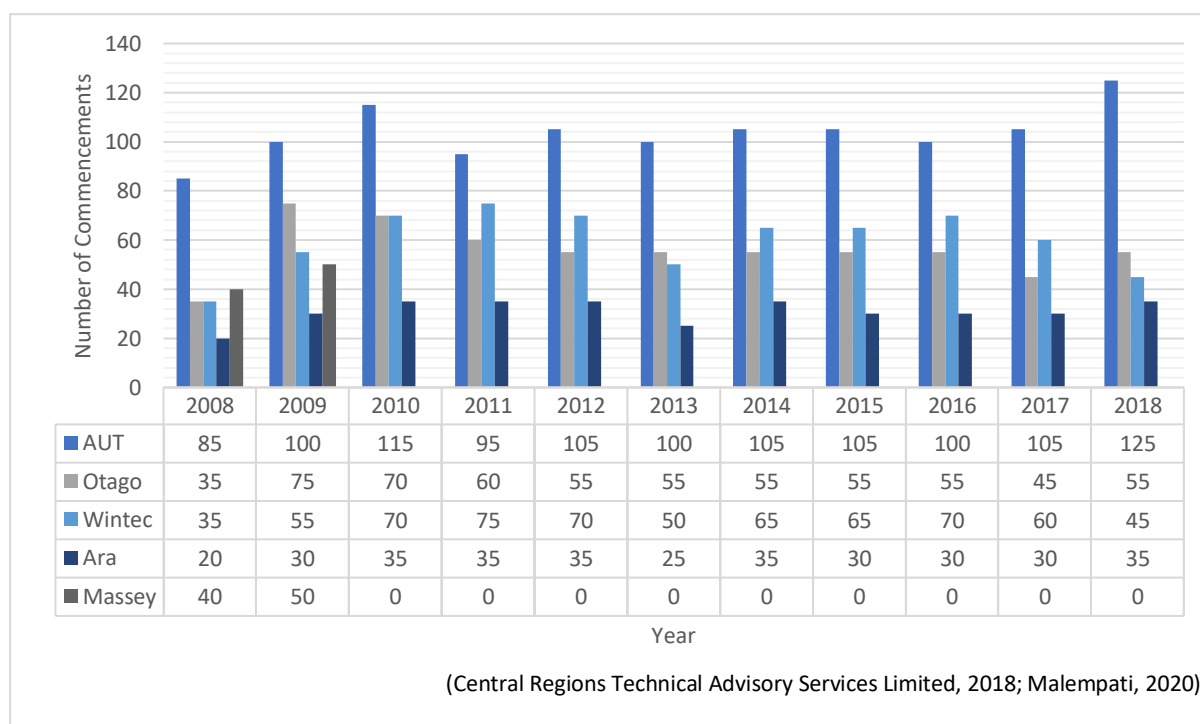
Figure 23 shows the annual number of students enrolled in midwifery programmes in Aotearoa, across all years of study from 2008 to 2018.

Figure 23: Total enrolments and Māori enrolments in midwifery programmes 2008-2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total	580	675	735	755	760	710	715	715	730	735	760
Māori	85	105	130	145	150	145	130	120	130	150	155

(Central Regions Technical Advisory Services Limited, 2018; Malempati, 2020).

The actual number of commencements in midwifery programmes (students who first start the midwifery degree) in Aotearoa is much smaller than enrolment numbers across all years from 2008 to 2018, as shown in Figure 24 below.

Figure 24: Commencements in midwifery programmes 2008-2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
AUT	85	100	115	95	105	100	105	105	100	105	125
Otago	35	75	70	60	55	55	55	55	55	45	55
Wintec	35	55	70	75	70	50	65	65	70	60	45
Ara	20	30	35	35	35	25	35	30	30	30	35
Massey	40	50	0	0	0	0	0	0	0	0	0

(Central Regions Technical Advisory Services Limited, 2018; Malempati, 2020).

Completions in midwifery programmes for Māori have been low since 2008 compared to the number of enrolments. Over a ten-year period from 2008 to 2018 there were 1,445 Māori enrolled in a midwifery programme and only 230 completed, which is 15.9% of Māori enrolments, as shown in Figure's 23 and 25.

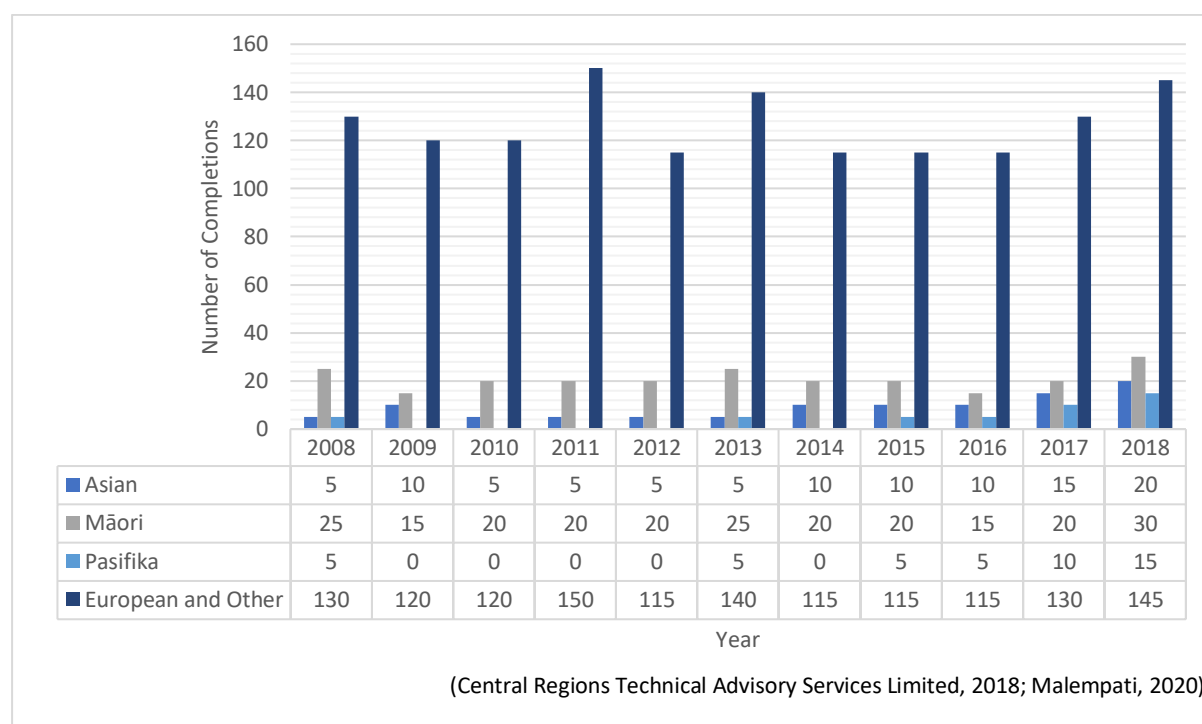Figure 25: Completions of midwifery programmes, by ethnicity 2008-2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
▪ Asian	5	10	5	5	5	5	10	10	10	15	20
▪ Māori	25	15	20	20	20	25	20	20	15	20	30
▪ Pasifika	5	0	0	0	0	5	0	5	5	10	15
▪ European and Other	130	120	120	150	115	140	115	115	115	130	145

(Central Regions Technical Advisory Services Limited, 2018; Malempati, 2020).

Figure 26: Completions of midwifery programmes, by provider 2008-2018

(Central Regions Technical Advisory Services Limited, 2018; Malempati, 2020).
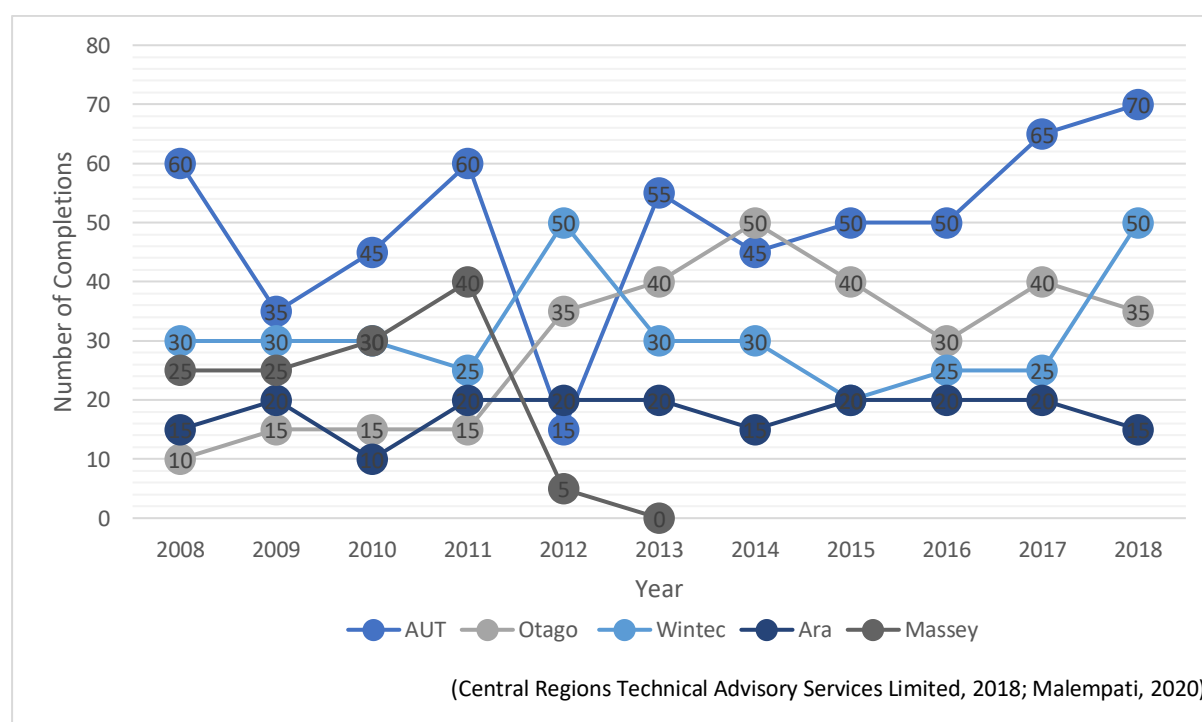
Figure 26 gives completions in midwifery programmes in Aotearoa by provider and shows that numbers have fluctuated across the providers from 2008 to 2018. The majority of completions are from AUT, relative to having the greatest number of students that commence study in the midwifery programme.

Only 21% of Māori midwifery students are completing their midwifery qualification in three years, while 60% are finishing within five to six years (Jo, 2020).

The gap between Māori compared to European students in tertiary education in Aotearoa is substantial, despite Government policy effort aimed at increasing higher achievement for under-represented groups like Māori and Pasifika. Three factors found internationally to contribute to achievement in higher learning are, prior academic performance, parents' educational attainment, and socioeconomic status (SES) (New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

Meehan et al., (Meehan et al., 2017; Meehan, Pacheco, & Pushon, 2019) tracked a cohort of 200,000 young people born between 1990 and 1994, who were enrolled in a University in Aotearoa during their 15th and 16th year of age. Meehan et al., (2017, 2019) looked at how degree-level participation, retention and completion rates differed by ethnicity in Aotearoa, and to what extent controlling for individual, school, household and parental characteristics closed the ethnic gaps, and whether the adjustment was similar for Māori and Pasifika gaps with European students. They followed the cohort through enrolment, progression and completion in bachelor level study by ethnicity, accounting for previously known factors for academic success, such as SES, parents' educational attainment and student's prior academic achievement.

 Of the three factors found to contribute to achievement in higher learning, prior school performance is by far the largest contributor to the ethnic gaps in tertiary education in Aotearoa. It was identified that Māori and Pasifika in the study cohort were significantly less likely than other groups to enter bachelor level study, stay for the second year, or complete the qualification (Meehan et al., 2017, 2019); which is consistent with previous research by Earle (2007).

Programme completion rates are lower across all levels of study for Māori students compared to European or Asian students, and particularly at higher levels of study. Māori tend to have higher first-year retention rates than Europeans for level one to three certificate study on the NZQA framework, but this pattern reverses for study of bachelor degrees and level five to seven diplomas and certificates (Central Region Technical Advisory Services Limited, 2018; New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

Figures 27 and 28 identify reasons for the gap between Māori and European participation in bachelor level study.
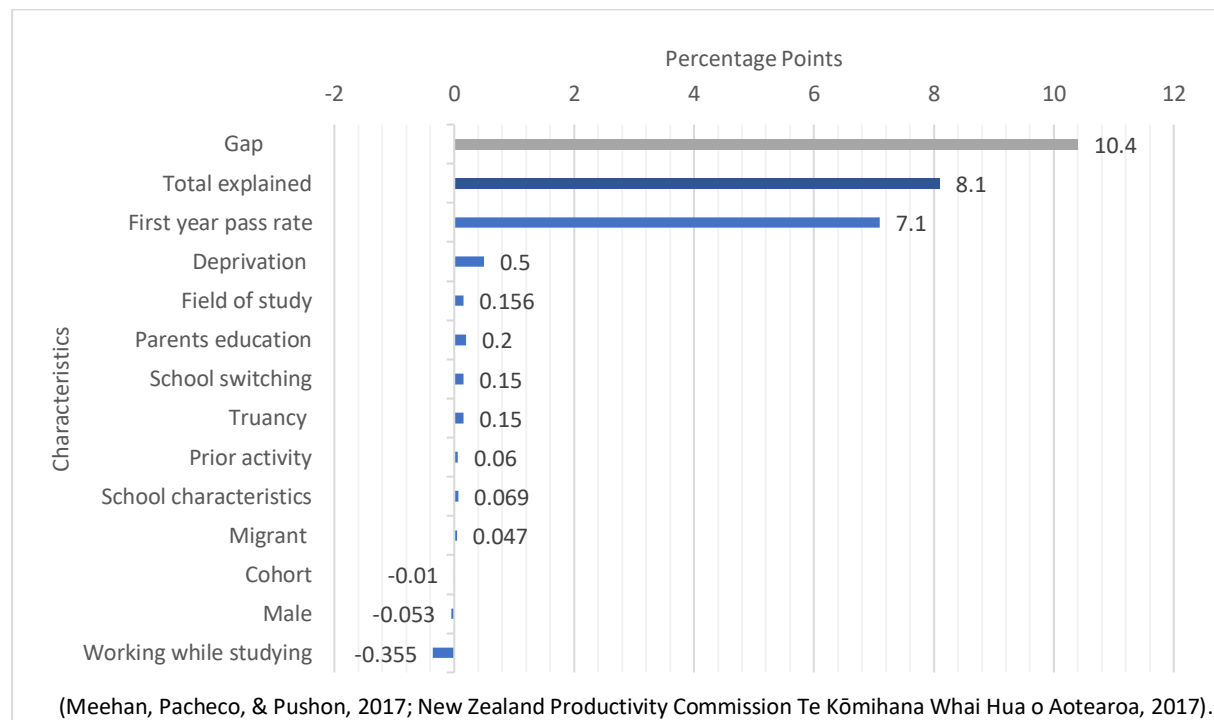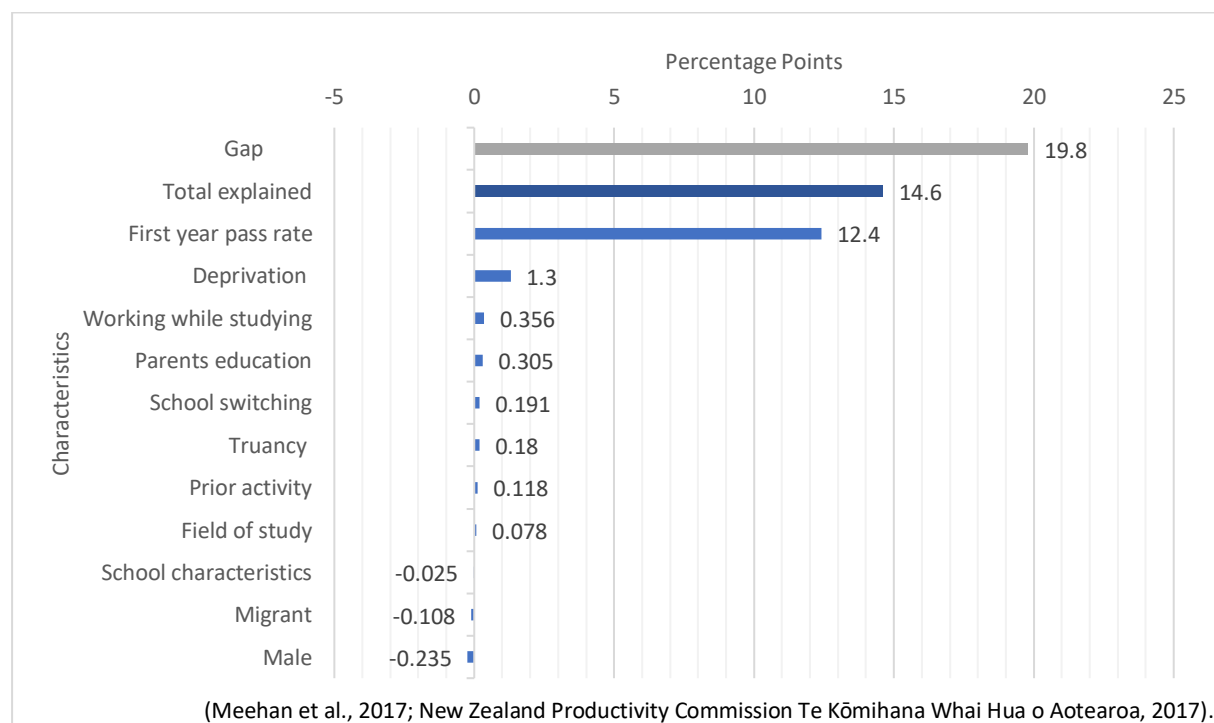
Figure 27: Māori - European retention gap

(Meehan, Pacheco, & Pushon, 2017; New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

Figure 28: Māori - European completion gaps

(Meehan et al., 2017; New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

Once in tertiary study, the largest contributor to the retention and completion gap was first year pass rate which is based on an Equivalent Full-time Student (EFTS) weighted variable and is a more appropriate measure than prior school performance. The second largest contributor to retention and completion was deprivation. But, even if Māori had the same characteristics as their European peers, there would still be a gap in retention and completion rates (New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

Figure 29: Contributors to the gap between Māori - European study at bachelor's level

(Meehan et al., 2017; New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).
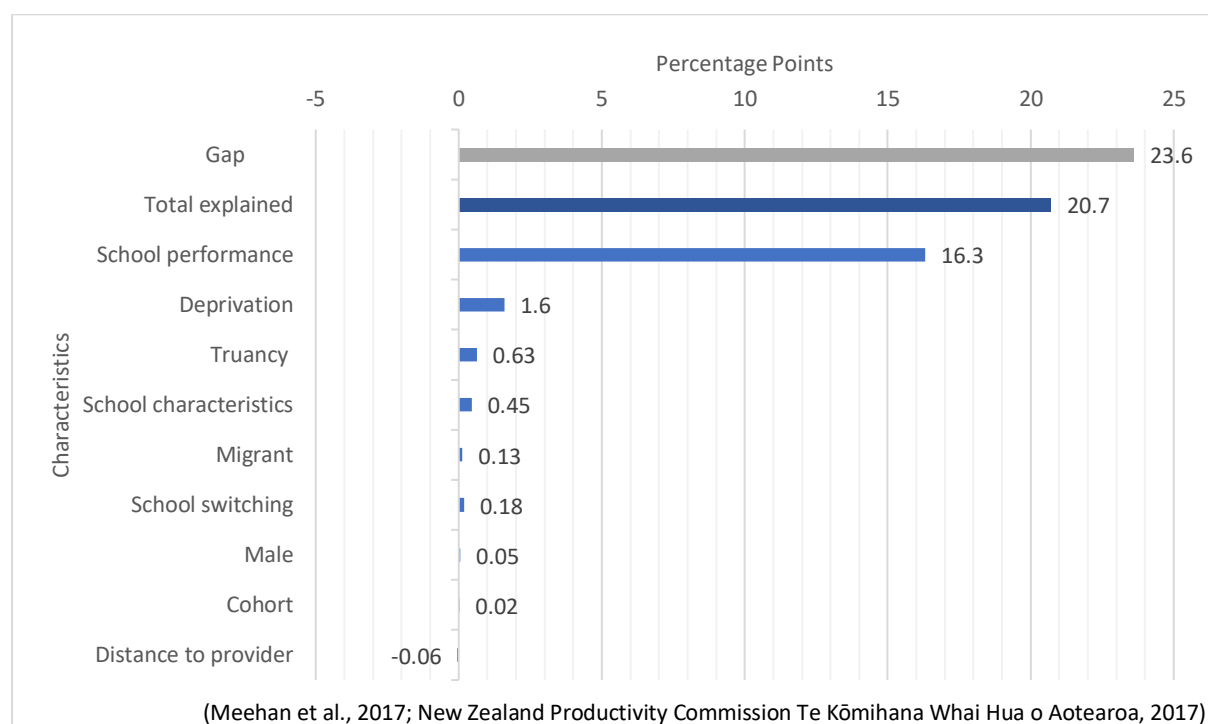
Most, but not all, of the gap between Māori and European participation in bachelor level study is explained by differences observed by Meehan et al., (2017), which accounts for 86% of the gap. The size of the unexplained 14% portion of the gap between Māori and European achievement at bachelor level is an unknown factor that the research team has attributed to possibly a cultural-specific gap or another variable that they did not study (New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

For Māori, doing well in the first assessment at bachelor level is crucial for ongoing success throughout the remaining time of their tertiary study. The vast majority of the explained gaps between Māori and European are due to differences in first year course completions (New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa, 2017).

The Midwifery Council commenced consultation on potential changes to the education standards because of suggestions the extended four-year programme is associated with higher rates of student attrition and issues of academic staff wellbeing (Midiwfery Council of New Zealand Te Tatau o te Whare Kahu). It is plausible the additional year is contributing to attrition rates for Māori students, but it is unlikely to be a significant factor, based on current evidence of contributing factors to completion rates.

Cultural gaps in midwifery education was one of the reasons for the formation of Ngā Māia almost 20 years ago. Anecdotal evidence from Māori midwives who have been midwifery educators over the past decade, is very troubling, with accounts of patronising behaviours and undervaluing of Māori knowledge by their peers, tokenism, intellectual theft, and bullying or obstructive actions from colleagues or midwifery leaders to silence Māori colleagues. In addition, concerns have been raised about the ability of the current midwifery education system to adequately serve the needs of Māori midwifery students. Many believe a Māori midwifery programme with an indigenised curriculum is needed to grow a culturally competent indigenous midwifery workforce that can cater to the diverse needs of all Māori women.

10. Cultural Competence in Midwifery

Cultural Competence arose from Cultural Safety, that was conceptualised in an Aotearoa context by Dr Irihapeti Ramsden, to help nurses in Aotearoa understand the way their attitudes towards patients from a different cultural background, affect nurses' interactions and quality of care (Ramsden, 1990).

The HPCA Act was introduced to regulate health practitioners in Aotearoa which includes the establishment of the inaugural Midwifery Council.

The main purpose of the HPCA Act is:

to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

(New Zealand Government Te Kāwanatanga o Aotearoa, 2019a, Section 3).

Setting standards for Cultural Competence is among the competencies that the Midwifery Council is required to put in place by law. Specifically:

to set standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession.

(New Zealand Government Te Kāwanatanga o Aotearoa, 2019a, Section 118i).

The Midwifery Council's view on Cultural Competence is:

The ability to interact respectfully and effectively with persons from backgrounds different to one's own. Cultural competence is more than awareness of or sensitivity to other cultures.

For midwives, cultural competence means both recognising the impact of their own culture and beliefs on their midwifery practice and being able to acknowledge and incorporate each woman's cultures into the provision of individualized midwifery care. It means having the knowledge, skills and attitudes to understand the effect of power within a healthcare relationship and to develop respectful relationships with people of different cultures.

Positive healthcare relationships lead to improved health outcomes. In order to enhance their relationships with women and their families, midwives will draw on the practice frameworks of:

1. *Midwifery partnership,*

2. *Cultural safety, and*

3. *Turanga [sic] Kaupapa.*

(Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2009, p. 3).

In order to determine whether a midwife is culturally competent, the Midwifery Council is required to have "a consistent accountability regime" (New Zealand Government Te Kāwanatanga o Aotearoa, 2019a, Section 3.2a). Underpinning the Statement on Cultural Competence for Midwives is the Scope of Practice (the legal definition) of a midwife that is defined by the Midwifery Council and must be in the Gazette.[29] The Scope of Practice of a midwife states:

A midwife works in partnership with women on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.

A midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance and implements emergency measures as necessary. When women require referral, a midwife provides midwifery care in collaboration with other health professionals.

A midwife has an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.

A midwife may practise in any setting, including the home, the community, hospitals or in any other maternity service. In all settings a midwife remains responsible and accountable for the care she provides.

(New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015, p. 4).

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[29] The New Zealand Gazette Te Kāhiti o Aotearoa, commonly referred to as the Gazette, is the official newspaper and authoritative journal of constitution records since 1841 of the Government of New Zealand. See: https://gazette.govt.nz/

The Midwifery Council also sets standards for approval of pre-registration midwifery education programmes and accreditation of tertiary education organisations with processes for approval, accreditation, on-going monitoring and audit (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2019b).

There are three main points at which midwives will have opportunities for education or training in Cultural Competence which are; prior to midwifery education, at the point of midwifery education, and once they are registered midwives and practising in the workforce.

Prior to entering midwifery education, midwifery students enrol with very uneven knowledge of Cultural Competence concepts. They will have different social, economic, cultural and education backgrounds. Some may have prior tertiary qualifications with existing insight into society in Aotearoa as a result of their education, or not. Te Tiriti has never been a core curriculum subject in schools in Aotearoa in which the concept of partnership with Māori might arise. Cultural Safety is a concept common to the Aotearoa health sector and unless students have worked in the health sector as a health professional, it may be new learning. Tūranga Kaupapa is specific to midwifery in Aotearoa, and students who commence midwifery education may not have heard about Tūranga Kaupapa although they may be familiar with the concepts within Turanga Kaupapa.

Midwifery education is the point at which students' knowledge can be evened out. Midwifery schools have a degree of freedom in the design and delivery of their content for Cultural Competence, which could contribute to the delivery of uneven information, including the portrayal of Māori women as a 'static other' (Paul, Ewen, & Jones, 2014).

Māori midwives are under-represented in midwifery education as teachers, and there is no Head of School in any of the midwifery programmes in Aotearoa, who is Māori, which means that the contribution of Māori midwifery perspectives on the curriculum is problematic.

Once midwives are in the workforce, there are no compulsory recertification requirements for Cultural Competence, and therefore the profession is entirely reliant on their preparation in midwifery education or broadly related employer requirements. Apart from one DHB of the 20 throughout Aotearoa that implemented a mandatory Tūranga Kaupapa education programme from 2018 to 2019, there are only voluntary opportunities for Cultural Competence education.

With the theme of 'safety' for Māori women as a primary function of the Midwifery Council, the matrix in Table 9, with the three tenets of Cultural Competence, is used as a crude measure of the checks and

balances that currently exist in the midwifery profession, to prepare midwives working with Māori women.

Table 9: Three tenets of cultural competence, a crude measure

	Partnership	Cultural Safety	Tūranga Kaupapa
Prior to Pre-Registration Education	Uneven knowledge	Uneven knowledge	Uneven knowledge
Pre-Registration Education	Uneven preparation, assessment criteria and outcome measure	Uneven preparation, assessment criteria and outcome measure	Uneven preparation, assessment criteria and outcome measure
Post-Registration	No compulsory recertification requirements	No compulsory recertification requirements	No compulsory recertification requirements

The HPCA Act (New Zealand Government Te Kāwanatanga o Aotearoa, 2019a) sets out requirements for registration that must be met by any applicant for registration and entry to the Register of Midwives. The Midwifery Council relies on each Head of Midwifery School to confirm by statutory declaration that applicants have completed the prescribed midwifery programme, demonstrated competence to practise, which includes cultural competence, demonstrated the ability to communicate appropriately in English and demonstrated fitness for registration as a midwife. First language te reo Māori learners are disadvantaged by Midwifery Council requirements.

The purpose of Cultural Competence in midwifery education in Aotearoa needs to be reassessed. International literature commonly identifies that the contributing factors to inequities are a complex combination of the midwifery infrastructure (system), midwives (health professionals) and women (consumers) (Paul et al., 2014).

Paul et al., (2014) use Hafferty's taxonomy of curricula (Hafferty, 1998) to describe Cultural Competence formal, informal and hidden curricula in medical education in New Zealand. It is asserted that addressing inequities in health (sometimes referred to as disparities) should be the purpose of Cultural Competence education (Paul et al., 2014).

Formal curricula should aim to address interventions that help midwifery students or midwives identify and correct for their own unconscious bias and stereotypes that are known to impact on communication, interactions and quality of care. Formal curricula should also focus on the complexity of clinical interactions rather than simple 'formulaic notions' of communicating with others (Paul et al., 2014).

Informal Curricula comprises the 'off the record' conversations that happen outside of formal learning, between teachers and students, or among students. The under-representation of Māori students means the majority of the demographic has a significant influence over the informal curricula and their attitudes or behaviours may be reinforced by role modelling outside the classroom (Paul et al., 2014).

Hidden curricula are embedded in policy development, evaluation, resource allocation and institution slang. Paul et al., (2014) refer to Cultural Competence as institutional slang that has as an element of hidden curriculum used to focus on the other, because cultural competence is rarely, if ever, about the culture of health professionals (Wear, Kumagai, Varley, & Zarconi, 2012).

Midwifery in Aotearoa has made significant contributions to the development of the profession worldwide, with the Aotearoa model of midwifery internationally renowned. We have come too far, not to go further.

11. Māori Health Workforce Initiatives

There are several initiatives in Aotearoa that can be credited with having success factors that build on, contribute to and sustain the Māori midwifery workforce. Four examples of such initiatives are, Kia Ora Hauora, Ngā Manukura ō Apōpō, Pū Ora Matatini and Te Rau Puāwai.

11.1. Kia Ora Hauora (KOH)

Kia Ora Hauora (KOH) is a national Māori health workforce development programme that was established in 2009 to support Māori into a health career and increase the overall number of Māori working in the health and disability sector at all levels and in all professions. The programme engages with Māori students, current health workers, and community members seeking a career in health and promotes health careers, both clinical and non-clinical (Kia Ora Hauora, 2020).

The programme is sponsored by Tumu Whakarae, the National Reference Group of Māori Health Strategy Managers within DHBs and the MOH. KOH is led by four regional DHB hubs who actively deliver the programme within their regions and provide knowledge, tools and resources to assist people to get started on a health career pathway (Kia Ora Hauora, 2020).

KOH provide increased opportunities for Māori to see the 'health sector in action' through mentoring and local events including open days, hospital visits, science days, wānanga, café, workshops and tertiary events. The programme engages with students across secondary schools, wānanga, polytechnics and universities. KOH is an accessible programme supporting all ages who may want to choose a career in health and has the highest number of Māori registrations across any 'Careers Programme' in the country (Kia Ora Hauora, 2020).

Nationally, Māori health workforce development is a key strategy for supporting Māori participation in the health sector. Building capacity through robust targeted approaches in line with the national and local workforce needs. KOH is investing in the growth of Māori workforce in the health sector. It has a priority focus to increase Māori employment in DHBs to reflect their local populations by 2025. This means 6,500 new Māori health workers in the next seven years across the health sector (Kia Ora Hauora, 2020).

KOH has supported the activities of Māori midwifery groups through financial grants and merchandise and has created an established place for Māori within the health workforce sector through collaborative relationships, formal partnerships, employer engagement and national communications.

11.2.   Ngā Manukura o Āpōpō

Ngā Manukura o Āpōpō, is a National Māori Nursing and Midwifery Workforce Development Programme, that was developed in partnership with the District Health Boards New Zealand (DHBNZ) Champions (made up of a cross-sector reference group of workforce leaders from within DHBs, non-government organisations, health professional organisations, tertiary institutes and the MOH (King, Pipi, & Moss, 2014).

In 2006, the MOH published Raranga Tupuake, the Māori Health Workforce Development Plan (Ministry of Health Manatū Hauora, 2006). Raranga Tupuake sets out a 10 to 15-year plan to build a competent, capable, skilled and experienced Māori health and disability workforce. The strategy aimed to increase the number of Māori within the sector, expand their skill base, and enable equitable access to training programmes.

In 2008, a report commissioned by the MOH, the Rauringa Raupa report (Ratima et al., 2007), provided the health sector with a comprehensive analysis of barriers and influences which increase Māori participation in the health workforce as well as identification of retention issues. The report highlighted Māori leadership as a critical component to the successful development of the Māori health workforce and goes on to make several recommendations. Some of the recommendations include, consistent and coordinated leadership, strategic investment of dedicated, secure and adequate levels of funding, and prioritisation of piloting workforce development initiatives with Māori (Ratima et al.,2007).

In 2008 the MOH announced a significant four-year investment aimed at strengthening the Māori health and disability workforce. The investment included a commitment toward the implementation of initiatives which focus upon the clinical leadership and professional development of Māori nurses and midwives. The MOH appointed the Auckland District Health Board as the first host DHB to set up and implement the National Māori Nursing and Midwifery Workforce Development Programme under the leadership of the time (Ngā Manukura o Āpōpō, 2020).

The project team developed a proposal in November 2008 that was agreed to by the MOH in March 2009. The Advisory Group was then established in September 2009 and gave the name Ngā Manukura o Āpōpō to the programme of work. The kaupapa for the programme focuses on, identifying potential leaders, career pathway options, providing direction and guidance, and giving support and encouragement (King et al., 2014). In October 2012 the programme transferred to the Northland District Health Board. In December 2017 the MOH extended the contract for a further three years to December 2019 (Ngā Manukura o Āpōpō, 2020).

11.3. Pū Ora Matatini (POM Māori Midwifery Programme)

The Pū Ora Matatini initiative was created in 2008 by the AUT Head of Midwifery School and Counties Manukau Health Director of Midwifery at the time, with the aim of recruiting and retaining Māori midwifery students in the AUT midwifery programme to address equity, service provision and workforce development issues (Counties Manukau Health, 2019).

In 2010, with funding and support from the Tindall Foundation, the Counties Manukau Health Pū Ora Matatini Māori Midwifery Programme (POM Programme) had a co-ordinator appointed and implemented a scholarship programme. The POM Programme has been providing financial, academic and pastoral wrap-around support to Māori midwifery students enrolled in the AUT midwifery programme since, with a focus on raising the number of Māori midwives in South Auckland to reflect the Māori birthing population (Counties Manukau Health, 2017, 2018, 2019).

The AUT midwifery programme proposed a joint venture partnership (JVP) with Counties Manukau Health in 2013 to further develop the POM Programme, with a focus on students in the AUT Manukau Campus cohort. The JVP went ahead and a Māori Midwifery Liaison and Student Support role based at AUT was introduced in 2014 (Counties Manukau Health, 2017) and worked alongside the Counties Manukau Health Māori Health Workforce Manager and Workforce Co-ordinator. In 2016 the role extended to include co-ordination of the POM Programme (Counties Manukau Health, 2017).

Since its establishment, the POM Programme, as at 2018 had supported 22 Māori women to graduate from the AUT midwifery programme and one to graduate from the AUT Bachelor of Health Science standard pathway. Of these graduates, 11 were employed by Counties Manukau Health, eight were LMC midwives in the Counties Manukau community and one was employed by Waitematā DHB. Furthermore, the POM Programme has provided scholarships to support 29 Māori women, who demonstrated leadership and a commitment to Māori Health (Counties Manukau Health, 2018).

The number of Māori students enrolling in the AUT midwifery programme has steadily increased since 2014. In addition, a significant decrease in the attrition rate of Māori midwifery students from the AUT midwifery programme has been observed, from its highest in 2011, 71%, to 33% in 2015, and down to its lowest in 2017 and 2018, 4% and 4% respectively (Counties Manukau Health, 2019).

In 2018, two Māori Liaison midwives were employed, who continue to provide wrap-around support to AUT Māori midwifery students and promote the programme out in the community. Funding was also provided at this time for peer mentors and the establishment of a Māori midwives alumni (Counties Manukau Health, 2019).

11.4.   Te Rau Puāwai

Te Rau Puāwai scholarship programme remains an important initiative within MU, having supported over 400 graduates in psychology, social work, disability, nursing, Māori health and studies, public health, rehabilitation, midwifery, health management, and health science (Te Rau Puawai, 2017).

Te Rau Puāwai started as a JVP between the former Health Funding Authority and MU, and it set a goal to support 100 Māori students (hence the name Te Rau Puāwai [100 blossoms]) to graduate with mental health qualifications within five years. The goal of Te Rau Puāwai to build Māori mental health workforce capacity exceeded expectations in two years (1999 to 2001) with 56 bursars completing qualifications and achieving an average 80% pass rate compared with a 65% pass rate for all students at MU (Te Rau Puawai, 2017).

After its first two years Te Rau Puāwai was evaluated by the Māori and Psychology Research Unit (MPRU) at the University of Waikato to report on the programme's success and identify recommendations for improvement. The 2002 evaluation highlighted successes that included, employment of an enthusiastic and committed coordinator who provided an essential foundation for the programme; an efficient and effective system of support for bursars; good leadership and the ability to maintain confidence of the funder and the Māori mental health sector; adequate funding; a whānau approach that enabled networking between bursars and the Te Rau Puāwai team; and an innovative structure to accommodate the needs of mostly part-time, external, mature students such as head start hui, regional and phone support (Nikora, Levy, Henry, & Whangapirita, 2002).

Programme barriers included sustainable and guaranteed funding to meet demand because of a high number of applicants; the need for closer relationships with Māori mental health providers; the challenge for bursars to reconcile Māori and Western world views particularly with regard to employers expectations; the workload created by the programme for Māori academic staff; finding students committed to working in the Māori mental health field particularly at undergraduate level; and improving the academic mentoring system in place (Nikora et al., 2002).

Te Rau Puāwai negotiated further funding from the Mental Health Directorate of the MOH under its Mental Health Workforce Development Strategy 2002. A further evaluation of Te Rau Puāwai was carried out in 2004 at the request of the MOH to provide a descriptive record of programme activities and progress from 2002 to 2004 (Nikora, Rua, Duirs, Thompson, & Amuketi, 2005) further emphasising the successes and necessary improvements to Te Rau Puāwai.

12.   Wayfinding for Revolutionary Change

The manifestation of differing values and ideas is reflective of the contrast between philosophical bases that Māori and Western world views descend from. If we continue to hope for the co-location of different world views in the guardianship of Aotearoa midwifery and engage in a business-as-usual model, nothing will change.

A restoration of balance, power, equity and unity is needed to carry forward any strategic direction. As the midwifery profession seeks to experience a new horizon of revolutionary change that opens a vista of the midwifery landscape that has not been seen before, the four stages of the wayfinding process can be used to chart a pathway forward. The four wayfinding stages are:

1. Orientation determines one's location relative to their surroundings. Orientation is improved by dividing the space into small parts, providing locations with identities that are easily remembered, and signposting the pathway forward.

2. Route decision selects a pathway to the desired destination. Wayfinding may need to be adaptive, so shorter routes and the minimisation of navigational choices is beneficial.

3. Route monitoring tracks the selected route is heading towards the destination. Having pathways that have a clear beginning, middle and end, assists in connecting destinations.

4. Destination recognition enables the destination to be discerned. Destinations require clear and consistent identities.

(Downs & Stea, 1973; Lidwell, Holden, & Butler, 2010; Pūhoro Stem Academy, 2019; Spiller, Barclay-Kerr, & Panoho, 2015).

The next four sections relate to each stage of the wayfinding process to signpost a pathway forward.

13. Orientation: Locating Māori Women

Māori women have a history of courageous, innovative and ground-breaking contributions to the political, social, cultural, environmental and economic landscape of Aotearoa. To locate Māori women in relation to their surroundings the role of pre-colonisation Māori women and examples of what is occurring among Māori across Aotearoa today, led by Māori women will be explored.

13.1. Māori Women as Guardians

The role of Māori women in cosmology and their unique power and influence on the creation of humankind is a common theme of tribal oral traditions in Aotearoa, with them often being responsible for ensuring that the creation of whakapapa was formed and maintained. Cosmology shows that Māori women were at the beginning and the end of life; for example, Papatūānuku at birth and Hine-nui-te-pō after death (Ruwhiu, 2009). For Māori midwives it is a privilege to carry the mantel of their whakapapa.

Pre-colonisation the status of Māori women was to maintain the integrity of the group, and for the whānau, hapū and iwi to survive and flourish balance between male and female attributes had to be upheld (Walker, 1990). Both men and women were essential components of the collective whole, with each having their own intrinsic value (Mikaere, 1999).

Māori women were guardians of Māori spirituality and were able to link the past with the present and the future (Jenkins, 1992; Mikaere, 1999, 2003; Ruwhiu, 2009). Within the whānau, hapū and iwi, Māori women played a critical role as whare tangata and whare mātauranga. Māori women were tohunga, matakite and could hold chiefly roles; they were instigators and peacemakers during tribal warfare and were able to revert a situation from tapu to noa (Ruwhiu, 2009).

The leadership roles that Māori women held are described in literature and oratory narratives such as waiata and pūkōrero. Some Māori women became leaders through whakapapa and others through the need to save their people or lead their iwi into prosperity. Māori women were known for their ability to create ideas that advanced their people (Ruwhiu, 2009). The flexibility of Māori women enabled them to negotiate disputes or issues constructively (Madden, 1997) and their role depended on balance and harmony, and regular communication and interaction with others in the community (Mikaere, 2003).

The main function of whānau was to form whakapapa by procreating and nurturing children, of which women had a considerable role (Walker, 1990). As an investment in the future, children were nurtured

and taught specific rules and regulations, knowing that they would pass on their learnings through the generations (Morehu, 2005; Ruwhiu, 2009).

For Māori women, birth often took place in a designated dwelling called a whare Kohanga, or outside in the open space (Mikaere, 1994; Wepa & Te Huia, 2006). Māori birthing women were attended by those with the skill and purpose for being present, often described as being other women. Tohunga with technical knowledge of the birth process were responsible for supporting the woman and for reciting whakapapa throughout the birth. Although support for Māori birthing women may have included men, only the hoa rangatira of the woman would make contact with the abdomen and genital region (Makereti, 1938; Ruwhiu, 2009).

The spirituality of Māori women was practiced within childbirth processes, particularly where they were able to connect the physical and spiritual worlds through karanga (Ruwhiu, 2009). Karakia was recited to Hine atua such as Hine-te-iwaiwa, the goddess of childbirth to ease the birth (Mikaere, 1994). Labour and birth was further supported by an atmosphere described as one of storytelling, waiata, laughter, rongoā Māori, mirimiri and warm baths (Wepa & Te Huia, 2006). Generally, Māori women maintained a quiet control as they endured labour contractions, positioning themselves in a squatted position for birth (Makereti, 1938). The customs of old were to create an ambiance of relaxation for the woman and a welcoming environment for the baby (Madden, 1997).

The significance of whakapapa, leadership, transmission of knowledge and childbirth highlights the importance of Māori women and their role within whānau.

13.2.   Māori Women and Constitutional Transformation

Māori women have a history of politicking for their civil rights on behalf of their hapū and iwi. Meri Te Tai Mangakāhia, campaigned in 1893 for Māori women to be able to vote and run for office in Te Kotahitanga, the autonomous Māori Parliament. She argued that many Māori women owned or administered their land, and that men had not been successful in protecting Māori land (NZ History Ngā Kōrero a Ipurangi o Aotearoa, 2018).

The pursuit of Models for constitutional reform are described in a report by an independent working group that was mandated by the Iwi Chairs Forum, which has representation of the Chairs of over 60 iwi organisations in Aotearoa. The Independent Working Group (IWG) was chaired by Professor Margaret Mutu alongside Dr Moana Jackson. Between 2012 and 2015 the IWG held 252 hui throughout the country to understand Māori views of different types of constitutionalism that is based

upon He Whakaputanga and Te Tiriti. There were also 70 wānanga convened by rangatahi for rangatahi.

The Terms of Reference (TOR) for The Independent Working Group on Constitutional Transformation were deliberately broad, stating:

To develop and implement a model for an inclusive Constitution for Aotearoa based on tikanga and kawa, He Whakaputanga o te Rangatiratanga o Niu Tireni of 1835, Te Tiriti o Waitangi of 1840, and other indigenous human rights instruments which enjoy a wide degree of international recognition.

(The Independent Working Group on Constitutional Transformation, 2016, p. 7).

The report by The Independent Working Group provides six different models for constitutional arrangement, with iwi and the Crown represented equally in each model, with various decision-making configurations.

13.3.   Māori Women and Whānau Ora

Whānau Ora was introduced as Government policy in 2010 under the Minister of Whānau Ora at the time, Tariana Turia.[30] The purpose of the Whānau Ora policy was to adopt a Māori solution to addressing health inequities for Māori by prioritising attention on individual and collective contexts and aspirations, rather than generic, prescriptive and ineffective solutions used by successive governments. Despite being under-resourced, Whānau Ora has seen remarkable results but ten years on, the Government reneged on a promise for increased funding.

Dame Tariana Turia, Dame Rangimārie Naida Glavish, Merepeka Raukawa-Tait, Lady Tureiti Moxon and Dame Iritana Tāwhiwhirangi, filed the Wai 2948 Whānau Ora Commissioning Agency claim to the Waitangi Tribunal on the 31 January 2020 on the grounds of a contemporary breach of Te Tiriti. The withholding of funding for Whānau Ora Commissioning Agency services under the current Minister of Whānau Ora is central to the claim.

13.4.   Māori Women and Iwi Aspirations

The Manahautū Chief Executive of Te Rūnanga o Ngāti Awa is Leonie Simpson, and 50% of Te Rūnanga o Ngāti Awa Board of Hapū Representatives are Māori women (Te Rūnanga o Ngāti Awa, 2019).

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[30] Dame Tariana Turia received a Dame Companion of the New Zealand Order of Merit in 2015 for her services to Parliament.

Engagement with Ngāti Awa whānui in 2008 by Te Rūnanga o Ngāti Awa identified iwi aspirations into 2050. Ngāti Awa of all ages were united in their view that the survival and revitalisation of their identity and culture into the future was paramount. Ko Ngāti Awa Te Toki - Our Iwi Vision 2050 is presented within Te Tirohanga Whakamua: Our Future Looking Ahead, an online video. The video includes aspiration statements from whānau; including:

This is my time, this is your time, this is our time.

We want to have a living culture, a culture that is vibrant, where we have confidence and pride in who we are and where we are from.

Education is also important, it creates opportunities, we need to achieve higher levels of education, it's about reaching your potential, we need access to educational and training institutions that are right for us, and we need more Māori teachers.

Toi Ora represents optimum wellbeing and that's about reaching our potential, our dream is to be able to fully engage in the world around us while maintaining our unique identity, and to achieve lifelong health and wellbeing for ourselves and our whānau.

My culture is important to me and as a Māori, I want to represent my culture at the highest levels.

Together, we can achieve these visions.

(Te Rūnanga o Ngāti Awa, n.d.).

The CEO of Te Whakakitenga o Waikato Incorporated that represents the statutory rights and interests of Waikato-Tainui and ensures the growth of benefits for future generations is Donna Flavell. Prior to Donna Flavell's appointment Parekawhia McLean was the CEO.[31] Two representatives from each of the 68 Waikato-Tainui marae are elected to form Te Whakakitenga o Waikato tribal parliament (Waikato-Tainui, 2020).

Waikato-Tainui recognise that future generations will live in a significantly different world than the present day. Informed by this, Waikato-Tainui embraced an approach for moving forward that focuses on developing their people. Whakatupuranga Waikato-Tainui 2050 is the blueprint for cultural, social and economic advancement for the people of Waikato-Tainui (Te Arataura Te Kauhanganui o Waikato

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[31] Te Whakakitenga o Waikato Incorporated was previously named Te Kauhanganui Incorporated until March 2016.

Inc, n.d.). Three fundamental elements Waikato-Tainui have identified to equip future generations with the capacity to shape their own future are:

1. A pride and commitment to uphold their tribal identity and integrity.
2. A diligence to succeed in education and beyond.
3. A self-determination for socio-economic independence.

Determination to develop and grow tribal assets referred to in point three is consistent with the vision inherited by Waikato-Tainui from Kiingi Taawhiao, which states "Maaku anoo e hanga i tooku nei whare - to build our own house in order to face the challenges of the future" (Te Arataura Te Kauhanganui o Waikato Inc, n.d., p. 2).

Goals that are identified by Waikato-Tainui include having 85% of their iwi members aged 18 to 64 years old gain a level two NCEA qualification or equivalent and to have 75% of tribal members earning the median income. Another goal for Waikato-Tainui is to have 80% of tribal members increase their proficiency in te reo to fluent and for 100% of tribal members to know and practise tikanga and kawa (Te Arataura Te Kauhanganui o Waikato Inc, n.d.).

13.5.   Māori Women and Health Strategy

In 2019, Tricia Keelan, in her role as the General Manager Māori Health Gain and Development, and later, the Manukura Executive Director Toi Ora at the Bay of Plenty District Health Board (BOPDHB), led the co-design and implementation of Te Toi Ahorangi 2030. Te Toi Ahorangi 2030 is the Toi Ora Strategy determined by Te Rūnanga Hauora Māori o Te Moana a Toi (Te Rūnanga). Te Rūnanga represents 17 of the 18 iwi within the region of Te Moana a Toi and is the mandated Tiriti partner of the BOPDHB (Te Rūnanga Hauora Māori o Te Moana a Toi, 2019).

Te Toi Ahorangi has been endorsed and adopted by the BOPDHB and is one of the DHBs two core strategic plans (Te Rūnanga Hauora Māori o Te Moana a Toi, 2019). The BOPDHB say they "…want to be the first genuinely Te Tiriti led district health board" (Te Rūnanga Hauora Māori o Te Moana a Toi, 2019, p. 3).

Achievements of Te Toi Ahorangi 2030 include:

1. Strategic ownership of Te Tiriti at BOPDHB.
2. Partnering with iwi and Māori to achieve their aspirations for health and wellbeing.
3. Partnering with the BOPDHB CEO to lead paradigm shifts towards the Toi Ora vision.

4. Manukura role being a member of the Executive Leadership Team and partner to the organisation's CEO.

5. A full contingency of Toi Ora Māori leadership for the new Māori Health Gains and Development Service Group structure.

Māori make up 25% of the population served by the BOPDHB. Te Toi Ahorangi affirms the unified vision, voice and intention of tangata whenua and sets a clear direction for BOPDHB to achieve whole-of-system transformation and improve the wellbeing of Māori in Te Moana a Toi to achieve Toi Ora (flourishing descendants of Toi) (Te Rūnanga Hauora Māori o Te Moana a Toi, 2019).

The success of Te Tiriti partners, Te Rūnanga and the BOPDHB, and Te Toi Ahorangi will be measured by improvements in the lives of Māori residing in the Bay of Plenty region (Te Rūnanga Hauora Māori o Te Moana a Toi, 2019).

13.6. Māori Women and Equity

Te Rōpū Wāhine Māori Toko i te Ora (Māori Women's Welfare League Inc [MWWL]) was formed in 1951 and is the only national Māori Women's organisation in Aotearoa. The MWWL promotes Māori women's leadership led by current president, Prue Kapua. The first MWWL President was Whina Cooper[32] and Princess Te Puea was the Patron, and they began the relationship between the MWWL and the Kiingitanga (Te Rōpū Wāhine Māori Toko i te Ora Māori Women's Welfare League Inc, 2015).

MWWL branches throughout Aotearoa have their own structure and are the foundation of the organisation which has a focus on driving the achievement of wellbeing for wāhine, whānau and tamariki. In 2019 the MWWL had 156 branches and 1,872 members (Te Rōpu Wahine Māori Toko i te Ora Māori Women's Welfare League Inc, 2019). Aotearoa Māori Netball and Māori Women's Development Incorporated (MWDI) were established by the MWWL (Aotearoa Māori Netball, 2020; Māori Women's Development Inc, 2019).

In a commissioned report to the Department of Internal Affairs in 1960, multiple health and socioeconomic gaps between Māori and non-Māori were identified and social reform including the relocation of Māori from rural to urban areas was recommended and became official Government policy (Hunn, 1961; Meredith, 2015). In 1984 the MWWL conducted the first quantitative research to be undertaken by Māori for Māori and about Māori in Aotearoa.

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[32] Dame Whina Cooper received a Dame Commander of the Order of the British Empire in 1981 for her services to the Māori people.

Findings of the MWWLs ground-breaking research raised concerns about the health and wellbeing of Māori women that includes abuse and violence in the home, and the rise of preventable illnesses caused by cigarette smoking, alcohol and obesity (Rehu-Murchie, 1984). Thirty-six years on, findings of the MWWLs research continues to cause major concerns for the health and wellbeing of Māori women in Aotearoa.

In 1993 Dame Areta Koopu, Dame Whina Cooper, Dame Mira Szaszy, Dr Erihapeti Murchie, Dame Georgina Kirby, Violet Pou, Dame June Mariu, Hine Potaka, and Aroha Reriti-Crofts filed a contemporary claim, WAI 381, with the Waitangi Tribunal on behalf of the MWWL. The basis for the WAI 381 claim being the Crown has prejudiced Māori women by depriving them of their spiritual, cultural, social and economic wellbeing, and the Crown failed to meet its obligations to uphold the rangatiratanga of women under Te Tiriti.

Since the MWWL WAI 381 claim, a series of claims to the Waitangi Tribunal by Māori women have been filed on the basis of further injustices for Māori women, which will be collectively heard under a combined Mana Wāhine Kaupapa Inquiry, Wai 2700 (Kahui Legal, 2020).

Te Rūnanga o ngā Toa Āwhina represents the Māori membership of The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (PSA). PSA are the largest union in Aotearoa, representing more than 75,000 workers in central and local government, state-owned enterprises, health boards and community groups (Public Service Association Te Pūkenga Here Tikanga Mahi, 2020).

Included among the range of enquiries that span breaches of Te Tiriti concerning Māori women's health and housing, is a claim, WAI 2864, filed by Georgina Kerr, Llani Harding, Paula Davis and William Newton on behalf of Te Rūnanga o ngā Toa Āwhina. Te Rūnanga o Ngā Toa Awhina claim that breaches of Te Tiriti continue to have a detrimental impact on the mana of Māori women as a result of inequities they face in employment including pay equity. The WAI 2864 claim will now be heard as part of the Mana Wāhine Kaupapa Inquiry, WAI 2700 (Waitangi Tribunal Te Rōpū Whakamana i te Tiriti o Waitangi, 2019a, 2019c).

The Health Services and Outcomes Kaupapa Inquiry, WAI 2575, is a thematic based enquiry on health-related issues that is to be heard in three stages.

Stage one of the Inquiry was targeted into the policy and legislative framework of the Primary Healthcare system, in particular hearing from the Māori primary health organisations and providers which is WAI 1315 and the National Hauora Coalition which is WAI 2687.

The Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry was released to the public in July 2019. A letter to the Minister of Health, Dr David Clark, the Minister for Māori Development, Nanaia Mahuta, and the Attorney-General, David Parker was within the report. The letter states:

> Our stage one report addresses claims concerning the way the primary health care system in New Zealand has been legislated, administered, funded, and monitored by the Crown since the passing of the New Zealand Public Health and Disability Act 2000 ('the Act').
>
> The stage one claimants alleged that the primary health care framework has failed to achieve Māori health equity and is not sufficiently fit for that objective in its current state. The claimants raised concerns about the role of, and resourcing for, Māori primary health organisations and health providers, broadly arguing that Māori are not able to exercise tino rangatiratanga in the design and delivery of primary health care.

> (Waitangi tribunal Te Rōpū Whakamana i te Tiriti o Waitangi, 2019b, p. xii).

> We have made two overarching recommendations, that:

> (a) The legislative and policy framework of the New Zealand primary health care system recognise and provide for the Treaty of Waitangi and its principles. To that end, we recommend an amendment to the New Zealand Public Health and Disability Act 2000 to include a new Treaty of Waitangi clause. We have also gone on to recommend several principles for adoption and use in the primary health care sector.

> (b) The Crown commit itself and the health sector to achieve equitable health outcomes for Māori. To that end, we recommend an amendment to section 3(1)(b) of the New Zealand Public Health and Disability Act 2000.

> (Waitangi tribunal Te Rōpū Whakamana i te Tiriti o Waitangi, 2019b, p. xv).

Stage two has commenced with tribunal commissioned research comprising four reports, one that is focused on Māori mental health including suicide and self-harm, another report is focused on alcohol, tobacco and substance abuse for Māori, the other two reports are concerned with Māori with disabilities. All four reports were completed in 2019. Stage three is yet to commence (Waitangi tribunal Te Rōpū Whakamana i te Tiriti o Waitangi, 2019b).

It is important for midwives to understand the inequities experienced by Māori women, babies and whānau across all determinants of health and the political processes aimed at addressing them to facilitate improved health and wellbeing for Māori.

14. Route Decision: Six Signposts for Revolutionary Change

14.1. Tiriti-led Partnerships

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

The discourse that midwives work in partnership with women is embedded in professional and regulatory frameworks for midwifery, and underpins the Partnership Model of Midwifery Practice in Aotearoa (Guilliland & Pairman, 1995; New Zealand College of Midwives Te Kāreti o ngā Kaiwhakawhānau o Aotearoa, 2015). The midwifery profession has overlooked a critical step in formulating its Partnership Model of Midwifery Practice by omitting to forge a Tiriti-led partnership between Māori and Pākehā midwives first and foremost, as a pre-requisite to a Tiriti-led midwifery service for women.

The Midwifery profession must start favouring Māori in its policies, strategies, programmes, services, and balance of power, with a view to eliminating inequities for women that are served by midwives, and to address inequities for Māori in the midwifery profession (Health Quality and Safety Commission New Zealand Kupu Tauranga Hauora o Aotearoa, 2019). It is indefensible for the midwifery profession to continue the status quo. A Tiriti-led partnership to lead the midwifery profession is well overdue. It is time for midwives to move the profession to one that is Tiriti-led and to do so, presents several challenges.

The first challenge in moving the midwifery profession to one that is Tiriti-led is to determine who the Tiriti partners are and on what grounds they are the Tiriti partners. The existence of counterproductive behaviour will not serve the conquest of this challenge. Preferential conversations by leadership with colleagues they like, so as to avoid, those they do not like, will achieve little. Any past grievances between groups of midwives need to be reconciled, and midwives who assess another according to their own measure need to consider their own stereotypes. Poor treatment of women by women is contrary to a woman-centred ethic.

The second challenge is for the partners to determine the purpose of a Tiriti-led partnership. Building relationships and enabling each other to realise their full potential should be the main focus of the partnership. Eliminating inequities will naturally arise from strategic collaboration.

A third challenge is to discuss the terms of the partnership. The structures, systems and policies that the midwifery profession has developed over time will be tested and changes should be anticipated from the outset. Co-designing and co-driving a deliberate cultural shift in the midwifery profession's operational landscape is the starting point.

A Tiriti-led partnership requires equal representation, courage and an authentic intention to trust in the process, have faith in collective intelligence, communicate, compromise and negotiate in a way that is mana enhancing for each partner.

14.2.   Māori Data Sovereignty

Data is a taonga that is of strategic value to Māori (Te Mana Raraunga Māori Data Sovereignty, n.d.-b). Due to the open data environment in Aotearoa there is a need for Māori rights and interests in data to be protected. In alignment with Te Tiriti and the United Nations Declaration on the Rights of Indigenous Peoples, Māori data sovereignty asserts the right for Māori to have governance over Maori data to support the realisation of Māori and iwi aspirations (Te Mana Raraunga Māori Data Sovereignty, n.d.-a).

Over the course of this literature review, three major data issues have been identified which are:

1. Data discrimination: Women and babies in Aotearoa are assigned risk profiles such as the NZDep. Māori women and babies are at higher risk of having high risk profiles assigned to them in comparison to their non-Māori counterparts. Such risk profiling has the potential to prejudice the service that Māori women, babies and whānau receive.

2. Data misuse: Māori data while collected is not always used. There were difficulties accessing information because data often resided with multiple institutions and at times was inconsistent. Brevity and a lack of critical data analysis pertaining to Māori was common, and therefore it is puzzling as to whether data is actually being used to facilitate timely decision making of solutions focused interventions. The unwillingness of some stakeholders to provide pertinent data also raises questions about their commitment to upholding Te Tiriti and urgently addressing inequities for Māori.

3. Māori data sovereignty: It was not evident how Māori governance over Māori data is being implemented. It is possible that organisations are not aware of Māori aspirations for data sovereignty that are described in Te Mana Raraunga Charter (Te Mana Raraunga Māori Data Sovereignty, n.d.-b) and therefore do not have in place Māori data governance arrangements.

Investment in timely, current, comprehensive and robust reports on the state of the midwifery profession and maternity outcomes for women and babies should be a priority. The development of a centralised repository for all data associated with the maternity sector would assist with literature review and data analysis to inform planning and priority setting, and resource allocation.

14.3.   Māori Midwifery School

Under the Education Act 1989 the Minister of Education is required, as part of the tertiary education strategy, to set out the Governments long-term strategic direction for tertiary education that must address the social, economic and environmental goals, and development aspirations of Māori (New Zealand Government Te Kāwanatanga o Aotearoa, 2020, Section 159aa).

Māori Midwives have long been dissatisfied with the single midwifery education pathway available in Aotearoa that is dominated by western ideals of childbirth and midwifery knowledge. Across all midwifery schools in the last 10 years, on average only 20 to 25 Māori midwifery students each year completed a midwifery degree. Even with the addition of VUW now offering an undergraduate midwifery programme, there is room for another midwifery school. A Māori midwifery school will focus on increasing Māori enrolments through to completions that will aide in reaching the additional 37 completions required per year from 2021 to reach the MOHs 2029 Māori midwifery workforce goal.

In alignment with themes identified throughout this literature review and requirements of the Minister of Education, the establishment of a Māori midwifery school would achieve:

1. Social: Facilitation of increased fluency in te reo Māori; exposure to Māori health systems and structures; and strengthened understanding of Te Ao Māori paradigms to inform and enhance midwifery practice.
2. Economic: Investment into quality teaching and unique resources; development of Māori intellectual property; and advancement of Māori midwifery workforce capacity and business acumen within a Te Ao Māori context.
3. Environmental: Increased capacity for Māori midwifery scholarship, research, leadership and political diplomacy; promotion of professional relationships and a place to belong and thrive, and appropriate curriculum content, educators and education practice informed by Māori methodologies.
4. Development aspirations: a Māori midwifery school that is governed and led by Māori with Māori content and educators that upholds the intent of Te Tiriti within the midwifery profession and facilitates success in higher education for Māori students.

14.4.   Cultural Competence Framework Review

The purpose of Cultural Competence is to ensure that women and babies are safe under the care of midwives (Midwifery Council of New Zealand Te Tatau o te Whare Kahu, 2011; New Zealand Government Te Kāwanatanga o Aotearoa, 2019a; Ramsden, 2002). There is strong evidence that a review of the midwifery Cultural Competence framework is needed.

On balance, inconsistencies exist in Cultural Competence curriculum content and assessment criteria within pre- and post-registration midwifery education and the recertification programme. An evaluation of the current midwifery Cultural Competence framework and the introduction of an outcome measure and monitoring system is yet to occur. Identified inadequacies challenge the rigour being applied to Cultural Competency in the midwifery profession and provides an opportunity for redress. A Tiriti-led exploration of the Cultural Competence framework will assist to reaffirming underlying intentions and in turn, formulate a comprehensive framework to uphold those intentions.

14.5.   Māori Midwifery and Childbirth Research

Māori midwives need a repository of Māori knowledge to inform their midwifery practice and facilitate their learning from a Te Ao Māori perspective. Research is an important tool to develop what is known about the childbirth continuum and research can help Maori midwives to test their ideas, better understand, and increase public awareness of issues relevant to Māori women, babies and their whānau.

Increasing the opportunities for Māori midwives to progress into supported postgraduate study will facilitate their discovery of research as a focus for their career and should form part of a deliberate indigenous research programme within the midwifery profession. Māori midwives doing research need to know where to access financial assistance if it is not available within the profession; they should have opportunities for guidance and mentorship from experienced Māori midwife researchers; they need exposure to Māori research methods; and they need opportunities to attend Māori research forums for their professional development.

14.6.   Māori Midwifery Leadership Capacity Building

This literature review highlights that in the broader Māori landscape, Māori women are highly competent and trusted to lead their people into the future, they run billion-dollar organisations, spear-head political challenges, and innovate the co-design of strategic pathways with Tiriti partners.

Māori midwives are exposed to positive and high-performing Māori female leadership role models outside of midwifery, which is a stark contrast to their experience in midwifery.

A critical mass of Māori midwifery leadership is necessary for succession planning. Leadership plays a pivotal role in guiding organisational performance and results. Leadership practices are often culture specific and should not be confined to institutional structures, titles and positions. Midwifery should be developing its own brand of leadership to cultivate leadership prowess across the midwifery profession and a psyche of high performance that advances the potential of midwives and facilitates the growth of leaders with functional expertise and relevant sector experience.

Many midwives self-manage their careers simply by moving from employment to self-employment. A portfolio career is built around a collection of skills and personal interests with career self-management being a consistent theme, which is a working style well suited to midwifery.

A leadership strategy that focuses on assisting midwives to develop portfolio careers would enable them to learn specialised skills and move from one functional learning opportunity to another within the context of midwifery. Māori midwives have previously articulated their leadership aspirations (Te Rau Matatini, 2009) and a wider conversation is necessary to enable this to be achieved within the profession. The midwifery profession should collaborate with, for example, Māori health and workforce organisations, iwi, DHBs, HWNZ, the MOH, the Ministry of Education, and the Ministry for Business, Innovation and Employment on a collective strategy to foster conditions that optimise the talents of Māori midwives across the whole sector, and accelerates a competitive advantage for Māori midwives.

Tables 10 and 11 provide examples of the leadership qualities that are required of future Māori leaders.

Table 10: Attributes of Māori Leadership

Good Leaders	Bad Leaders
Are servants of their people	Make their people become servants
Encourage unity so people can work together	Create division amongst their followers in order to strengthen their position
Realise the dream and aspirations of their followers	Are more interested in their own dreams
Join other networks so that their followers can have greater opportunities	Develop walls so that outsiders cannot get in and insiders cannot get out
Explore the future so that their followers can move with the times	Resist change and cling to the past
Develop others so that they can take up leadership roles	Are threatened by new leaders
Earn respect and loyalty from their followers	Demand respect and loyalty from their followers
(Durie, 2018; Te Ahurei a Rangatahi, 2017).	

Table 11 provides detail of a Māori women's perspective of leadership qualities.

Table 11: A model of leadership from Māori women's perspectives

A Model of Leadership Qualities from Māori Women's Perspectives	
Mahia te mahi	Leaders just get on and do what needs to be done. This is about work ethic, discipline, commitment and tenaciousness. This is about staying focused on what needs to be done and seeing it through to completion.
Ako ki te whakarongo, whakarongo ki te ako	Leaders are good listeners. They learn to listen and listen to learn.
Aroha o tētahi ki tētahi	Leaders are respectful and caring of others supporting them to realise their potential, celebrating achievements and recognising the contributions of others.
He oranga ngākau, he pikinga waiora	Leaders are passionate, enthusiastic and positive. They are clear about their mission. When guided by their heart they have a sense of wellbeing. This is about doing the right thing.
Whakapapa	Leaders know who they are and where they are from. They are grounded and connected. They have a heightened sense of awareness of self and others.
Te kai a te rangatira, he kōrero	Leaders understand the importance of meaningful and regular communication to mobilise and sustain action and support over time.
Ngā ahuatanga Māori	Māori leaders understand the importance and relevance of using Māori frameworks for planning, design and decision-making that have their origins in Māori values, concepts and perspectives.
Kaitiakitanga	Leaders are committed to serving the needs of others. This is also about nurturing leadership within others, or succession planning, to enable them to come through.
Mehemea ka moemoeā ahau ko ahau anake, mehemea ka moemoeā a tātou, ka taea tātou	Leaders do not lead by themselves but with others making it possible to achieve great things thus blurring the leader-follower distinction.
Whanaungatanga	Leaders create a strong sense of interconnection and belonging – a sense of community based on mutual respect and responsibility. The sense of community shows through leaders and followers working together for the collective good and is also reflected through the interconnectedness to whānau, hapū and iwi.
(Reynolds, 2013).	

Pīngao ki te Tū, Tūturiwhatu ki te Tai
Accelerating Revolutionary Change in Māori Midwifery

From	To
• Colonisation • Siloed empire building • Division • Mātauranga at the periphery • Māori deficit	• Oritetanga • Taumata kotahi • Kotahitanga • Mana mātauranga • Mauri ora

• Racism • System that contributes to inequities • Western philosophical prioritisation • Under-resourcing • Personal agendas • Strategic disarray • Māori maternity outcome disparities • Under-representation of Māori midwives • Poor data collection, analysis and utilisation • Cultural competence rhetoric • Loss of collegial respect • Exploitation and disregard of Māori intelligence and technology	• Equality • Challenge the status-quo to achieve system equity • Change the perception of Māori philosophy • Fair and deliberate investment in Māori midwifery • Accountability for decisions and actions • Transparent and authentic communication • Shared guardianship of birthing outcomes • Cohort approach to recruitment and retention • Data affects revolutionary change • Professional integrity • Reconciliation of grievances – 'clean slate' • Mātauranga Māori and Māori values at the core of midwifery psyche

Opportunities

• Co-design a Te Tiriti-led midwifery profession
• Support Māori data sovereignty and a central repository
• Establish Māori tertiary institution-based midwifery schools
• Correct cultural competence standards and sector implementation
• Conduct and utilise Māori midwifery and childbirth research evidence
• Develop Māori midwifery leadership and create positions of influence

Actions

• Secure Government funding to resource an independent working party to lead the pursuit of opportunities in 'Pīngao ki te Tū, Tūturiwhatu ki te Tai'
• Convene an independent team to develop Terms of Reference (TOR) for the working party that includes a member appointment process

16.   Destination Recognition

In alignment with the stages of wayfinding 'Pīngao ki te Tū, Tūturiwhatu ki te Tai' is a whakataukī and a framework that provides a destination for which the midwifery profession can aspire to realise.

The destination will be reached, and the success of Te Tiriti-led partners will be measured by improvements in the Māori midwifery workforce and maternity outcomes for Māori women, babies and whānau in Aotearoa.

17.   Barriers to Revolutionary Change

- There is no Tiriti-led partnership to lead the midwifery profession.

- The Māori midwifery workforce is under-represented in all areas.

- Māori midwifery and organisations, such as Ngā Māia are under-resourced.

- There is no Chief Midwife or Midwifery Director who is Māori in any of the 20 DHBs (New Zealand College of Midwives te Kāreti o nga Kaiwhakawhānau o Aotearoa, 2019).

- There is no Head of School that is Māori in any of the five midwifery schools.

- There is no full-time permanent Māori midwife working in a strategic leadership position within NZCOM, MMPO MERAS or the Midwifery Council.

- The midwifery Cultural Competence framework is overdue for review.

- Midwifery schools lack capacity to support first language te reo Māori speakers to undertake their education journey in te reo Māori.

- The Midwifery Council National Examination is only available in English.

- Institutional Racism.

- Undermining of equal rights; for example, employment interview and appointment processes, and selective inclusion and exclusion of Māori midwifery representation in planning, negotiations and decision making.

- No Māori midwifery school or Māori curriculum to cater for Māori students.

- Same voices on the decision-making tables and in positions of influence.

- No collective Māori midwifery workforce strategy.

- No collective Māori health strategy by midwifery.

- No collective Māori midwifery leadership strategy.

- Poor critical data analysis and utilisation.

- Māori-deficit stereotypes.

- Disregard for Māori intellectual discourse.

- Disregard for Māori technology, such as muka and wahakura.

- Pākehā determination over Māori knowledge (New Zealand College of Midwives te Kāreti o nga Kaiwhakawhānau o Aotearoa, 2018).

- Lack of pathways to grow Māori midwifery research capacity.

18. Conclusion

Rapua te Aronga-a-Hine has gone beyond the brief for this literature review to unbundle the multiplexity of the Māori midwifery landscape in Aotearoa.

This is the first ever comprehensive literature review of Māori midwifery that explores the inter-connections between midwifery education outcomes and workforce recruitment and retention; the cumulative effect of an under-represented workforce on maternity services provision; the potential consequences on an already underserved Māori community; and the absence of an authentic Tiriti-led partnership within the profession for Māori midwives.

By locating the full extent to which Māori women, babies and whānau are served by midwives, the literature review has illuminated the urgency for revolutionary change to address the needs of whānau and the needs of the Māori midwifery workforce to support them.

This literature review provides a corpus of information for the midwifery sector and should be the impetus to work together to elevate the mana of Māori women, and to do better.

19.   References

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