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Iho – a cord between two worlds.
Traditional Māori Birthing Practices.

Kelly Tikao

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Science Communication

Centre for Science Communication, University of Otago, Dunedin, New Zealand

December, 2012
Iho
a cord
between two worlds

Kelly Tikao
Whakarāpopotanga / Abstract

Traditional Māori birthing practices are a fascinating insight into how Māori once lived, survived and perceived their world. This thesis aimed to take a closer look at traditional Māori birthing practices and rituals that aided pregnancy, labour and birth. Providing more knowledge on this take (subject matter) and highlighting the relevant health strategies already in place, could aid the potential recognition and integration of traditional Māori birthing knowledge into all maternity services. This course of action could potentially contribute towards the improvement of hauora Māori (Māori wellbeing) and bridging the gap between Māori and non-Māori health inequalities.

Information collected through qualitative interviews with 20 Māori participants aged between 26 – 86 years and representing a range of iwi and hapū are presented alongside knowledge obtained from the small yet rich array of literature.

A kaupapa Māori framework assisted collection and analysis of the information shared by participants. This was deemed the most appropriate and relevant framework to use for this study. An explanation is given in this thesis as to what is a Kaupapa Māori framework and how it was utilised in this piece of research.

A story of how the world was created according to my Great Grandfather is shared, alongside other known deities representing birth and conception in Te Ao Māori (the Māori world). The rest of the information provided by the participants or found within the literature is pan tribal.

The heart of the thesis focuses on traditional Māori birthing practices and rituals - what were these practices and why did Māori follow these traditions? The thesis then moves to consider possible reasons for why Māori strayed from their own birthing knowledge and practices, in favour of Western medical birthing models.

An overview of New Zealand’s midwifery history and the role of Māori kaiwhakawhānau (birth attendants) prior to colonisation and our Māori midwives registered currently is elaborated on in the later chapters.

The creative component of the Masters of Science Communication Degree was to produce a 25-minute documentary that complimented the theme of this thesis. The film, "Iho – a cord
between two worlds" provided a synopsis of what are traditional Māori birthing practices told through the sharing of birthing experiences of four Māori whānau. The use of drama, interviews, archival images, filmed workshops and footage that captured intimate birthing moments, allowed the knowledge within the film to be expressed.

Like the cycle of life, this thesis concludes with a return to the beginning, a rebirth, and a look at what has been learnt from this research, from those who have shared their knowledge and memories for the purposes of this study; and within previously recorded literature. Once this knowledge has been established the question then becomes, will midwives, Māori whānau, medical professionals and District Health Boards take this knowledge, grow it and implement traditional Māori birthing practices into the services they provide. This will ensure such services meet their obligations to their overarching Health Plans and would ultimately allow them to have an exciting influence on ensuring whānau Māori have a positive and enriched birth experience.
Ngā Mihi / Acknowledgements

To my whānau who have endured the last so many years of my constant need to pursue this “take” (subject matter) and find time to: plan, research, film, refilm, write, rewrite, edit and present. This is a team project and I am glad that this little piece of mother’s guilt about not being fully there for my tamariki (children) will be reduced upon the completion of this Masters degree.

Rihari, Karamū, Wairāmia, Hinekaea, Toi and Maio you keep me grounded yet creatively you help me to fly. To my loving parents who were as determined as I was to get this thesis completed. He mihi aroha ki a koutou.

To all those people who shared their kōrero, their stories, their waiata, their memories and their visions. Your narratives bind this thesis together and make it so special.

Acknowledgement must also be given to those whānau, hapū, iwi and communities who continue to teach, resource and use traditional Māori birthing knowledge to enhance their own birthing experience and who understand the importance of keeping cultural traditions alive.

I would also like to mihi to all the amazing midwives that have guided, affirmed, shared, laughed and cried with my whānau during our four birth experiences. You all hold a special place in our hearts. Thank you for your trust and encouragement to include traditional Māori birthing practices within each of our birth journeys.
He Kura Pounamu/ Some precious people

Teone Taare Tikao, Maurice Gray, Huata Holmes, Kukupa Tirikatene, Bunny McClean, Awhitia Mihaere, Noi Hudson, Pereme Porter, Herena Stone, Brian Allingham, Roka Ngarimu-Cameron, Aroha Rereti-Crofts, Joanne Rama, Janet Taiatini, Amber Clarke, Nanny Bella Morrell, Tungane Kani, Priscilla Cowie, Leisa Aumua, Rua McCallum, Robyn Kahukiwa, Brigit Mirfin-Veitch and Jean Fleming.

(See Appendix #1 for more detail on these precious contributors to this body of work)

Mo Te Iwi Māori / Dedication

I would like to dedicate this thesis to all wāhine and tane Māori. Although we are Māori, we can walk different paths, from different tūrangawae, from different beginnings, from different realities yet bound by race and the right to know who we are and what gifts we have to share with all. Mana motuhake ki a tātou katoa.
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Kōmata - nipples
Kōrari - flax stalk
Kore - nothing
Kōrero - communication
Kōpū - womb
Kōtiro - girl
Kōwhaiwhai - rafter painting
Kupu - word
Mahi - work
Mako - shark
Mamaku - Black tree fern
Mana - divine right, influence, prestige
Mana Motuhake - autonomy, self-determination
Manāki - care for
Manu - bird
Marama - moon
Mātauranga - knowledge
Mauri - life principal, psyche
Mihi - greeting
Mihi whakatau - informal welcome
Mirimiri - massage
Moana - sea
Mokopuna - blueprint, tattoo, grandchild
Muka - flax fibre
Noa - free from tapu, ordinary, neutral
Pā - stockaded village
Panga - puzzle
Pānui - announcement
Papakainga - home village
Papatūānuku - earthmother
Pēpi - baby
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The Hapū Framework

I have structured this thesis to reflect a pregnancy (hapū) timeline. This allowed for the research gathered to be aligned with the timeline of birth such as: conception, pregnancy, birth and post birth. Consequently, the information in the first chapter titled, Ko te Tīmatanga / The Beginning represents a relationship. In this instance it is the relationship I have formed with this research project and the relationships I have with my immediate whānau, hapū and iwi. It is also my relationship with those who have been involved with my birthing experiences, those I have met through this project and those who have imparted knowledge to aid the recovery of indigenous practices. I then outlined the method used to gather the information from both the literature and participants and I briefly addressed the topic of mātauranga and Western science.

In Chapter Two, titled Te Kākano Tuatahi / The First Seed, the relationship formed in Chapter One has led to conception. The seed of life has been created and lays nestled in the warmth of the womb. The platform is now in place to share the story of creation told from a Southern perspective followed by the creation of the first wahine and her journey of discover and eventual departure to the realm of death.

Chapter three titled, Hapūtanga / Pregnancy represents the swelling of the whare tāngata (uterus) and the growing of the foetus inside the kōpū (womb). This is where I have placed the bulk of the thesis knowledge. This is the longest chapter and perhaps captures the essence of what this research project was about – collating traditional Māori birthing practices and rituals, in the hope that this knowledge base will attract more knowledge, more discussion, more awareness and ultimately more whānau practising these birthing processes. This chapter covers traditional Māori birthing practices and rituals used in Aotearoa prior to hospitalisation of births. It then addresses the decline in these practices and some probable reasons for this.

In Chapter four the pēpi is born, hence it is titled, Whānau Mai / Birth. This chapter looks at those the aid the pregnancy and consequent birth, the kaiwhakawhānau, the midwives and the Doctors. The historical maternity legislation that occurred instigating the
transition of birth from home to hospital through to the current working reality for Māori midwives and Māori midwifery students. Reclaiming of mātauranga Māori in a maternity setting will require more Māori midwives to remain in the profession and more students to grow their skills in this arena. There lies the answer and the challenge.

The fifth chapter looks more closely at the pēpi (baby) and for this project the pēpi refers to both the production of this thesis and the film *lho – a cord between two worlds*. This chapter allowed me to discuss the “pregnancy” and the “labour” or the growth and the challenges that took place in the crafting of the film and the post-production. It gave me the opportunity to provide the whakapapa to the film, the meaning behind it’s fabrication that perhaps may not be obvious to all who view it.

The final chapter, “Kei te tupu ake/ Growing Up” looks at where to from here. Once the child has been born, their growth, learning and understanding of self, and their place in this world. The thesis looks at what we can take away from what has been shared within this thesis and how can current Government Health policies and Health Services assist the potential integration of traditional Māori birthing practices into maternity services in Aotearoa. Allowing whānau to make an informed and supported decision about choosing components of traditional Māori birthing practices within their birthing plans, either in the home or clinical setting. Having this option could be an exciting step forward and one that aligns itself closely with the desired and promised outcomes of the Tiriti o Waitangi.

The thesis then concludes hypothetically around the same time, as a lead maternity carer would finish working with their client post birth. Thus, concluding the hapū cycle and allowing the pēpi and whānau to forge ahead as a whānau unit. This is the time that I, as the researcher, return to my whānau to reflect upon my own journey with this kaupapa, yet know that the journey of gathering knowledge is yet just a small bud and with more research around Aotearoa, listening, reading, observing the bud will puāwai (blossom) into another body of work that I hope can feed the desire by te iwi Māori to reclaim, restore and remember what knowledge we have always had.
He Whakatauākī / A Proverb

E kore e taea e te whenu kotahi ki te raranga i te whāriki kia mōhio tātou ki ā tātou.

The tapestry of understanding can not be woven by one strand alone.

Kukupa Tirikatene
Chapter 1: Ko te Tīmatanga / The Beginning

1. Ka Tīmata / Introduction

When I was hapū with my mātāmua (eldest boy) I asked a prominent Taua (older wāhine/grandmother) of my hapū about traditional Māori birthing practices and what I could incorporate into my first birth. She pondered briefly over my pātai (question) and then she looked me gently in the eye and said, ‘Ki a koe darling, ki a koe...” (over to you, over to you) and with that she smiled and gracefully turned and headed back to the hui. I was perplexed. Didn’t she know anything about traditional Māori birthing practices? Was she implying that I would instinctively know Māori birthing practices if I delved deep into my psyche? Was she telling me to do the research and find my own answers to this pātai?

This Taua has now long passed and I have since birthed more tamariki. In retrospect, I now understand her wero (challenge) to me and I offer it back out to the community with a similar wero, “Ki a tātou, ki a tātou”. It is now over to us all to contribute, support and sustain mātauranga Māori (Māori knowledge) for the wellbeing of all.
I wanted to produce a thesis and documentary about traditional Māori birthing practices, to highlight what these entailed and to prove that birthing practices and tikanga from Te Iwi Māori around conception and birth defy age and technology, and are still relevant in today's context. Not only are they relevant, but also I believe these practices can enrich the whānau birthing experience.

Probing into my past and meeting with Māori around Aotearoa provided the basis for this thesis. Learning about some of the more unique Māori practices around: conception, pregnancy and birth were both intriguing and enlightening. Producing a resource, such as the film, *Iho – a cord between two worlds*, provides a brief glance into some of the customs and knowledge in a contemporary context. It is the first of many steps needed to draw out information that may have been forgotten or not asked about for a very long time. The film and this thesis will also aid knowledge retention for Te Iwi Māori, in the hope that the knowledge shared in this thesis is empowering and practical for all who read.

For some, learning birthing knowledge can inform them of a past they perhaps never knew. It provides a potential link that may enrich a person's birthing experience if they have chosen techniques indigenous to Aotearoa. Not all Māori and non-Māori will want to incorporate Māori birthing practices and tikanga (customs) into their birthing experience, but all Māori and non-Māori should be offered the information to be able to make an informed decision.

In the book *Ukaipo - The Place of Nurturing Māori*, it stated that in this contemporary world it is important to remember that not all Māori are the same. We are all living very different lives with differing connections to our taha Māori (Māori heritage). Ukaipo applied the phrase "diverse Māori reality" to encapsulate the reality for Māori today (Rimene, Hassan, & Broughton, 1998, p.22).
Mason Durie (1994) says Māori generally fall into three broad groupings:

i) Some Māori are connected with a number of Māori networks. They have involvement with Kōhanga Reo, Marae, Kapahaka Roopu (groups), and Māori sports teams and can speak or understand Te reo Māori.

ii) Some Māori identify as Māori but may have limited connections with the Māori community and are integrated into mainstream society.

iii) Some Māori will identify as Māori but will not connect with any Māori organisation or any mainstream service. They become isolated from both the Māori and Pakeha society (Durie, 1994).

Having an awareness of this “diverse Māori reality” acts as a reminder to not assume that because traditional Māori birthing practices is something many Māori have shown an interest in, not all Māori feel the same.

The hope is to empower more wāhine Māori (Māori women) to use the maternity services that are offered but to also consider incorporating some birthing practices used by their ancestors.

I have presented this research, associated still images and the documentary, at a range of public gatherings and received very positive feedback, endorsing the need to learn more, to make the knowledge active again and to support this work in all birth settings.

The resurgence of te reo Māori (Māori language) has instigated the resurgence of mahi toi (Māori arts), rongoa Māori (Māori medicines) and other tikanga me mātauranga Māori (Māori traditions and knowledge), so that these taonga (treasures) are not lost to Te Iwi Māori and indeed to all New Zealanders (Himona, 1992; Pihama, 2001).

I include the documentary “Iho – a cord between two worlds” into the reclamation of taonga. The documentary talks about: pride, identity and responsibility. These are core values that are lacking in some of our youth in Aotearoa and many youth services have incorporated these values in various forms into their programmes. The ultimate goal being to uplift the mana (pride) of the young people, to have belief and courage to seek a pathway that is conducive to their own wellbeing and that of the society they live in (Adolescent Health Research Group, 2008).
This is also true, for learning traditional Māori birthing practices, as this is the kākano (seed, beginning) of identity. If we knew how our ancestors perceived conception, pregnancy/hapūtanga, birth and the tamaiti (child), we may have a better sense of our collective responsibility towards the child and towards the whānau unit with all roles valued.

Traditional Māori birthing knowledge has been passed down through the generations to hapū and whānau, but many hapū have over time lost a great amount of knowledge they once held. As the generations pass the remaining snippets of knowledge left may diminish even further. There is however, a growing interest by whānau Māori around Aotearoa who are very eager to explore traditional birthing knowledge and practices. The difficulty lies in accessing the information and guidance needed to incorporate the knowledge into their own birthing care.

What I have learnt from my own birthing journey feels small in comparison to what our tūpuna practised. Yet with each birth I incorporated another practice and perfected a practice I had previously used.

I am not a midwife and I do not write this thesis to give that impression. I have written from the perspective of someone who has had experience in the clinical and community health sectors as a registered comprehensive nurse.

I also write as a passionate Māori mother with a relative grasp of te reo Māori and tikanga. I am like many who struggle to learn and maintain Te reo Māori and tikanga Māori in an environment that doesn’t always support the official language nor encourage the use of it. I understand the inherent responsibility to my tūpuna and to my tamariki to keep this treasure alive and present, so that the pathway remains strong for all other taonga (treasures), to also be valued and conserved.

I come from a perspective of wanting to articulate and write about Māori practices that I believe are relevant in today’s birthing services. I do not write to persuade all to use traditional Māori birthing practices or to criticise processes that are currently insitu. More to understand how incorporating traditional Māori knowledge into our current health models can be beneficial for all and not too different to what is already in place.
Traditional Māori birthing practices and customs in the ancient world of Māori were woven into everything they did - the philosophies they lived by gave them boundaries and portals to other worlds: the respect they had for the environment that they depended on; the tribal warfare that was their reality and the oratory that forever linked them to their ancestors and tribal stories. Some rituals and practices in birth and concepts around birth were similar all over Aotearoa, yet others very different. Climate, natural resources, kainga (village) location, trading ability, illness, strength of hapū (sub tribe), access to tohunga (specialists) and rangatira (Chiefs) all had an impact on the language used to describe certain kawa (ritual), plants, objects, ngā atua (gods) and practices pertaining to birth (Gray, 2010).

I have chosen the kupu (word) “Iho” to describe the umbilical cord for this thesis and film. Pito is another term frequently used for the umbilical cord but is associated more often with the piece of umbilical cord nearest the pépi. Iho denotes the middle portion of the cord that connects the mother to the child and is reflective of a number of things: sustenance, old world - new world, light and dark, communication, the triptic threads representing the spiritual, physical and the whānau and so forth (Ngata, 2010). Another term used is: tāngaengae and according to Te Aka Dictionary, this kupu is associated with the cutting of the umbilical cord and ritual blessings for strength, (Hakopa, 2011; Moorfield, 2011) There will be other terms for umbilical cord that are specific to hapū and iwi that will not be mentioned in this project, but acknowledged in thought.

My goal was to gather and to analyse some of the knowledge written in literature and some from oral accounts to provide a source of information in both documentary style and in thesis form. I am aware that this is only a thimble full of knowledge that is known around these practices and I know like Chinese Whispers when knowledge gets transferred and transmitted by many mouths and through writings with cultural bias, then it does run the risk of being not quite right in some instances. By writing this information down and then talking about it to other whānau, midwives, midwifery students, hapū wāhine, wāhine, tane and Kaumātua, we can then collectively find some links, fill some gaps and ponder over other pieces of this research puzzle.
The principals of Kaupapa Māori Research framework embrace a Māori world view and my Māori world view is perceived through my Waitaha, Kāti Mamoe, Kāi Tahu affiliations, as a mother, researcher, art practitioner, nurse, broadcaster and student. I have also been guided by my life experiences and narratives shared to me by friends, colleagues, whānau whānui (extended family) and the research participants.

I understand my place in this research and that is as a kaimahi (worker) and not in any way an owner of the knowledge gained through this research project. The mana (pride) of this mātauranga rests firmly with Te Iwi Māori and those who are repositories of Māori tikanga (traditions) pertaining to childbirth. Each generation of Māori have an inherent responsibility, whether they are aware of it or not, to carry the knowledge of their tipuna through to the next generation. Therefore, this thesis and documentary are a contribution towards the continuum of Māor: mātauranga to today’s children.

Information has been collected from: tangata Māori (Māori informants), literature gathered from the libraries of The University of Otago, Auckland, Canterbury, Waikato and Massey and the Otago Medical library, Midwifery College of New Zealand, previous PhD’s and Masters thesis material, research reports and presentations, a variety of online resources, the National Library of New Zealand for archival images, waiata, oriori (specific creation and birthing lullabies) and karakia (incantations).
I have purposely chosen to use the word *information* rather than *data* in this thesis, as I feel it is a more respectful term to use, given that a good amount of knowledge has come from personal informants.

### 1.1 Kaupapa Māori Principles

Both the thesis and documentary have been guided by the principles of kaupapa Māori. These principles enabled me to approach the thesis topic appropriately and also informed the research methodology.

There is a growing group of Māori writers, thinkers, doers and inspirers who have surged forward with wānanga (workshops) sharing whakāro (thoughts) around kaupapa Māori, kaupapa Māori knowledge, kaupapa Māori theory and frameworks. They have aided in the reclamation of Māori knowledge and the mana motuhake (Māori sovereignty) that lies within mātauranga Māori (Māori knowledge) (Mahuika, 2008; Pihama, 2008; Simmonds, 2011; G. Smith, 1993; L. Smith, 2000).

Helen Mountain Harte (2008) says Kaupapa Māori research is about tino rangatiratanga (Māori sovereignty) and not having to define the intangibles but instead allowing them to hold their place as they are spoken. She says it starts and ends with the researcher and why they are pursuing their particular research, their links, their worldview, their ways of engaging with their research based on their own understanding of taha Māori (Māori perspective).

Kaupapa Māori is a very old concept. It’s origins according to Tuakana Nepe (1991), lie within the realm of Rangiātea where the first Whare Wānanga is located in the home of Io Matua Kore. Nepe said that Tane (the human male) brought the gifts of knowledge to earth via the three kete: te kete Tua-uri, te kete Tua-atea, te kete Aro-nui (see Chapter 3 for explanation of the three baskets of knowledge), Tane was able to transfer the intangible knowledge into the tangible (Nepe, 1991; Pihama, 2008).

It appears we have academics debating and writing about Kaupapa Māori theories and research frameworks in today’s context and at times applying analytical processes to assess the validity of kaupapa Māori philosophies in the place of science and research (Keenny, 2009; Mercier, 2007; Nepe, 1991; Pihama, 2001; G Smith, 1990; G. Smith, 1993; G Smith, 1997; L. Smith, 1999, 2000; L. Smith, Hudson, Tiakiwai, & Hemi, 2008).
Rangimarie Mahuika (2008) found that not all agreed that a kaupapa Māori approach was best for Māori as it was often perceived from the largest viewpoint and did not appear to take in the significant iwi, hapū and whānau differences. Mahuika said other critics have suggested that kaupapa Māori creates a “tribal elite” that can be oppressing to those not perceived to be in the elite iwi. Therefore instead of kaupapa Māori liberating all Māori, in short, it could have the potential to suppress some Māori whilst advancing others (Mahuika, 2008; Rata, 2006).

Graham Smith (2003) asserts that kaupapa Māori:

“Is not a rejection of Pākehā knowledge and or culture, however it does understand the critical factor of how knowledge can be controlled to the benefit of particular interest groups. Kaupapa Māori advocates excellence within Māori culture as well as Pākehā culture.” (G Smith, 2003, p.5).

Merena Taki broke down the word kaupapa to ka u papa. This interpretation gets to the essence of the origins, “ka” is a verb particle for an action about to begin, “ū” meaning breast or heart of something, connection, link, source, towards land, goal; “papa” meaning base, layers, sea lake bed and it is also strongly connected with Māori words such as Papatūānuku (earth mother) an tūpāpaku (dead body). This could be then interpreted as “adhering to the essence of the subject matter that may contain many meanings” (Pihama, 2008).

The dictionary description from PM Ryan defines kaupapa as a strategy and theme (Ryan, 1995). Although used frequently today to describe many scenarios the term kaupapa is extremely old. Academic and facilitator of Kaupapa Māori Research Hui/Wānanga and anthologies on the same, Leonoie Pihama speaks of kaupapa relating to the concept of foundation and philosophy. It provides an Māori worldview she says, and a base to place our values and beliefs upon that then can guide a way of operating.

Janet Taiatini, a midwife with over 20 years experience in Auckland and currently in Rotorua summisises that to activate kaupapa Māori research and dialogue with Māori is to acknowledge the importance of world view and that this encompasses the relationship Māori have with their Ao (their world), their taiao (their environment) as “kaitiaki (guardians) of the resources they utilise” (Taiatini, 2009).
I chose to use a kaupapa Māori framework or lens to arrange, gather knowledge and present the information back to the public, because it reflects who I am as a Māori researcher. The topic is Māori and the outcome is to ultimately improve the wellbeing of Māori by providing knowledge around: identity, childbirth, childcare and whānau ora.

Kaupapa Māori, for me, is viewing this research project through Māori eyes, Māori values and intentionally selecting other Māori writers, speakers and concepts to validate the knowledge that has been shared with me, which can then be shared with others.

Kaupapa Māori according to Pita Sharples is a way of life. It was relevant to our ancestors and it has remained relevant to Māori today. It is about valuing ourselves and valuing the knowledge we have within our own cultural processes and that each of these processes or protocols is a theory – is a way of thinking that reaches an outcome (Pihama, 2008).

The pōwhiri (welcome), poroporoake (farewell), the tangihanga, the karanga all contain a framework that is uniquely Māori, but can also provide living metaphors for other concepts, stories, knowledge, theories. Tukutuku (woven panels), kōwhaiwhai (scroll painting on rafters), whaikario (carvings) are all repositories of knowledge and values. They allow the maker and the viewer to be part of a process of values and beliefs that tell narratives of the past and the future (Ryan, 1995).

Leonie Pihama says that we need to reclaim our theories as something we have done for a very long time and feel brave and right to use them within our studies and research projects to support and analyse our findings. Kaupapa Māori theory is how we understand the world says Pihama and it lies within the core of all Māori. It’s about "action, practice and changing our lived world" (Pihama, 2008).

Linda Smith addresses the kaupapa in a researcher; what is the kaupapa to enable the researcher to do particular research she asks and what are we (as researchers) bringing to the research and from what perspective are we coming from? What is the ethical framework for the research project and what are our own ethical frameworks? (Pihama, 2008).

As a researcher working and studying within mainstream organisations, there are two ethical processes. In the first, a research proposal is assessed by a special ethical
committee and then either given the OK to proceed or is required to be amended before you can continue. The other for Māori researchers is the ethics of intellectual property and tikanga, and as Smith advocates, for choosing our own ethical frameworks that work for Māori. This, Smith believes, is conducive to good research practice and potentially encourages more Māori to get involved in research (Pihama, 2008).

Kuini Jenkins (2008) says that Kaupapa Māori claims space for te iwi Māori to develop their own directions, pursuing mauri ora (wellbeing) by their own developers and creators. Jenkin's consequently highlights the importance for Māori to hold onto Kaupapa Maori theory and to be cautious about mixing other indigenous theories into the mix too soon. Her concern is to prevent the situation where one indigenous theory is lost in the other. Kaupapa Māori theory needs to maintain it's mana motuhake, it's own rights and it's own mana (Jenkins & Pihama, 2001).

1.2 Mātauranga Māori and Western Science

Are traditional Māori birthing practices considered to be a matter of science? This question was raised discretely a number of times whilst conducting this research under a Master of Science Communication degree. Was my chosen topic scientific enough?

It is important then to begin with a consideration of what is science? Who has the authority to define what science is or not? And is mātauranga Māori (Māori knowledge) only deemed to be science when Western Scientists prove it to be?

Mātauranga Māori can be described as an indigenous knowledge system that has a Māori identity and reflects the "collective experience of Māori" (L. Smith, et al., 2008).

Dr Ocean Mercier (2012), a lecturer in Māori studies at Victoria University believes that bringing Western and Indigenous knowledge together can help overcome shared problems.

"Convincing people that we have always been scientists, and we continue to be scientists our brand of science may be a little different from Western Science, but none the less, it has enabled us to work in the world, to be in the world, to live in the world and survive in the world for generations and thousands of years" (Mercier, 2007).
Western Science and Mātauranga Māori are two knowledge systems that are based on similar theoretical parameters. Ocean Mercier said scientists carry science and therefore the onus is on scientists themselves to embrace other worldviews within their science projects. Bridging Western Science with mātauranga Māori can be evolutionary and beneficial for shaping an exciting science future (Mercier, 2007; Roberts & Haami, 1999)

While a lot of diverse interpretations exist around the boundaries of Western Science and the role of mātauranga Māori in this paradigm. Many do gravitate towards some central tenets that highlight that these two "knowledge systems" can work together. The wero (challenge) is in the acceptance of what each system can bring to the table and whether both groups of scientists are prepared to equally collaborate.

1.3 Ko te Mahi/Methodology

Similar to the kōrero (what was said) above, this study needed to find a way to gather the information that honoured kaupapa Māori values and to present the information in a format that met Western academic presentation standards of post-graduate research.

The following sections detail the method that I used to achieve both these imperatives.

Consultation

Before this project began advice was sought by a number of people and groups.

I approached the Mana Whenua Hauora Working Party; this is a collective of representatives from the four Otago Runanga and other invited members. They take research projects and issues back pertaining to health to their individual runanga to raise awareness and seek feedback and advice.

I consulted with the Ngāi Tahu Research Consultation Committee at the University of Otago who supported the project and were interested in the findings.

This project was carried out under approval 10-247 from the University of Otago’s Human Ethics Committee under the Category A Ethical Approval of a Research Proposal involving Human Participants.
Seeking ethical approval from the Ethics Committee is a necessary component of meeting a national standard that protects both the interviewee and the interviewer from unethical processes. However, when gathering old knowledge often passed down through the generations and some tapu (sacred) knowledge taught anciently in the Te Whare Wānanga or Whare Maire (Houses of Learning) places a weight upon the research and a sense of responsibility for the dissemination that personally goes beyond the requirements of this Masters Degree (Beattie, 1994; Best, 1929).

The participant or interviewee signs a consent that tells them that the end product of the research, in this particular instance the film and thesis, will be copyrighted to three parties: Natural History NZ, the University of Otago and myself. We become the decision makers on where and how the film and thesis will be shown, shared and sold. It is on this issue that both the talent/participants and myself have paused and hesitated about handing over knowledge that wasn’t going to be exclusively left in Māori hands, but would also rest with two large predominantly non-Māori organisations. That this was the dominant approach for academic research was a reality I accepted however it posed some interesting ethical and intellectual property challenges that I tried to meet with honesty and acceptance.

I attended the 2010 Hui a Tau for Ngāi Tahu and made myself available to be approached about the research I was doing. I was fortunate to gain three excellent contacts who went on to provide both guidance and narratives for this research. Christine Rimene was one of the contacts and her research alongside her colleagues Connie Hassan and John Broughton, initially designed for Otago Medical students in the mid 90's has evolved into a much-used resource titled, Ukaipo (Rimene, et al., 1998). This is a valuable resource containing birthing stories from Māori of all ages including pertinent issues around traditional Māori birthing practices and customs.

Christine provided the initial advice to ensure the research stayed grounded, truthful and aligned with other midwifery groups such as, Ngā Maia o Aotearoa me Te Waipounamu and with individuals (taua and pōua), who would provide sustenance through support and wisdom. She concluded our conversation with a reminder to put the people (participants) first and protect their kōrero (talk) from being edited out of context within the thesis.
Cultural Advisor

It was also important for me to seek a cultural advisor for this research project and thesis - to have someone to exchange ideas, information and concerns or highlights around particular pieces of writing or footage. I was grateful to have Rua McCallum fulfill this role and she was able to provide practical wisdom on a variety of components throughout the filming and writing of this research.

Using a kaupapa Māori framework seemed natural and appropriate, but working from within sometimes means the obvious eludes or excludes us as researchers. My cultural advisor was that outside cultural perspective that held my waewae (feet) while I flew - allowing me to go wide with my thoughts and research, but kept me anchored to Papatūānuku (earth mother) in order to rein the research in and to get something down on paper.

Literature

A search of literature on Māori Birthing Practices revealed snippets of information that felt like taonga (treasures), like the barbs of a feather. When located it was precious and rewarding. Finding enough barbs to restore the function of the feather and then enough feathers to create flight is similar to the development of the knowledge for this thesis.

When pieces of information were located, the challenge then was to find the knowledge source beyond the historian who published the book. Similar information was also sought to aid confirmation that this did occur and to broaden the narrative that was taking shape.

Many of the narratives or segments of knowledge throughout this thesis are waiting for more strands, more barbs to be added. These will come in time.
Recruitment and Interviews

The tāngata Māori or Māori informants were not only those I specifically interviewed for this thesis but anyone who mentioned something to me upon hearing what I was studying. These "throw away" comments were then noted and later researched and have since added to the growing knowledge base on this topic.

I interviewed 22 people around Aotearoa aged between 18 and 86 years of age representing many hapū and iwi. I recruited my participants by advertising in the local Ngāi Tahu Runanga Newsletter, Te Pānui Runanga, at local and national Hui and through the local "kumara vine" (word of mouth in the local Māori community), and via emails that circulated some of the Otepoti (Dunedin) Māori health and social networks. From these initial emails, advertisements and Hui presentations I was able to produce a list of names. From this list some people declined to take part because they felt they could not remember any information relevant to this study, others declined due to being unwell and some because their birthing experience was only within the hospital setting and traditional Māori birthing practices had long been forgotten.

Interviews took place in: the work place, home setting, in a park, at the Marae, in a Mall wherever the participant felt comfortable and I was able to gain an audible audio recording of the interview.

The filming of interviews also provided information to this thesis, not only from the talent being filmed but also from the whānau in attendance. For these members sitting and watching, listening to the stories from their dad, uncle, mum and aunties brought back memories for them also, and I would often turn off the camera and whilst packing down the film equipment people would then share their memories or birthing stories that provided another layer of information missed on film but included into this thesis.

I reviewed all the recordings, footage and information deemed imperative to this thesis were then selected and detailed notes taken about them. These notes were then scanned for themes and directed to the appropriate thesis chapters.

Some of the participants requested that the pieces of their dialogue I intended to use in the final draft of the thesis be sent to them for their approval. I chose to do this for other
participants to ensure I had captured their kōrero correctly, especially the wairua (spiritual) content or tone of delivery.

- Some interviews were predominantly in English, two almost entirely in Māori and the rest contained scatterings of te reo Māori.

- Most interviews began with a karakia either led by the interviewee or myself. Some concluded with a karakia to enclose the information shared and also served as a reminder of how precious this information was. All interviews included a mihi (acknowledgement of the person I was interviewing) before any questions were asked. Prior to any questions being asked time was given to establish a rapport based on no hea koe, no hea au (finding out who we both were via iwi affiliations).

- All interviews led with the question of “What do you know about traditional Māori birthing practices and how did you learn this knowledge?”

Kai (food) played an important part in the interview process. It was my entry and/or exit offering. Bringing a plate of food to all interviews acknowledged the tikanga of kai to whakanoa the research or filming process once completed and kai in some situations, commenced the kōrero (conversation).

When read, this thesis hopes to talk to all peoples, but in particular to wāhine Māori (Māori women) and their whānau (family) about the mana (pride) and responsibility allocated to procreation and childbirth by tūpuna Māori. Great consideration was undertaken by rangatira and tohunga to strategically align couples from within the hapū and other hapū/iwi for the betterment of whānau and hapū (Best, 1929; Gray, 2010; Walker, 1990). Partnering appeared to be for many a collaborative decision and not just the choice and want of the individual or couple. It leads me to ponder if more rangatahi (youth) were aware of traditional knowledge around child birth and were able to grasp the underlying values such as: ensuring the relationship is strong, waiting until you and your partner are ready to conceive, ensuring all supports are in place to ensure a healthy conception and pregnancy, the hapū wāhine is treated with respect and is nurtured during her pregnancy, the tāne or partner has an important role within this experience and that child birth is natural, we may be able to rectify or rebalance some of the negatives that have crept into child birth for whānau Māori with detrimental
consequences to the wellbeing of the tamariki and the whānau kātoa (whole family) (Gray, 2010; Ngamoke, 2011; Rama, 2011).

A number of informants confided in the author that the information they were sharing was not for the author alone nor the University perse, but to be produced into an eventual resource for Te Iwi Māori, in the hope this knowledge would not die with them and be lost to all.

The current informants with this knowledge are mostly aging and once they have left us we are reliant on what they have imparted, if indeed they choose to impart their knowledge at all. Then we are left gathering the strands of what can still be remembered, what is still being practised and any other links that may be the thread that weaves the stories together.
1.4 Whakarāpopoto / Summary

Chapter One sets the scene for this thesis by putting forward the intent for discussing the topic of traditional Māori birthing practices and rituals. That being, that these practices have a place in improving the imbalances between wāhine Māori and tane Māori, thus contributing to rectifying the health inequalities between Māori and Pakeha in the area of maternity care, and could also provide the impetus to encourage the acknowledgement of cultural rituals and spiritual values within all health settings. It is my contention that education can assist health professionals and the general public to become more aware of and more included into these specific cultural practices and to develop a better understanding of how these have a powerful impact on people’s wellbeing.

The DVD resource Iho – A Cord Between Two Worlds, is introduced and highlighted as another medium to provide information about traditional Māori birthing practices.

Acknowledgement is given to the variations of tikanga and te reo Māori between hapū and iwi and also between Māori individuals. Traditional Māori practices will not suit all Māori, but having access and support to pursue traditional Māori birthing practices for those who are interested is important and necessary.

There are hapū who have retained knowledge around conception and birth, but this does not appear to be the norm as many hapū have forgotten their practices associated with this particular take (subject matter).

The differences around tikanga and terms used can be attributed to the location of the hapū. This determined what natural resources were available to them to grow and hunt for food, make utilities, resources and gather rongoa (herbal remedies).

The information gathering process for this thesis was a combination of seeking literature found in a variety of written sources, including karakia (incantations) and waiata and from informants who shared their teachings, upbringing, memories, whānau memories and stories. It is also highlighted that this thesis is only a mere segment or chapter in the overall body of knowledge around birthing rituals practiced by tupuna Māori. The next positive outcome would be to use this research as a platform from which more knowledge can be gathered and layered upon.
How this information is gathered, perceived and cared for was discussed under the section titled, Kaupapa Māori principles. These principles include respect, honour, aroha, time, listening, sharing, kai and embracing the Māori worldview. An holistic approach is intrinsic to kaupapa Māori and highlights through a Māori lens what is and what is not happening within birthing experiences for wāhine Māori today and how the inclusion of traditional Māori birthing practices could amend some of the inequalities and gaps in the health care system experienced by Māori.

The next chapter views conception in the widest context, that being the creation of the world and the conception of the first wahine (woman).
Chapter 2: Te Kākano Tuatahi / The First Seed

A thought that would often give me strength and I suppose place some normality to my impending labour and birth was the fact that billions and billions of woman had birthed before, multiple births, tens of children, painful and not, my mother had birthed, my grandmother had birthed and I too will birth – it can be done and I can do it. This became my mantra to smother the worried feelings that would infiltrate my thinking nearing birth. It also made me curious about how other women birthed?

When we think back to our ancestresses and beyond them to life’s creation and again to the world’s creation these are events that can all be seen as births, beginnings and ends, seeds that grow, energy that gathers more energy until it releases, the coils that begin somewhere and end in another “where”. These creation stories are true to those that believe them and are kept alive by being shared through: literature, lectures, sermons, speeches, presentations, film, radio and collectives of interested people.
Māori also speak about their view on the creation of the world and people, variations of similar stories spread throughout Aotearoa with their own hapū and iwi perspective that firmly ground the creation story uniquely to them (Beattie, 1990; Marsden, 2003; Orbell, 1995; Pohatu, 2000; Pomare, 1934; Reed, 2004).

Given the very nature of this thesis being centred on Māori and birth it felt right to then look at the topic of conception more broadly. What are some Māori beliefs around the creation of this Ao (world) we live in, the atua (gods) and the tāngata (people)?

There is a whakapapa (genealogy) that came before people and by delving gently into this matter at the beginning of this thesis places birth into a larger context honouring the many layers of papa (the many lineage lines) that shape our future.

Therefore I will not attempt to tell anyone else’s version of the creation story for fear of being incorrect and disrespectful. I have chosen to share the kōrero my great grandfather Teone Taare Tikao shared with historian Herries Beattie in the 1920’s, over a course of eight long days, from the early hours of the morning to late into the night. Screeds and screeds of writing and knowledge that spilled from my Poua’s (great grandfather’s) lips as he told the history of the Banks Peninsula and much more, all captured in the book, *Tikao Talks* (Beattie, 1990).

Beattie said in the foreword of *Tikao Talks* that the knowledge gained from Poua Tikao was unlike anything he had read and very different from Murihiku (Southland) knowledge. He even admitted to finding it very difficult to keep up with Poua Tikao. I have heard that Poua took over at one point and wrote out the notes to ensure the correct Māori and grammar was provided: something that pleased and surprised Beattie once again.

Poua Tikao knew that the future Tikao descendants needed to be given this information in a literary form – we were losing our reo Māori and it would be a number of generations later before we could interpret what Poua Tikao was telling us. He knew oral history would be sadly lost to some extent on the next few generations – what he perhaps didn’t know was that the passion and love for him and his parents would be the defining factor to keep the current generation still motivated and on a pathway of learning te reo Māori. We acknowledge Teone Tikao strongly today in our waiata and in our mihi of who we are and whom we descend from.
“E pa, in this changing world, full of complexities, conflict and contrast. We only move in fast forward and never reverse, for fear of stopping. But perhaps in death’s instance, we see the truth like it always was and not how we wanted it to be. I will tell the creation story you have been taught and the memories you have remembered and share them with the readers of this thesis. Tēna koe e Pa.”

Before us, before humans, before planets, before the earth and the moon, before any trace of what we now call the world there was nothing, absolutely nothing except the sea that covered everything and darkness, many many stages of darkness. Within these periods of Po (night) were long ages of Kore (nothingness) (Beattie, 1990).

Sung in ancient waiata were words depicting the shape of the earth not being round like a globe, but flat like a plate, with the water being kept in by sandbanks, beyond this being the vastness of space. Piko Piko i Whiti was the name given to the whole sandbank. Various other names were given to the east, west, north and south sections (Beattie, 1990).

My great Poua spoke of the 10 stages of Po (darkness) and at the completion of these evolving and interchanging periods of po and kore was Io the supreme god. It was Io who raised Rakinui (the sky father) and Papatūānuku (the earth mother) into being. Poua Tikao was taught to say the following words: Io whatata (he went one way on top of the water), Io whatamai (he went another way on waste water), two heke (ebbs of
water) merged from this movement, creating Hekeheke i Nuku (hanging upright and shifting) and Hekeheke i Papa (hanging horizontal or flat), once these were raised above the water they became Rakinui (Ranginui) and Papatūānuku (Beattie, 1990).

It was through the marriage of Maku a celestial being born from the darkness and Mahara Nui A Tea (the vista of white) that the sun was begat and whom they called Rehua. Maku's second child (to another wife Huareare) had another son, Marama (the moon) (Beattie, 1990).

The luminous rays from both the moon and the sun were hidden within the layers of Papatūānuku (Earth Mother) and Rakinui (Sky Father). Their closeness omitted all other expression until the moaning from their children who dwelled in their dark embrace reached the ears of Rakinui. He heard their calls for more space and more light and in turn said to his son Tane that this could only be achieved by separating himself and his beloved partner Papatūānuku. The wero (challenge) was how this could be orchestrated, after many attempts and heated discussions Tane used a large pou (poll) called Pou Tu i te Rangi. One end rested on Papatūānuku and the other on Rakinui, the ten (hono) joints of the pou created the ten heavens, one upon the other (Beattie, 1990).

Poua Tikao was taught that Rakinui was once called Rakiroa, but once Tane pushed him up into the air with the Pou Tu i Te Raki, the effort to lift the size and weight of Raki encouraged Tane to rename his father Rakinui. In turn, his father was so impressed by his son's massive effort to accomplish the separation task; he named his son Tane Nui a Raki (Great Tane, son of Raki).

It is also said that Tane was directed by Papatūānuku to check on the Pou, which he did when he returned to his mother to report that all the hono (joints) were in alignment. Papatūānuku then guided him to turn it now from an upright to a horizontal position, from North to South is where it remains today (Beattie, 1990).
2.1 Hine Titama / Creation of Woman

Poua Tikao talks about the creation of woman and how it was Rakinui (Ranginui – the Sky Father) who sent down the soul of one of Tane’s sky daughters (Hine Titama – the Dawn Maiden) to keep him company on earth. When Hine Titama’s wairua (soul) arrived from the heavens it was not in a form suited to live on earth. So Tane moulded soil from Papatūānuku around the Hine Titama to create the human form.

The second version of this story also told by Poua Tikao pertaining to the creation of the first woman is driven by Tane’s own desire for a partner. Tane crafted a womanly form from the soil and clay (known as Hine Ahu One), but unfortunately it was merely a shape with no soul. Rakinui’s watchful eye upon his son’s actions foresaw he needed a spirit to bring the flesh alive, so he sent Tane’s sky daughter Hine Titama to fulfil this role. Tane married Hine Titama and they had children together, until one day Hine Titama was told by two celestial beings that her husband was also her father. Disgusted by what she had heard, Hine Titama fled, taking two of her daughters with Tane in pursuance. They argued, yet in the end Hine Titama refused to return to earth. She angrily told Tane to go and look after the rest of their children and that she will continue her battle to drag them to her in the realm of death. Hine Titama journeyed to Te Reinga (Cape Reinga), where she became Hine Nui o te Po (the Great Lady of Darkness), in this realm she drags men and woman to this deathly domicile (Beattie, 1990).

Hine-te-Iwa Iwa was also referred to as Hine-Uri and Hine Keha. The Goddesses of childbirth and these names would often be recited in karakia (incantations) associated with conception and birth. Hine te Iwa Iwa appeared to be the goddess most commonly seen as the kaitiaki (guardian) for birth (Heuer, 1974). Best (1975) wrote that Hine Te Iwa Iwa personifies the moon and is closely associated with Māori legendary ancestral characters, such as Maui, Tinerau, Tiki and with Tuna the eel.

Hine Korito, Hine Makehu and Hine Kotea are other moon Goddesses associated with childbirth, Hine Korako is another, and she is often portrayed as the lunar bow or moon’s halo (Best, 1975; Mead, 2003a).
Another goddess revered in childbirth was Pani or Hine-Tinaku, she was perceived as the mother of kumara. It was no surprise to Māori when wahine would crave for this sweet potato during their hapūtanga (pregnancy), (Riley, 1994).

Naomi Simmonds (2011) wrote how Māori cosmology stressed the mana of wahine for carrying the future generations, but also nurturing the whakapapa - the lifeline of te iwi Māori.

Papatūānuku (the earth mother) is also seen as the first mother of humanity. It is through Papatūānuku that life cycles were begat and how she now personifies primal motherly instincts such as love, protection and nourishment (Mead, 2003a; Palmer, 2002).

Whakairatia

Creation and conception kōrero exists throughout this thesis. The general thinking appears to be that tane Māori (Māori men) held the seed of life, the seed itself came from the Supreme Being Io and the wahine provided the receptacle or vessel to nurture, shelter and grow the kākano (seed).

It has also been said that it is not until the foetus has formed eyes that the wairua (spirit) of the child comes alive. The foetus develops the ability to think soon after and it is the collaboration of these two developments that transforms the foetus into a tangata (person) (Best, 1929; Mead, 2003a).

Te Whare Tāngata

Mā te wahine, mā te whenua, ka ngaro te tāonga.
By women and land do men perish.

The above whakataukī honours the relationship between the land and wahine and the importance of keeping the mana of both.

The whare tangata or te whare tapu o te tangata are terms used to describe the womb. These terms translated to the house of humanity or the place of conception and the beginning of mankind, the place where whakapapa dwelled and set forth (Palmer, 2002; Rimene, et al., 1998).
For te iwi Kāi Tahu, once a girl transitions from hine (girl) to a wahine (woman) post her first menstruation, her whare hihiri (hihiri is a term to describe pure energy in reference to the young girls uterus) also transitions to Te Whare Tapu o te Tāngata (Gray, 2010; Marsden, 2003).

**Hapū**

Hapū describes the state of being pregnant, but it also relates to a collective of whānau that are seen as a subtribe to the overarching iwi (tribe). So when a Māori woman becomes pregnant or hapū she is increasing the mana of her hapū and the iwi. The term hapū is sub tribe and hence the word hapūtanga or the state of pregnancy can be seen as the ultimate tohu (sign) of Māori wellbeing (Best, 1929; Kahukiwa & Grace, 2000; Palmer, 2002).

**Ahuru Mowai**

The ahuru mowai is a term frequently associated with the wai (amniotic water) in utero. The amniotic fluid is perceived to be sacred water as it provides sustenance and wellness to the pēpi ki roto (inside the mother), a cosy haven or a safe place. Offerings in karakia (incantations), oriori and waiata often refer to the Ahuru Mowai of a child (Mihaere, 2011; Wikaira, 2010).

**Whakapapa**

Whakapapa is a person’s genealogy, their cultural identity – who they are. The term whakapapa implies to layer or to have layer upon layer, such as the flow of the generations. Stephanie Palmer (2002) says blood binds one generation to another and it is in this process that ancestors are kept alive, remembered and linked. The creation story contains the birth of Papatūānuku and Rakinui, they then birth their tamariki and in a process of prolific birthing throughout the realms of land and sea, sky and beyond, terrestrial and spiritual. It is the “process of creation” that a whakapapa evolves and defines kinship groups (Palmer, 2002, p.13). Hirini Moko Mead (2003) connects whakapapa and tūrangawaewae (home) as concepts that define a person to a time, location and position. Whakapapa he says validates membership into a whānau, hapū and iwi. Through whakapapa a person can access resources of their hapū and iwi.
2.2 Whakarāpopoto / Summary

The concept of birth to Māori does not only pertain to the birth of a pēpi, but the birth of the Universe. Southern Kaumātua Teone Taare Tikao describes the world as flat as a plate, with water in the centre and surrounded by sandbanks. In the darkness and within this pool of water, it was Io who drew up Papatūānuku (the Earth Mother) and Rakinui (Ranginui – the Sky Father) from the water (Beattie, 1990).

The darkness still reigned upon this Ao even after the birth of the sun and the moon; their rays could still not protrude the darkness that Papatūānuku and Rakinui created through their embrace. Their son Tane Māhuta took the pou (poll) his father directed him to and wedged it in between Papatūānuku and Rakinui to commence te Ao Marama (the world of light).

Tane, again with the guidance of his father crafted the first wahine from the soil of Papatūānuku. Rakinui sent the soul of the Dawn Maiden, Hine Tītāma to give life to Tane’s moulded wahine (Beattie, 1990).

Wāhine were made with the ability to produce tāngata (people) in their womb, referred to as, Te Whare Tāngata (the house of people/womb). It was within the safe haven (ahuru mowai) of the whare tāngata that the foetus took shape and was sheltered, nurtured and prepared for it’s journey through “te ara tauwhāiti a Tane” (birth canal) (Mead, 2003a).

The next chapter looks specifically at how Māori prepared for birth, the natural resources used to aid labour and to reduce post birth complications and the rituals that surrounded the generation of the Māori population.
Chapter 3: Hapūtanga / Pregnancy

3. What are traditional Māori Birthing Practices?

Birth in many cultures appears to be influenced by economics and status (Bhasin, 1989; Franzmann, 2000; Hewitt, 1989; Ortnel, 1974; Simmonds, 2011; WHO, 1989). It is the same for Māori. The ranking within the hapū and/or iwi appeared to predetermine who would be coupled to conceive their first child, the karakia that will be given and the style in which they birthed. Birth was orchestrated to meet the greater good of the hapū, political alliances, land base collaborations, taonga (treasures or resources specific to that area i.e pounamu, tītī, tuna), trading and also at times to bring peace to feuding clans. Seeing pregnancy as a way of meeting collective rather than individual need was associated more so with high ranking whānau, or those aligned with or whānau of the Rangatira (Chiefs) of hapū (Beattie, 1954, 1994; Best, 1929, 1934; King, 2003; Makereti, 1938; Walker, 1990).

The wellbeing of the pēpi (baby) born out of this union then plays a far more significant role in the wellbeing of the two hapū/iwi. Consequently the care and attention given
towards the hapū wahine is of the highest order. She was considered tapu (sacred), and in many hapū, she was moved towards the end of her pregnancy to birth in a specially constructed whare kōhanga (temporary birthing whare). (See later in this Chapter under Te Whare Kōhanga).

The birthing practices of a Māori pēpi to lower class parents were more simple (although the wahine was still considered tapu), with fewer ceremonial rituals conducted (Best, 1975; Kupe-Wharehoka, 2000). Similarities can be seen between wahine Māori and Native American Indian women birthing. Old Western movies for example often portrayed lone labouring Indian squaws who walked off to have her baby, later returning with baby in arms to the happy village (Shoemaker, 1995). The overall perception one has of birth from films like this is that birth for indigenous people was normal; women were independent and knew what was expected of them. Historians later wrote that perhaps birthing alone was a reality for some Indian clans, but it was more probable that a family member(s) would attend alongside someone seen as the midwife for the village (Best, 1975; Kupe-Wharehoka, 2000; Perdue, 1998; Shoemaker, 1995).

This particular scenario hasn't to my knowledge been illustrated for Māori through films, but it does remind me of familiar stories I have read and heard through my informants for this research. Informants talked about separate birthing places often birthing trees and rocks that hapū wahine would birth on or near, sometimes by themselves or with another attendee and then like the Indian squaw would return to her kainga (village) with pēpi (baby) in arms (Beattie, 1994; Best, 1929; Tikao & Tikao, 2010).
Tapu and Noa

Tapu and noa are concepts of balance and unity. They embody a function within ceremonies that are similar to concepts of: on and off, open or close, restrict or release. Tapu according to Rose Pere (1997) is "an excellent means of social control, self-discipline and conservation preservation" (p.40). Once instituted, tapu placed upon people, an object, a space or a landmark immediately implies rules that are self imposed and respected. The offence of infringing tapu is also self-imposed and people can be affected spiritually and physically by their mistakes. Often misfortunes are perceived as an infringement of tapu, therefore the person(s) at fault often accepted that they would suffer retribution as a result (Pere, 1997).

Wāhine were tapu during pregnancy and childbirth – this affected what they could and couldn’t do. Being tapu restricted what work they could do and what areas they could be in. Some hapū wāhine, for example might be restricted from working in the gardens or gathering kaimoana. More restrictions were placed upon those of Chiefly lines. This was to ensure that all precautions were undertaken to heighten the chances of a successful birth and a healthy whaea (mother) and pēpi. It also guaranteed the continuation of whakapapa (genealogy) and survival of the hapū (Manihera, Pewhairangi, & Rangihau, 1992; Marsden, 2003; Palmer, 2002).
Noa is the opposite term to tapu. Noa, says Pere, is applied to everyday living and ordinary occasions or situations. It plays a crucial role in formal and complex rituals and can be seen as ceremonial purification. It is what takes place once a tapu has been lifted and embraces spiritual freedom (Pere, 1997).

**Makawe**

Although there is very little mention in the literature in regard to refraining from cutting a hapū wahine’s hair while pregnant. This traditional is known orally and has been passed down through the generations as something to be aware of if observing traditional Māori birthing practices and rituals. Hirini Moko Mead (2003) made a reference to the head and therefore hair being tapu. Careful disposal of the hair so that no one can find it and transgress your tapu becomes essential to protect the mana and tapu of oneself. Given that the wahine is tapu curing her pregnant state it is perhaps perceived as not taking any risks to harm the foetus growing in utero by not cutting the hair and leaving it intact and safe within the realm of taputanga. It has been said also in the past that leaving the hair to grow does not distract the energy and attention away from the pēpi, again encouraging optimum chances of survival and wellbeing (Mead, 2003b).

**Karakia**

Karakia (invocations/incantations) were used from conception to after the birth had taken place. Karakia played multiple roles and functioned on multiple levels. Best spoke about the hierarchy of karakia and that those that affiliated to superior lineage will have karakia involving the higher gods such as, "Io" known as the Supreme Being. Those not of high lineage will use karakia containing the “departmental” everyday gods (Best, 1929, 1934; Hakopa, 2011; Pitama, 2011).

Maurice Gray (Waitaha, Kāti Mamoe and Kāi Tahu) shared some of the birthing knowledge passed on to him by his Aunty Erena Raukura Gillies. Erena had obtained her teachings specifically around high ranking births and the significance of the conception karakia from Poua Teone Tikao.
Maurice said that the *conception karakia* was recited prior to the young puhi (chiefly virgin) being married, just after her transition from being a hine (girl) to a wahine (woman), signified by the commencement of her first menstruation.

The karakia would be performed at night under the full bloom of the moon, in the presence of Hine Marama, Hine Te Iwa Iwa and Hine Akeake to name a few of the goddesses that would be invoked through the karakia to assist the wahine to conceive and that the eventual conception and birth will be successful.

A suitor could then be arranged for the puhi (virgin) and after the rituals of marriage had been completed the tohuka (specialist) would then return and the conception karakia would take place for both of them, again under the presence of a full moon and whilst standing in the water of the river (known as a Waipure) (Gray, 2010; Holmes, 2011). The karakia would call upon their kairarahi (guardians) from the heavens and these being the tuna mairehe (particular type of eel) in the Banks Peninsula area. The tuna mairehe would be called to bond the marriage and unify them. The water would symbolically dissolve them as individuals and unite them as one form when they stepped out of the water, reformed, reshaped and insoluble. Now they were prepared to conceive (Gray, 2010).

The karakia for conception were very long, yet Gray highlighted that although lengthy these karakia had a clear structure that had an order based on “patterns of rhythmical vibrations” assisting the elocution of these karakia.

Kāi Tahu perceived an entry and exit portal or gateway from which souls could come into Te Ao Marama (the world of light, the living world) and then depart through this same portal system. Ancient Māori acknowledged this gateway within their karakia and through symbolism. For instance, Māori from Koukourarata used the toetoe flower to represent the spiritual pathways within a ritual process (Gray, 2010).

Once the wahine did conceive, the karakia process by the tohunga would continue throughout her pregnancy, alongside mirimiri (massage) of her whole body, given by her taua Ruahine (wise elder wahine). The intention of the mirimiri was to work on the body of the hapū wahine on a physical level, but also to work on bringing in atua (goddesses) to ensure that the pēpi remains calm and free to move around and grow within this realm. These Taua were also matakite (seers) they had to detect any mākutu
(evil, curse) that may have been placed upon the hapū wahine and deal with them immediately. They would be watching for any change of status in three areas: wairua (soul/spirit), mauri (life principal) and the physical condition of the pregnant wāhine. These three arenas were essential in securing the whakapapa (genealogy) of these Chiefly lines. Any altercation in the any of these three energetic forces could jeopardise the hauora (wellbeing) of both the mother and child (Gray, 2010).

Berys Heuer wrote *Maori Women* (1974) in which she said that many karakia and rituals associated with birth referenced Hine Ahu One for the purpose of inducing conception. Conception karakia according to Heuer were recited over particular leaves such as kāretu (a scented grass) and kawakawa (a type of shrub). These leaves could then be placed beneath a wahine wanting to conceive or between her breasts during intercourse.

Stones or trees were known to hapū and iwi as places wahine can go alongside tohunga that were believed to hold special powers that aided in conception. In Kawhia they had a rock known as Uenukutuwhata and in Ohaua, Tūhoe a hīnau tree was perceived to have conceptive powers (Best, 1975).

Karakia as a form of rongoa in most of the literature is an integral component in all health and spiritual processes and at all stages. In contrast to karakia there is mākutu or the fear that can lead to illness and may have been caused by transgressing a tapu (a sacred lore), creating harm to others or self that inevitably leaves the person out of sorts and prone to being ill (Ahuriri-Driscoll, 2008; McGowan, 2000).

Teone Tikao (1990) surmised that karakia were used to ask a favour of the gods or a particular god, but it could also be used to cast a mākutu (curse) or bewitch people. Some karakia initiated tapu and others dispelled it. He said it depended on the occasion as to what the purpose of the karakia would be. It was vital that karakia were recited word perfect. It was believed that detrimental affects would occur if a mistake was made during the recital, therefore the expertise and knowledge that a tohunga (expert) carried was revered. Tohunga were held in the highest regard and treated with the upmost respect. They themselves were treated as tapu (sacred), often being fed by others so they did not have to come in contact with things and objects that could
diminish their mana and ultimately lead to their death, such as cooked food (Beattie, 1994; Best, 1975; P. Smith, 1899).

In the Chatham Islands the Moriori tohunga dipped the branch of a kawakawa tree into the water and waved it over the wahine while he performed karakia (incantations) to ensure the baby would be protected from harmful spirits.

Te Arawa tribes often addressed Hine Korako in their karakia, she was a goddess personified by the moon. The moon’s lunar cycles are associated with menstruation and therefore also linked to conception and wellbeing during hapūtanga (pregnancy) (Riley, 1994).

Hirini Mead (2003) said that karakia were often dedicated to specific gods depending on the sex of the child. Karakia for male pépi were often associated with the god Tūmatauenga (God of War) and girls with Hine Te Iwa Iwa (Goddess of Birth).

**Oriori**

Oriori are mōteatea that provide the whāriki (mat or medium) of which to place upon: knowledge, history, whakapapa, the desires and visions for the child’s future whom it is being sung to. Similarly, there are goals imparted to parents through oriori to meet their challenges and to pursue desired pathways for their new tamaiti (child) (Best, 1975; Royal, 1997).

Te Akukaramū Charles Royal in his paper to the Otākī Historical Society in 1997 clearly defined the realm of oriori by saying,

"...oriori outlined the philosophical and conceptual world in which his or her people dwelt and within their world is constructed" (1997, p. 2).

Amster Reedy of Ngāti Porou iwi has completed his PhD involving Māori childrearing practices. He has practised and grown his knowledge of oriori over a period spanning 30 years and he has conducted classes and workshops to teach parents oriori, so they in turn pass this knowledge on to their tamariki and mokopuna. Reedy says oriori can begin prior to conception when a person is preparing to conceive through to after the pépi is born (Reedy, 2008).
One of the most significant times to perform oriori is at the point of birth. Reedy says the child has completed their spiritual journey into the physical realm. This is the time for the imparting of kauae runga and kauae raro – the realms of celestial and terrestrial knowledge (Morgan, 2011).

Kauae runga is depicted by Māori Marsden as an institution for higher learning also known as Te Whare Wānanga. Kauae runga is literally the upper jaw of a person. Kauae raro (lower jaw) is the knowledge learnt within the Whare Maire (house of special learning) about occult lores and different forms of karakia (blessings) (Marsden, 2003).

Most of the classic oriori chants are over 300 years old and were composed from iwi all over Aotearoa. Oriori were often gifted to other iwi upon travel as an offering for their manāki (kindness). Reedy is in awe of how profound and poetical oriori are, and how they highlighted how intimate our tupuna were with the world around them (Morgan, 2011).

Ancient oriori express with poetical ease the relationship between humans and animals, humans and the taiao (world around us) and humans with gods. Oriori flow and literally widen the singers view on the world they are singing about and the world the singer currently is singing from (Morgan, 2011).

**Waiata**

Alongside oriori, waiata (songs) were used to calm and at times distract the labouring wāhine and her pēpi in utero. According to midwife Amber Clarke (2010) singing opens up the glottis and this has a relationship to the perineum and can relax both the mother and child, consequently this is a technique she encourages in her own midwifery practice. Ricki Pitama (Ngāi Tahu) recalled his mother Malta, referring to her knowledge of her ancestress Amiria Puhirere, and her kōrero about the gathering of Taua (southern term for grandmothers) around the labouring wāhine to perform waiata about whakapapa (genealogy), giving mirimiri (massage) and kai (food) as a way of comforting the wāhine hapū and preparing the new pēpi to come forth (2011).
Kanikani

Stephanie Palmer (2002) spoke about particular dance movements such as the tignonioni and the pōtēteke, that involved a tilting of the pelvis and swaying of hips, not only used in a sexually alluring way, but these movements also strengthen the pelvic area and improved flexibility. Kanikani is another method employed to prepare wāhine for childbirth.

Ngā Kete o te Wānanga

Reedy discussed the importance of acquiring knowledge and refers to Tane nui a Rangi’s pursuit of knowledge when he ascended to the highest of heavens and returned to earth with the three kete (basket) of knowledge (Reedy, 2008).

Te Kete Tua Uri translates as the basket of darkness: sacred knowledge. This knowledge is beyond us, “stands under” our sense perception. It is the creation space, where according to Māori Marsden, all things are “gestated, evolve and refined” (2003, p 60.). It is for Māori an understanding of using our senses to penetrate into the higher order or “beyond” the natural world.

Te Kete Tua-Ātea can be defined as the basket of light: tūpuna knowledge. This kete contains knowledge about spiritual realms. Ātea means space and this word was often connected to wā (time), space and time were relative to each other and created the structure from which things were created, that then led to another creation and so forth.
Marsden describes Tua-ātea as the “world beyond this space-time framework” (Marsden, 2003, p.62).

Te Kete Aro-nui is the basket of pursuit: life knowledge. This is the kete of what we see before us (aro-nui), this is the natural world around us. Marsden addresses this kete as the way Māori closely observed their world, taking into account the details around cycles and events and then transmitted this learning to the next generation (Shirres, 1982).

It is not for parents or pakeke (adults) to tell the tamaiti (child) which kete is for them, but for the tamaiti to choose their kete (Reedy, 2008).

*Mōmonatanga*

If couples had difficulty conceiving a child a tohunga (specialist) was asked to meet with the couple and perform karakia (prayers) to clear the fertility pathways and allow the child spirit to enter. The tohunga would also use special plants either ingested or shaken over the couples to break any mākutu (curse) that may be in place preventing a child being conceived. A tohunga would also be called upon if a couple wanted a particular sex; trees like the karamū (*coprosma*) tree would be used in this ceremonial process to produce a boy.

Elsdon Best wrote that Māori were familiar with the ovulation cycle and when best to have coitus for greater chances of pregnancy. They also believed in predetermined places, trees, rocks and patches of forest that were known to promote fertility. Wearing hei tiki (the hei to suspend around the neck and the tiki representing the primal human) and carrying a whakapakoko (a small fertility statue) heightened their pregnancy chances (Best, 1929).
There were many rongoa used prior to conception, throughout the pregnancy and postbirth that our ancestors employed to aid the journey of carrying a life successfully into the physical realm (Best, 1929, 2005; Moon, 2003, 2005; Riley, 1994).

Janet Taiatini (2009) midwife and researcher with over 20 years experience completed a research project with six Rongoa Māori practitioners. Her study titled, *Rongoa Uses in Hapūtanga* was instigated by the need to find out more about rongoa practices and how they can be integrated back into her midwifery practise.

Janet said that rongoa came in many forms such as: karakia, mirimiri, romiromi, rakau, wai, inu, kaukau, hinu, hikoi (walking), poultices, kōhatu, kai and more were identified as vessels or conduits that acted towards wellbeing for the recipient.

Linked intimately with rongoa is the expression of karakia (incantations). Karakia highlighted the atua (gods) most appropriate to healer’s mahi (work) with the rongoa or the mahi to be undertaken after the collection of the rongoa. Blessings or incantations opened the spiritual pathways for healing and protected the person administering the rongoa. Karakia can also be perceived as a sign of respect to the gods who look after the forests and if the practitioner is collecting rongoa from outside their tribal area, karakia acknowledge the local people. Overall, the use of karakia in rongoa aligns the spiritual with the physical realm in order to best cure the ailment (Beattie, 1994; Taiatini, 2011).
Some practitioners never used rongoa rakau (medicine from the trees) for pregnancy. Many appeared more favourable to kawakawa with this plant appearing to be one of the more commonly used rongoa throughout hapūtanga (pregnancy). Kawakawa can be fused with oil and ingested as a drink. Post birth drops of kawakawa juice were placed into the pool of water the wahine was sitting in to aid whenua (placenta) removal or it could also be applied topically to the vagina and perineal area (Taiatini, 2011).

The inner fibres of the harakeke (*phormium tenax*) leaves (muka) were used to tie the umbilical cord. The base leaves were crushed and used as a poultice, similar to the kawakawa, and then applied to the vagina and perineum area, to aid healing post birth. Harakeke juice would be extracted from the crushed roots and once digested acted like a bowel stimulant that aided both the labour and birth of the whenua (afterbirth).

Kopakopa (plantain) leaves could be applied directly to the vagina to promote lochia discharge (Riley, 1994).

Other native plants used to bring on labour and aid the wahine post labour were the leaves of the nikau palm (*Rhopalostylis sapida*) as the pelvic joints became relaxed after the ingestion of the nikau (Taiatini, 2011).

Kaumatua Huata Holmes (2011) retold an oral account given by his mother Sarah Stott on traditional medicines and she said that ripe konini berries were mixed whole with syrup from the tī māru/tī kōuka (cabbage tree/*cordyline australis*), steamed and then ground together to form a paste. This rongoa was then fermented and given as a sedative in preparation for childbirth.

Titoki (*Alectryon excelsus*) oil extracted from the seed could be applied to the severed pito (the remnant of the iho closest to the pēpī) to soften it and relieve any local discomfort for the pēpī. This could also be used on sore nipples and breasts during lactation.

Bird oils such as weka (wood hen) oil were used to reduce wound inflammation. The oil from a seal could be dripped into a pēpī’s mouth post birth to facilitate a “clean out process” primarily to remove any fecal matter that may have been lodged internally during the labour and birth process.
The bark of the native tree kohekohe (*Dysoxylum spectabile*) once boiled could be drunk like a tonic to suppress lactation. This was a practice undertaken if the mother had lost a child in birth or was gifting her child to another whānau member (Jones, 2009; Riley, 1994).

Haha was a name given to oral thrush this was often treated by extracting juice from the pouaka or karetu grass by vigorous pounding and then wringing the juice out. Mothers could swab the juice around the mouth of their pēpi to remove the thrush.

The tūtai (droppings) of the kererū (pigeon) mixed with the oil of the same bird was then ingested to aid the removal of the whenua (after birth). The berries once eaten by the kererū and fermented and processed in the gut of the kererū produced a by-product that Māori knew stimulated the uterus, assisting the womb to contract and move the whenua (placenta) out (Gray, 2010).

The inner bark of the houhi tree (*hoheria populnea*), known as lacebark, made a natural bandage to hold poultices or to protect the pito while it heals and dries. Charcoal crushed into a fine powder could also be applied to the pito for similar reasons. The bark of the mangeao (*litsea calicaris*) tree could be ingested (boiled in water to produce a tonic) to facilitate labour (Best, 1975).

Other tonics made from boiling pipi shells and drinking the salty water, wild turnip or pohatu (*brassica rapa*) promoted healing and provided nourishing drinks for the mother post the birth of her pēpi and also reduced vaginal bleeding (Riley, 1994; Williams, 1971).

If a child was lost through miscarriage or stillbirth, kohekohe (*dysoxylum spectabile*) could be given to the mother to eat and this would inhibit her milk flow (Taiatini, 2011).

In 1993, the National Board of Māori healers, Ngā Ringa Whakahaere o te Iwi Māori established itself to provide a united front for traditional Māori healers. Primarily, the Board members worked towards protecting cultural practices around rongoa Māori, whilst encouraging the use and sustainability of this art form (Jones, 2009). There appears to be a growing acceptance of how rongoa Māori can contribute to healing on a physical level. More work is required to gain acceptance that rongoa Māori is not one
Mirimiri and romiromi (massage) were used to assist the hapū wahine through her hapūtanga (pregnancy) and during labour. The attendant(s) or husband would apply gentle mirimiri to the uterus in a downward motion on contraction. This process could perhaps be likened to an external guidance to aid the pēpi (baby) down the birth passage. Mirimiri to the tuarā, buttocks, arms, forehead, upoko (head), soles of the waewae (legs and feet) all aimed at releasing tension, directing pain out of the body and realigning spiritual and physical channels within the body (Beattie, 1994; Best, 1975; Mihaere, 2011; Taiatini, 2011).

Massaging the pelvic, peritoneal and inner thigh area during labour provided a physical manipulation to aid an opening into that area during birth. Mirimiri combined with karakia (incantations) and oils such as kawakawa (for backs) and karaka (over the puku) greatly assisted the labour process (Holmes, 2011; McLean, 2011; Pond, 1997; Stone, 2011).

A kuia from the East Coast gave descriptions of the three main motions she used to mould the baby’s bodies post birth. She defined mirimiri as short strokes using fingers, romiromi as a kneading motion and tukituki as the pummelling motion with the hands.
moving up and down over the body. Mothers or whānau members would gently massage the baby’s head, face, arms and legs regularly to promote features that Māori were keen to obtain, such as straight long legs, flat foreheads, straight feet, arms, front and back (Phillipps & Huria, 2008).

Mirimiri specifically over the ū (breast) and kōmata (nipples) of the hapū wāhine would commence towards the end of her first trimester of pregnancy. This would prepare the breast for lactation. Pēpi were breastfed until they were approx. 10-12months old, some longer. They could be weaned by rubbing kawakawa leaves over the nipples. This left a bitter residue and reduced the baby’s temptation to suckle (Papakura, 1938; Riley, 1994).

Awhitia Mihaere (2010) uses the pressure points at the top of the thigh near the vagina and perineum to apply koomirimiri (a preferred term used by Awhitia to describe a soft touch). Using her waewae (feet) she gently kneads this area to prepare the wahine for labour, and those already in established labour to facilitate the opening of the cervix. Mihaere said that she would begin this form of mirimiri with wahine hapū and their whānau three months prior to birth and right up to delivery.

Awhitia and her partner Manu’eu Suganuma run popular antenatal/hauora workshops in South Auckland and various other locations in New Zealand, and around the world. Manu’eu is from Hawaii and like Awhitia, sought consent from his elders to share some of the traditional Hawaiian birthing practices within these workshops.

Awhitia learnt her knowledge from her grandfather Wiremu Mihaere of Ngāti Maniapoto, who was a midwife in the Dannevirke area. Wiremu’s wife Lena Ngete Reweti Hamiora Nee Paewai worked alongside him preparing wāhine with rongoa during their hapūtanga and after pēpi is born, Lena also performed oriori mokopuna to the pēpi as they were travelling into this Ao (world). It is from her father’s side that Awhitia has learnt her knowledge around traditional Māori birthing practices.

Awhitia also acknowledges her learning’s with Hohepa Delamere (well known Māori Healer and te reo expert) in his wānanga (workshops) called, lhe tāngata, Ire tāngata.

Awhitia acknowledges the tuakana/teina relationship that exists within her collaboration with her partner Manu’eu. Hawaiki she expresses is the tuakana and
respect is always shown towards the ancient homelands from whence Māori travelled. Their workshops are about: rongoa (Māori medicines), kōmīrimiri (soft touch for pēpi), kōrero (discussion), Hawaiian hula (Awhitia and her partner teach the hula dance to expecting mothers and partners – this form of movement allows the pēpi to move gradually through the birth canal and waiata (song). These offerings provide the participants with resources and techniques that they can take away and practice and use throughout their pregnancy, labour and birth.

The use of mirimiri or romiromi as a rongoa for most body ailments continues to be a strong component of hauora for Māori today.

*Kōhatu*

Taiatini’s research found that the use of heated kōhatu (stones) to relax back muscles and to place upon the body’s pressure points provided relief (Mihaere, 2011). One of her research participants remembered a kōrero (discussion) about their nanny carrying heated kōhatu inside a ponga plant. Once beside the patient the ponga would be tilted to allow the hot kōhatu to roll down onto the ground. The kōhatu would then be wrapped and placed upon the person’s tuara (back) (Taiatini, 2011).

*Wai*

Water is another form of rongoa (medicine); resting in ngāwhā (hot springs) water is a relaxant and a way of slowing down a fast labour. The springs act as a form of mirimiri with the wai (water) bubbling around the puku, buttocks and chest area. Water can allow a labouring wahine to change birthing positions due to the buoyancy of her body and it is noted in the literature all around Aotearoa that water from creeks, waterfalls, rivers, salt water pools and ngāwhā (hot springs) have all been utilised to aid labour, birth and the expulsion of the whenua (afterbirth) (Best, 1929; Gray, 2010; Holmes, 2011; Pitama, 2011).

In Te Kaha, babies were born on the beach warmed by fires (Banks, 2000). The flow of water in creeks and rivers helped post birth to wash the mother and to push the whenua (placenta) forward, going with the flow of the current, meditating with the sound of the flowing water and relaxing after a tiring labour. An attendant could also use the bare sole of her foot to gently apply pressure to the mother’s abdomen while she sat in the
water. This again helps release the placenta and any blood clots. The cool temperature of the water helps to constrict blood vessels and stop ongoing blood loss (Holmes, 2011; Makereti, 1938; Taiatini, 2009).

Roka Ngarimu-Cameron (2011) recalls her kuia from Whakatōhea using seawater to bath the baby in post birth. Later doctors told them that there were germs in salt water and this practice was not safe, yet this was a common practice for them with no previous problems associated with it.

Noi Hudson recalls her Uncle telling her about her entrance into the world. Noi is one of the last surviving elders of the Whakarewarewa Pa in Rotorua. Whakarewarewa Pa has been, for many years, a living thermal village that attracts thousands of visitors every year. Tourists enjoy being guided around the thermal Māori village that sits upon active springs and bubbling mud pools.

Noi lived at Whakarewarewa Pā in the 1930 and 40’s. The members of the Pā would share their resources such as whare and kai. The community gardens were situated many miles away due to the inability to grow anything at the Pā because of the high sulphur content in the soil.

Noi spoke about the long walks to the community gardens that most had to undertake to ensure they shared the workload of maintaining the gardens and the produce when harvested.

Noi’s mother went into labour at the community gardens and had to walk back to the Pā by herself. When she arrived she hoped that a neighbouring wahine would be around to help her but this was not to be. Instead, Noi’s Uncle who was 14 years of age at the time walked in to see his sister in distress. Using his farmhand skills, he matter-of-factly helped Noi’s mother to birth. Lying on her side, Noi’s Uncle held her leg up and managed to catch Noi as she was born. Noi’s mother then went to the springs, used only for menstruating wahine and other situations such as birth, to clean her and the pēpi. Following a short rest Noi’s mother ventured back to the community gardens with Noi carried in a wrap on her back (Hudson, 2011).
Kai

A variety of foods were given to the hapū wāhine to facilitate labour. Murdoch Riley (1994) lists harore (mushroom), koromiko (a type of shrub), mamaku (black fern) and the inner flesh of the nikau plant helped relax the pelvic ligaments.

Kai (food) given to a mother to encourage good milk quality and quantity included berries, kererū (pigeon) meat, inaka (whitebait) and according to Janet Taiatini (2009) the Eastern Bay of Plenty iwi were said to have used prepared mohi (small fish) to nourish the labouring mother.

Taiatini’s study participants spoke about the importance of good healthy eating during pregnancy. The cultivation of the next generation was given the upmost respect and in ancient times it was written that some hapū wāhine were given the first taste of the seasons harvest of kaimoana (seafood), kai o te ngāhere me te māra hoki (foods of the bush and the cultivated gardens) (Taiatini, 2009).

The young fern fronds of the mamaku (Black fern – Cyathea medullaris) could be heated and included into a poultice directly onto the inflamed breast(s) to reduce breast inflammation but were commonly cooked or steamed and then eaten like a food. The desired affect from the mamaku fronds was to aid in placenta expulsion, similar to the medicinal usage of the puha plant (sow thistle – sonchus oleraceus). Puha was added to the roots of both the harakeke (flax) and raupo (bull rush – typha orientalis) to achieve the same affect as the mamaku (Best, 1929; Riley, 1994; Taiatini, 2009, 2011; Totoro, 2011; Whitau-Kean, 2011; Wiiliams, 1971).

In the Southern region of Aotearoa cooked seal blubber or hinu was a good medicine and food source for all, but in particular for pēpi. Other sources spoke about the oil of the seal being dripped into the mouth of a newborn to encourage the pēpi to kaka (defecate). The aim was to rid the newborn of any excrement inhaled during labour prior to the first breastmilk feed. Sealskins were also used to keep pēpi warm; this was noted in the areas with colder climates such as Te Waipounamu, but also amongst Tūhoe hapū (Beattie, 1994; Manihera, et al., 1992; Ngarimu-Cameron, 2011).

Labouring wāhine could bite down on dried mako (shark) flesh purposely prepared to endure the painful pangs of childbirth (Gray, 2010).
Simon Hoete a traditional birth attendant on Motūtiti Island said the juice of the popular sea urchin, kina, was also given to newborn pēpi as a rich nourishing tonic (Taiatini, 1998). Tuaki or tuangi (cockle) juice was another liquid option to feed babies if their mother had difficulty breastfeeding (Stone, 2011).

Broths made from boiled fish or kūtai have also been noted in literature as a drink offered to labouring or post natal wāhine to provide energy and replace lost electrolytes released from the body in the birthing process (Beattie, 1994; Best, 1975).

Kūmara was also a staple food source for wāhine during hapūtanga (pregnancy), (Best, 2005; Makereti, 1938; Riley, 1994).

Eating the flesh of young birds or the inner shoots that rest in the stem of the tī kōuka (cabbage tree), kūmara and fern root were all food sources that aided lactation (Riley, 1994).

_Taonga Pūoro_

_Hine Raukatauri_ is known as the Goddess of Flute music. The shape and overall look of the flute takes after the casemoth to which Hine Raukatauri is said to personify. It is within her camouflage case, that she has woven with tiny leaves and hanging from a branch she calls to her lover and it is this sound heard in the night that Māori try to mimic with their crafted kōauau (flutes) in remembrance of the quiet beauty emanated from an entrapped lover (Flintoff, 2004).
The sound of the kōauau lures the manu (birds) to reply. But apart from this human–nature interaction they were used to carry knowledge, to aid the memory, to retain indepth knowledge, to aid in healing, especially broken bones and to also impart knowledge to the foetus and to emanate healing vibrations for wāhine in labour (Flintoff, 2004; Nunns, 2011).

The late Dr Hirini Melbourne was told by Tūhoe elders many years ago about a specific kōauau used throughout pregnancy, birth and up until the child turns 22 months. The pūmotomoto had a notch at the top and only one finger hole. It’s husky, breathy tangi (sound) played near and around the whare tāngata (uterus) and transmitted upon the sound waves and vibrations: tribal knowledge, stories and whakapapa (family ancestral lines). These Tūhoe elders said they would continue playing the pūmotomoto until the last fontanelle on the pēpi’s skull become fused around 22 months of age. This signified the completion of this phase of learning for the growing toddler (Nunns, 2011).

Dr Richard Nunns and other fellow taonga pūoro players (traditional musical instrument players) are now bringing the sounds of the pūmotomoto and other kōauau to life again, not only to entertain, but as a form of rongoa (healing). Nunns has been experimenting alongside taonga pūoro maker, Brian Flintoff, proto types of the pūmotomoto as described by the Tūhoe elders to Melbourne a long time ago. Interest has also been growing amongst the wider Māori community in including taonga pūoro into their birthing experience. Nunns has witnessed the rewards of playing the pūmotomoto to a hapū wāhine over a period of time.

At a specific wānaka run at a whānau kainga north of Dunedin, Dr Richard Nunns demonstrated the effects of the pūmotomoto by playing them to hapū wāhine. Those witnessing this presentation saw the pēpi in utero gently move whilst the mothers appeared very relaxed. The feedback to Nunns at the end of this session from one of the mothers was that she felt her pēpi move about and she said the vibration from the pūmotomoto sound felt like an internal wind within her whare tāngata (uterus).
The Whare Kohanga also known to other iwi such as Tūhoe, as Te Whare Puhi or a Whare Kahu (also as Whare Whakakahu), all temporary houses used for high ranking births and possibly only for the first born (Heuer, 1974). The term kahu referred to the membrane that lined the uterus and enveloped the pēpi in utero. Some Tūhoe informants said that the mother would leave this temporary whare immediately after birth and others said she remained there for at least seven days post birth (Best, 1975).

It is also noted that the Whare Kohanga appeared to be more prevalent in the North Island than in the South. Southern Māori interviewed by Herries Beattie (1994) did not talk of a Whare Kohanga or anything similar to this instead they spoke of the tohuka (tohunga/specialists) doing specific karakia (incantations) over the wahine post birth to make her noa (common, not sacred).

The wahine hapū nearing her birth would remove herself along with her attendants to this temporary whare (house) established a short distance from her kainga (village), often near a source of water, for instance a river or creek.

Te Whare Kohanga (birthing nest) was a place of tapu (sacredness). Best (1929) reiterated this in his book aptly titled, Te Whare Kohanga. Hierarchy did exist in te Ao Māori and the kawa and tikanga (customs and practices) employed differed depending on status. Tohi and Tua (purification rituals) ceremonies seemed associated more so with higher ranked whānau.

Once the pēpi was born in the Whare Kohanga and had settled well on the breast. The wahine would prepare to leave the Whare Kohanga to present the pēpi back to her kainga. Upon her return she would be lavished with gifts for the baby and a celebratory feast. The whare kōhanganga would then be burnt to the ground to avoid people transgressing the tapu that had been implanted through birth and these sites would often be marked to signify to others to stay away from that area. These sites were often considered tapu for many years and not used by the hapū (Best, 1975).

The attendants were known to some hapū as tapuhi (other hapū had different names for the same role), and their tasks were to attend to all needs of the hapū wahine. The tapuhi were also deemed to be in a tapu state and therefore would prepare their own kai.
(food) and not return to their homes in the kairga (village) until the tapu had been lifted. In some iwi the attendants would be the husband of the hapū wahine or it could be another women in her whānau (Best, 1975; Makereti, 1938).

The Whare Kōhanga in colder times could be kept warm with an ahi tupopoto (smokeless fire). These were made with kahikatea bark that formed a hollow cylinder when dried. This was then placed in a vertical position into the earth floor of the whare, and filled with charcoal. Once it was ignited; as the charcoal burned the kahikatea cylinder was consumed at the same rate (Best, 1975).

**Ngā Whakatūria o te wāhine i whānau mai / Birth Positions**

Māori wahine would birth most commonly in an upright position, kneeling with knees apart. The attendants could then sit or kneel in front of her with their knees pressing on the top of the abdomen, gently pushing down with their knees on commencement of contractions. This is similar to how wahine, if alone, would use the pae whakaruru (birth support, see later in this chapter for more details), or a low-lying branch of a tree. As the contractions progressed the attendant would wrap her arms around the hapū wahine’s body, resting the wahine’s hapū belly upon her knees. As the contractions got stronger the attendant increased the pressure of the belly against her knees and released as soon as the contraction finished. Other informants spoke of squatting with an attendant in front holding the hands of the labouring wahine (Banks, 2000; Best, 1975; Holmes, 2011; Makereti, 1938; Stone, 2011).

Literature and oral accounts did speak about Māori birthing on their side with the top leg raised. Awhitia Mihaere (2010), a Māori health practitioner spoke about the side birth position with the top leg raised, sometimes held in position by an attendant or bent and placed over the lower leg resting on the ground to give balance and strength. She commented on how this position exposes the vagina and facilitates the opening of the birth canal.

Māori mothers birthing on their backs were ra-e and mostly unheard of. This is likely to be why Māori strongly resisted being forced to lie on their backs by hospital staff when birthing in hospitals became commonplace for all New Zealand women (Best, 1975; Holmes, 2011; Hudson, 2011; Makereti, 1938; Mihaere, 2011; Stone, 2011).
Kaiwhakawhānau and Kaimahi/ Birth Attendants

Waitaha Kaumātua Huata Holmes said that small children in his hapū were not deprived of any life events. They would frequently be a part of birth and death experiences, learning through watching the care and practices that took place (Holmes, 2011).

Yet on an esoteric level of knowledge and ritual, only few from his hapū would be graced with this duty. The elders selected those who would learn this specialist knowledge. It was important that those chosen would carry the knowledge wisely.

Holmes (2011) spoke of bugena a term used to describe both male and female specialists, who were consulted over matters such as: infertility, delivery positions, impotency and any other concerns during the pregnancy, birth and post birth.

It was noted in Best (1975) that those who cut the iho (naval cord) were known as tapuhi in certain hapū. They were seen as experts and this particular procedure was left for them to complete. The tapuhi could use a style of birth kōrero (talk), waiata or storytelling to encourage the wahine through her labour (Palmer, 2002).

Maurice Gray (2010) spoke about the attendants in Chiefly births being called Taua Ruahine (priestesses). These older women had special skills to holistically assess a hapū wahine’s state of spiritual and physical wellbeing and to raise any concerns in advance to the tohuka/tohunga (specialist) as quickly as possible. If they did not detect anything yet the pēpi and/or the mother encountered problems the taua Ruahine, would be blamed for the mistake. Therefore the work of the taua Ruahine was considered very tapu (sacred) and an extremely significant part, alongside karakia, in the whole birthing process.

Waitaha wahine were the main carers of hapū wahine, but the bugena (experts) were called upon for advice and guidance in regards to all matters of conception and childbirth (Holmes, 2011). Te Arawa used the name hunga whakawhānau iaia to describe a birth attendant.

All birthers knew how to check the whenua to ensure it was complete. It was well known that if any of the whenua remained inside the uterus it could lead to infection and maternal death (Best, 1975; Palmer, 2002).
Immediately after the pēpi was born some hapū would invert the pēpi and give it a gentle shake to release any residual secretions. It was also known that attendants would also relieve the secretions in the nasal cavity by placing their mouth over the pēpi’s nose and sucking the secretions out. This allows the pēpi to breathe and reduced the risk of secretions pooling in the nasal and lung area (Banks, 2000; Makereti, 1938; McLean, 2011).

The Role of Tane in Birth

It appeared that the role of the tane in many tribal locations was one of key support. If they were not birthing their own child, they were often birthing others, in the role of kaiwhakawhānau or they held a tohunga (specialist) position to perform karakia (incantations) during hapūtanga (pregnancy), birth and kawa (rituals) conducted post birth such as the maioha, tohi or pure ceremonies (welcoming and cleansing ceremonies). Male birthers were known to the hapū (subtribe), they attended most births in their kainga (village) and often their skills were passed down to them from their tūpuna and it was a given that they would then pass their skills to another whānau member (Exton, 2008; Harte, 2001; Makereti, 1938; Ngarimu-Cameron, 2011; Stone, 2011; Whitau-Kean, 2011).

Herena Stone (2011) spoke of her grandfather who was known in the Wairoa community as the local birther. It was his nanny who gifted him the skills and
knowledge around labour and birth. His nanny raised him and they attended births together between 1900 and 1910, staying with whānau leading up to birth and often until both mother and child were well post birth. At a very young age he assisted his nanny with birth preparation by boiling water, heating the kōhatu (stones for massage and relaxation but also to warm the blankets used to wrap the pēpi) and picking rongoa (Māori medicines). Stone said he would also collect the whenua (placenta) and bury it. As his nanny aged her eyesight began to fail her and so Herena’s grandfather took more of an active role in birth. Upon his nanny’s death it naturally fell upon him to attend births. He delivered many local babies and four of his own tamariki (children), but due to the new legislation that was enforced around this time it became illegal to birth babies unless formal training had been undertaken. Stone’s grandfather was pressured to retire from birthing and the rest of his own children were born in hospital. He told his granddaughter Herena, that he strongly believed that his children born in hospital were sickly due to the lack of ritual involvement. This component of birthing he believed was as crucial as the physical component (Stone, 2011).

There were some iwi that preferred the male to be removed from the birthing domain. They acknowledged that the wahine knew better in this area and could cater better for needs of the labouring wahine than their husband or male members of the whānau. The male role became more dominant post birth in rituals mentioned above (Best, 1975).

Helen Mountain Harte’s research prompted by the work of her mother Emere Kaa Mountain, a Māori health nurse and district nurse in the Bay of Islands during the 1930’s. Harte interviewed twenty-four wahine Māori who had given birth in the 1930’s for her research project and it was interesting to note how prominent in these interviews the men were in the births of their older children and how these kuia became remorseful when discussing the impact hospitalisation had on disengaging the input that men once had in the birth of their own tamariki (Harte, 2001).

“I had six at home, one with my Grand Uncle and one with my husband. They helped me and massaged my body. Lovely. Never leave you” Kuia 1 (Harte, 2001, p.95).

“Eight children were born at home here at Mokcu and two at Whangarei Hospital. It wasn’t so easy but my father was a good doctor so everything was OK. Was as good as a doctor. My father was good. I love my father. He had a gift for it. He was taught. My sister
and I didn’t go to a hospital. He was our doctor. Nearly killed me when he passed away.”

A retired matron and a maternity hospital supervisor shared their kōrero in Ukaipo (a publication reflecting the stories of wāhine Māori about their experiences of childbirth), she spoke about the social climate in the 1920’s that encouraged the removal of men in birth, as it was thought that the risk of infection was heightened with support people insitu and a sterile environment for delivery was upmost (Rimene, et al., 1998).

Ngāti Kahu Kaumātua Pereme Porter reflects on his time as a young boy chosen from his whānau to attend births and take part in a ritual, that made more sense to him as he grew into this role, than it did when he was first initiated into this line of mahi (work). Pereme’s role was to not only recite deep and lengthy karakia (incantations) that provided the whakapapa and welcome of the pāpi to this Ao (world), but he was the one to sever the umbilical cord. A job he assumed was undertaken by an edge of a mussel shell – this was not the case for Pereme’s people they bit the umbilical cord severing it with their teeth. The iho was then tied and the whenua taken to their birthing tree and laid to rest there with the many others that had also been returned to this significant spot over the years. Pereme realised over time that his job was an honour and a privilege. He was part of something so sacred and important that the learnings he came away with set him in good stead for the rest of his life. Pereme regrets that as the world has moved and changed so to has the Māori world. Roles once held have been forgotten and he believes are now undervalued. Especially for Pereme, the role of the wahine and the mana of birthing the next generation has been challenged and for many lost. Until this is rectified the balance and wellbeing of future Māori children is at risk.

"I was taken by the matriachs of my whānau to the birthing tree...here they guided me to hongi (press his nose) upon the tree...I thought they were mad and I didn’t want to do it...but anyway they made me do it and I walked up to the tree and I did a hongi to the tree and then turned around to see them all crying, hūpē (phlegm) running from their noses...they were doing karakia and then they guided me to the river and I had to go into the river while they continued to do karakia and tangi, more hūpē and roimata (tears). They told me I had the ihi (power) and now needed to share it with others. From then on I
had to attend all the births with them and my role was to recite karakia prior to severing the umbilical cord with my teeth” (Porter, 2011).

Charissa Waerea (2011) values the role her tane (partner) Tihikura played in the birth of their youngest child. Reclaiming tikanga (customs) and practices of her tūpuna around childbirth was and still feels according to Charissa to be the most “empowering act of tino rangatiratanga (self-determination) possible” (p.36).

“Tihikura’s role in my labour and birth was that of kaitiaki, a spiritual guardian or protector and securer of the environment. Physically he was there to help me through the pain, but more importantly he made sure the spiritual pathway was clear” (Waerea, 2011, p.35).

Tāne are kaitiaki of the whare tāngata and this included not only nurturing wāhine during haputanga but also understanding their role in conception and whakapapa. Knowing the importance of the whare tāngata (womb) and honouring the role wāhine have in protecting the whakapapa has and may again guide tane Māori to regain their place in birth today and the impact they can have on ensuring wāhine are looked after (Rimene, et al., 1998).

Rauemi Whānau /Birthing tools

Holmes (2011) included in his discussions a method of measuring gestation dates. He said the pregnant wāhine would tie knots in a string that was fastened to her malo (modest apron) to indicate her gestation dates. The string was a purple colour and this in itself indicated her hapū state. She would keep an eye on the passing phases of the moon and tie knots to the string as a way of keeping track with her birth date.

Paewhakaruru/Paeruru/Paiwhairi are a form of birth support. The appearance given in Best’s literature described this aid like miniature rugby posts with two vertical poles held in place with a horizontal pole strapped to each side. The labouring wahine would place one end into the earth and would kneel with her puku underneath the horizontal pole and upper body over the top. Pushing the paewhakaruru down towards her uterus would apply pressure to the abdomen and assist the wahine to bear down (Best, 1929; Hunt, 1952; Jeffery, 2005; Stewart & Tait, 1951).
Low lying branches of trees could be used in a similar fashion or leaning over large rocks were also employed to assist a wahine birthing alone. Kaumātua Huata Holmes (2011) retells a story about his grandmother that was told to him by Granny Wybrow nee Perkins. Huata’s grandmother was born in the Waitaki Valley, as a young hapū wahine she went on a hikoi (walk) on a seasonal inland track to Manuhaea. Her labour began and she stuck a pole into the ground that created a depression and then proceeded to squat over the depression while bearing down using the pole for support.

A rehu or korahi (flint or flakes of stone), such as quartz, obsidian and pounamu were used to sever the iho (umbilical cord). The edge of the kōhatu (stone), once flaked to the size needed could be sharpened with hoaka/hoanga (sandstone). This method of sharpening could also be applied to pipi shells or other forms of molluscs for the same purpose of cutting the iho (umbilical cord). These birthing resources often became taonga (treasures) and were passed through the generations (Best, 1975; McLean, 2011; Whitau-Kean, 2011).

![Image of a pounamu (Maripi Pounamu) by Kelly Tikao, 2009](image)

Murdoch Riley (1994) wrote that sometimes the iho (umbilical cord) of a baby boy was cut upon a patu (fighting club) to install the hopes that the tama (boy) would become a
great warrior. This was similar to placing the baby’s head on the weapons during birthing rituals such as the tohi.

Various plants provided a range of cords to tie the iho (umbilical cord) and depending what grew well in that area became the cordage of choice. The terms applied to this particular cord varied and names such as: taura muka, whītau muka, hungahunga, kakunga whītau and wānanga whītau (Best, 1975; McLean, 2011; Ngarimu-Cameron, 2011).

When the front and back leaves of the harakeke (flax) plant are scraped, the inner fibre is exposed. This inner fibre is called muka and was used for poultices on wounds, for weaving kete (baskets), korowai (cloaks), kākahu (clothes), taura (rope) for fishing lines, cordage to adhere things and it had numerous other applications. In regards to birth, muka was used to tie the iho (umbilical cord). Other hapū used makahakaha; this is a creeping plant and often located in coastal areas. The stem could be scraped and smoothed and submerged in water to keep it pliable. It could be used as is or soaked in oil such as that from the titoki tree (*Alectryon excelsus*) (Best, 1975). Pingao was also used in Te Arawa to tie the iho (McLean, 2011). Some hapū did not tie the cord with anything, but would simply knot the cord twice and cut in between the knots (Best, 1929).
Whāriki are woven mats made from harakeke (flax) or other natural fibres easily obtained in the village area. They were designed specifically for birth. Kaumātua Te Moana Nui a Kiwa McLean (also known as Bunny) from Tūhoi/Te Arawa remembers when he was a child raised by his grandmother in her papa kāinga (home village), she had taken Bunny with her to attend births and deaths. He said that there were two types of whāriki and it was his grandmother who looked after them for his kāinga. Bunny said the whāriki for birth carried symbols that reflected birth and growth. The whāriki that were used in death and often used to wrap the tūpāpaku (deceased body) or for the tūpāpaku to be laid upon during the tangihanga (funeral) process had motifs that were associated with death. Bunny emphasized the importance of getting the right whāriki for the right occasion. He remembers as a young tama (boy) having to carry the whāriki to the different whānau members (McLean, 2011).

Herena Stone of Ngāi Tahu and Ngāti Porou knew of whāriki being used in Little River (Banks Peninsula, Canterbury) for birth. Herena said that hapū wahine would squat over the whāriki with her partner behind holding her puku during contractions. The partner could apply pressure to her puku (belly) on contractions, similarly to how knees were used by partners or attendants whilst squatting in front of the labouring wāhine (McLean, 2011; Stone, 2011).
In Koukourarata and surrounding areas fine whāriki made from muka (flax fibre) would be used to wrap the pēpi (baby) in. The pēpi would then be taken to perform the tohi ritual in the waitapu (sacred waters assigned for this purpose), once the ritual was completed the whāriki (mat) would be released to the waters (Gray, 2010).

Another name associated with this type of mat is kaokao, it was noted that again the more elaborate kaokao or whāriki were produced for women of a higher status, yet most wāhine would try and prepare a birthing mat in the latter stages of pregnancy. If the pēpi is born in an emergency older korowai or kākahu would be placed underneath to birth the pēpi upon (Palmer, 2002).

Herries Beatties gathered knowledge from his informants about a soft moss that would be gathered in preparation for the birth, this provided a cool and gentle bed for the newborn (Beattie, 1994).

Rua

Small shallow depressions similar to hangi pits were created for labouring wāhine. Rocks would be heated and placed within the pits then removed. The wahine would then be encouraged to sit in the pit. Again oils could be used to omit a vapour to be inhaled and the heat used as a muscle relaxant. Steamed leaves were also placed below the women's bottom, post pēpi, to ease the afterbirth cramps.

A pit was also used to birth the pēpi into with the wahine squatting over it. Bracken fern or a whāriki would be placed in the rua (pit) to ensure a soft and nurtured landing for the newborn (Ngarimu-Cameron, 2011; Taiatini, 2011).

Leisa Aumua, a Kāi Tahu artist, teacher and mother to five tamariki began her journey of research and personal interest with traditional Māori birthing practices whilst she was hapū with her third child and studying Māori Art History. After having two very different birthing experiences with her two previous pregnancies Leisa found herself very curious about indigenous birthing practices. After starting this journey of discovery her interests turned to her own land of origin – Aotearoa.

Leisa spoke to a number of kuia from Kāi Tahu and other regions that shared some memories they had on this subject. Some spoke about a small hollow hole being dug out
and lined with scraped harakeke (flax). The labouring wāhine would then kneel over this small pit and birth her pēpi into it. Leisa was told that the attendants would mirimiri the labouring women’s back and once the pēpi (baby) was born; the whenua (afterbirth) could be placed directly into the rua (hole) and buried immediately (Aumua, 2010).

**Motu Whakawhanau**

Caesarean sections were performed in ancient times in Hawaiki as an accepted birthing method. The literature talks of a famous ancestor named Tura, known to te iwi Māori but noted in James Beattie’s book *Traditional Lifestyles of the Southern Māori*, as a man that many Southern Māori whakapapa to. He was seen as a super-being or perhaps a man who went against social logic at the time. Tura married a wahine (woman) of Rapuwai descent (known as the earliest inhabitants of the South Island, who previously were known as nomadic sea fearers), and it was common for her people to deliver their babies via caesarian section causing maternal death. Naturally Tura was concerned for his wife who was fearful of her impending birth. He refused for her be to cut and suggested she can push the baby out. This is where the story slightly differs in various writings some say that Tura constructed two posts, one behind her and one in front of her, and with karakia and the support of her husband Tura, she naturally birthed a healthy child. Others say that he took his wife’s pregnant belly between his knees and pressed her belly during contractions and the child was born, but all literature mention that immediately post birth his wife cried out in surprise of her accomplishment without having to be cut, “Taukiri e Tura” (taukiri – exclamation of surprise or alarm). This then became a common saying according to Riley (1994) by labouring wāhine in expression of the pain induced by labour and another more popular method of birthing was accepted in this and other areas of Hawaiki and eventually to Aotearoa (Beattie, 1990, 1994; Palmer, 2002).

**Iho**

The term lho (umbilical cord) has a few variations, again depending on location of iwi and hapū. Some refer to the umbilical cord as *pū iho*; pu representing the essence or root of something (Mihaere, 2011). Another term is tangaengae and is used in karakia (incantations) in reference to severing the naval cord (tangaengae) (Firth, 1929;
Hakopa, 2011; Wikaira, 2010). The iho is the middle portion of the umbilical cord, the pito is the section nearest the pēpi and the rauru denotes the section nearest the placenta (Mead, 2003a).

**Pito**

The pito (part of the umbilical cord nearest the baby or naval area) once dried and fallen away from the site is then buried by some iwi, similar to the whenua, in a variety of places such as: in the cleft of a rock, trees or tribal boundaries to mark ownership rights or buried. A pou (wooden post) or a stone might have been used to mark the spot it was buried. Best (1975) highlighted the Matahia district for placing their pito in stone. Small holes were drilled out to hold the pito and then plugged up to secure the pito insitu (Best, 1975). In the case of high-ranking births, Murdoch Riley (1994) said the baby's pito were also placed in a small stone box at the tūāhu (sacred shrine located in a designated outdoor area).

*Figure 15a and Figure 16b* Dried pito from two pēpi (encased in muka cordage). (Kelly Tikao, 2004)

Banks Peninsula hapū would gift the pito to the waters that the tohi rituals were conducted in; this was seen as the wahi tūturū (the correct place) for the completion of this custom (Gray, 2010).

Makareti wrote that the pito was placed in a variety of places in the Te Arawa area but often like the whenua (placenta) it was buried secretly to prevent enemies from placing a mākutu (curse) upon it causing harm or even death to the newborn. Pito could be
buried in the hollow of a tree or buried on the hapū/iwi boundary line or even in wooden or stone boxes and taken back to where the tohi ritual was performed (Makereti, 1938).

Tungane Kani (2011) said she was aware of elders who had kept the pito of their tamariki wrapped in a piece of cloth or placed in envelopes. This practice according to Kani was one she was familiar with. She said the pito would be kept close and then at the death of special whanaunga (relative) the pito would be placed inside the coffin or next to the body and buried with them (Kani, 2011).

**Whenua**

Maori Marsden (2003) links the strong connections Māori have with Papatūānuku, the earth mother, to why Māori use the same term of whenua for both the placenta and land. He states that the foetus is nurtured within the realm of the womb and upon birth is then placed on the breast of its mother and this is the same for all life forms.

"Man is an integral part therefore of the natural order and recipients of her bounty" (Marsden, 2003, p66).

Marsden explained this quote by expressing that Māori are therefore products of the earth and it should then be intrinsic for us to nurture and protect from whence we came for the betterment of the environment and for the good of humankind.

Iwi and hapū use different terms to describe the placenta or afterbirth. It has been referred to as the whenua kura or the ewe. The name *ewe is derived from ewēwe (blood relation)* (Best, 1975; Mihaere, 2011; Wikaira, 2010). Hirini Mead (2003) said the whenua is the link between the mother and child. The link between the whenua as in placenta and the whenua as in land is that they both provide sustenance for humans to grow from. The placenta feeds the foetus that then becomes a baby. The land grows people, to contribute to society and Mead says at death we are "born" again into the spirit world.

The whenua (placenta) was buried "whenua ki te whenua" (placenta to land). This enabled both the mana and the mauri of the pēpi to be preserved (Beattie 1990). The whenua when looked at closely looks like a tree with many branches spanning out from
it. Murdoch Riley (1994) in his book "Māori Healing and Herbal" likens it to exactly this. The body of the placenta representing the earth from which things grow, such as trees, and the blood vessels being the roots of the tree, the iho or umbilical cord representing the stem of the tree and the flower or fruit of the tree is the pēpi (baby).

Teone Taare Tikao said when Pakeha doctors and nurses incinerated the placenta of a live baby they removed the child’s mana and destroyed their mauri (life principal). Māori believed, that the whenua (placenta) should be buried in the whenua (earth), to preserve the child’s mana and mauri (Beattie, 1990).

![Figure 17. "Whenua" (Kelly Tikao, 2009)](image)

For other hapū (subtribes) traditionally the whenua could be placed into: rock clefts, below or in and around trees that were established as the hapū (subtribe) birth tree or buried in ancestral whenua or significant sites and marked by a pou (post) or rock which may or may not be adorned with a carving. This tikanga (custom) honours the value of the whenua and it’s role in nurturing the pēpi during gestation. Burying the whenua allows the mama to become pregnant again clearing the physical and spiritual space in the uterus to carry another life again (Beattie, 1990; Waerea, 2011).

In some rohe (regions) such as Ngāti Porou, the bark of a specific tree would be removed and a small section of the tree would be carved out to allow enough room to place the whenua inside and then the bark replaced. Some hapū utilised different trees for the sexes and others would place the whenua of a male child into a different part of the
same tree. Generations of whenua dwell within these trees and reflect a tradition that has held fast during the many social and environmental changes (Aumua, 2010).

Māori of Koukourarata (Port Levy) on the Banks Peninsula buried their whenua below a specific tree in the area (Gray, 2010). Makareti of Te Arawa said the whenua was sometimes taken by the mother or aunty of the new mother and buried in a secret place. It appeared to be the business of the close relative to dispose of the whenua allowing the mother to attend to the needs of the pēpi immediately (Makereti, 1938). There is a sense in the literature, that the burying of the whenua was a quick process that occurred shortly after birth if not immediately.

The most auspicious time to plant the whenua, so that the pēpi can grow with zest and vigour, is at sunrise when the sun is at its “zenith” vertically above the location (Beattie, 1990; Oxford Dictionaries, 2012).

Most hospitals in New Zealand today do acknowledge and often have it recorded in their cultural protocols about keeping body parts in case requested by the family for cultural reasons. Accommodating families to keep the placenta is now a much easier process, thanks to many Māori and non Māori advocates who fought for many years to have Māori values recognised and policies put in place in the hospital setting to ensure these values are observed (Ramsden, 2002).

We also have the current reality of many whānau living away from their Marae and Urupā (family cemetery) and therefore the time can vary between the birth and the burial of the child’s whenua. In order to preserve the whenua until a resting place has been decided or a trip can be arranged back to the Marae, they have often been placed in home freezers or temporarily buried. The latter practice is the preferred choice due to the tapu and noa cultural values. Placing something tapu (sacred) into the freezer that carries food (noa - not sacred) takes the mana away from the whenua and the pēpi that lived within it (Kani, 2011; Ngā Maia o Aotearoa me Te Waipounamu, 2009; Rama, 2011; Stone, 2011; Taiatini, 2011).

Placing the whenua into a bucket or container with soil that can be sealed and buried is a practical way to allow the whenua to decompose and also allowing more time to prepare for a trip or to settle in with the new pēpi. When ready to travel with the whenua to the Marae it can be dug up in it’s bucket and transferred within bags or
within another sealed container. Finally, transferring it into the ipu whenua just before it is buried or placed in a tree, rock or other chosen resting place. Some people prefer to use the ipu whenua from the beginning and take out the plastic bucket or holding container in between. With a greater number of Māori living away from their tūrangawaewae (home area) the tradition of burying whenua and the kawa around this has had to be adjusted to meet the diverse geographical locations that Māori are now living in.

There are a number of materials now used to create ipu (vessels) to hold the whenua and they range from: harakeke (flax), hue (gourds) elaborately adorned with feathers, shells and muka (flax fibre), pumice, uku (clay), wood and other materials. Learning to make these vessels is dependent on wāhine knowing how to do it themselves, a relative who can share her skills or local wānanga (workshops) being run by a passionate midwife or health service that are encouraging of whānau learning how to return the whenua to the whenua (Aumua, 2010; Ngamoke, 2011; Ngarimu-Cameron, 2011; Rama, 2011; Stone, 2011; Taiatini, 2011).
Ko te Pēpi

The pēpi would be wrapped with raurēkau (*coprosma grandifolia*), patete or mangeao leaves (*litsae calicaris*) and then wrapped again within a whāriki. The leaves varied depending on what grew well in that area (Palmer, 2002).

It is said that pēpi indicated to their parents when they were ready to be weaned from the breast. These clues consisted of when the pēpi began to roll over unaided, the arrival of teeth, or when they started to walk. For other hapū it was the mothers preference to when she would wean her child. If a mother had difficulty feeding her pēpi due to a breast infection or something similar, tuangi (cockle juice) could be given to the pēpi as a form of nourishment until the mother was able to resume breastfeeding (Best, 1975; Stone, 2011).

Mirimiri or romiromi (massage) were frequently applied to shape the bodies of the newborn and to relax them. (Please refer to the Mirimiri/Romiromi Section in this Chapter).

Pēpi were often carried in various forms of slings or pīkau (back pack) worn by the mother as she continued on with her daily activities. Sometimes the use of a type of swinging cradle called a porakaraka or a parakaraka. This would be suspended near where the mother was working. A rope attached to it would allow her to rock the cradle-type basket whilst she worked. A similar set up was also mentioned in Best’s (1975) writings that resembled today’s jolly jumpers. This was an enclosure constructed of supplejack and a whāriki that when the child was placed into it would hold the child upright allowing the child to hold its weight with its legs.

Mangemange leave (*lygodium articulatum*) or waewae koukou moss (*lycopodium volubile*) according to Murdoch Riley (1994), were used as nappies for pēpi.

Near Taihape, William Phillipps found sources that described nappies made from fine moss called kohukohu. Soiled sections of the kohukohu could be removed and replaced with fresh moss. A wrap enveloped the kohukohu called a kope. On the East Coast literature suggests that muka scrapings (flax fibre) were used for newborns and this was known as kukukuku. In the Hokianga region it was reported they used a perfumed
moss, waiwaikoko; this was dried and used in a similar way to other mosses mentioned above (Phillipps & Huria, 2008).

Koroingo/Maioha

This was perceived as a welcoming ceremony for the newborn and a celebration of achievement for the parents and whānau of the pēpi. The whānau would be part of a service often lead by the tohunga or another elder experienced in this particular procedure. Speeches would be made to the mother and father's whānau and then the infant would be addressed in the form of a maioha (welcome). The content of these speeches would carry messages of acknowledgement of the child’s journey to Te Ao Marama and the hopes and desires for this child to live a productive life that will aid his/her people (Best, 1975).

Tohi

The ceremony known as the tohi or tūā was conducted when the pito (the remaining part of the umbilical cord) came away; normally 6-8 days after birth. The tohunga would be informed and the child would be taken to the water and there the tohi ritual would begin. The tohi was a cleansing ceremony that took away the tapu status from the mother and pēpi. The tohi was performed to implore the atua (gods) to guide and nurture the pēpi throughout its life and to ensure great things were achieved by the deeds of this child. The tohi ceremony varied between the sexes and different incantations were conducted. If the child was a first born to a rangatira then the tohi would be more ceremonial (Heuer, 1974; Makereti, 1938). Best (1975) said the tohi rite according to his sources (predominantly from the Wairarapa region) were infrequently carried out for female infants and with the few cases he was informed that the female pēpi was the first born to a Chiefly line. Predominantly the tohi ceremony was performed for first-born male children of higher lineage.

The tohi process was conducted under a tapu (sacred) ceremony. It was to empower a child with mana (charisma, grace, spiritual power). The tohi took place in flowing waters with the tohunga in the water holding the baby. The water symbolises living waters. The gods were invoked to nurture the baby with the desired mental and physical qualities. The name of the particular gods were expressed and if the child
sneezed, coughed or yawned it was seen as a sign that the god mentioned prior to the babies reaction was within this child. Throughout the child’s life, in times of crisis, they can call upon this god for protection and guidance (Marsden, 2003).

Maurice Gray (2010) spoke about the tohi rituals that took place at Koukourarata (Port Levy). People from neighbouring Bays would bring their pépi to the sacred waters to conduct the tohi ritual. Maurice was the last person to have his tohi conducted at Koukourarata. It is important to Maurice that people today learn about these ancient sacred sites and what rituals took place so that they are valued and reawakened.

Mate

Infant mortality did occur but it is difficult to know how frequently or from what common causes. Literature indicates that if the baby was unwell and in some situations had birth defects it may be left to die naturally. It appears that due to the harsh and tough existence of many nomadic hapū and iwi on the move gathering kai and resources, keeping a sick newborn placed pressure on a travelling rōpu (group).

It appears that miscarriages and stillborn babies were quietly buried with little ritual put in place. This could be attributed to the strong tribal lores of tapu and noa. If a mother lost a child at birth it could have been perceived that she or someone in her whānau transgressed a tapu and consequently caused a grave error leading to death.

Some of the women who frequently lost their babies were believed to have a mākutu (curse) placed upon them. There were terms for women who could not birth babies and that was whare ngaro meaning a lost house or a uterus that produces nothing. Tohunga were often called in to perform karakia (incantations) to try and rectify the broken tapu in order for the women to conceive and birth a live child. It was also said to encourage a women to conceive she should stand over the whenua (placenta) of a newly born baby (Makereti, 1938).

In cases where the mother died at birth, the baby would be given to another young mother already suckling her young and she would raise the baby (Makereti, 1938).

If the birth became difficult the tohunga would be called in to administer rongoa (Māori remedies) and to perform incantations righting what was perhaps perceived as a wrong
doing by the parents or someone close to them in their whānau for “moral impurities” or breaking a tapu. The focus would turn to releasing the “hē” so the pēpi could be born. Kawakawa leaves (*macropiper excelsum*) were used in the Chatham Islands by the tohunga who would wave the kawakawa leaf over the labouring wāhine while performing karakia. Various other goddesses were called on in these times to open the pathways for a smoother delivery and assist with what was perceived as a wrong that must have occurred to be cursed with a difficult birth – these goddesses were Hine Korako known to the Te Arawa people as the goddess within the marama (moon) and therefore often associated with menstruation aligned with the lunar cycle. Hine-tinaku was the goddess of the kumara (sweet potato) and was also invoked at times of need (Best, 1975; Makereti, 1938; Riley, 1994).

Often babies were not recognized as a person according to Waitaha Kaumatua Huata Holmes until the passing of one year due to the risk of mortality (Holmes, 2011).

The wairua (spirit of a person) can also be affected by bad omens or a disruption to the status quo. It is said that the wairua is the soul of a person and is present when the eyes of a foetus are formed. The wairua is immortal and remains even when the body dies. When a mother miscarries the wairua of the pēpi can still remain (Moorfield, 2011).

Each soul contains a wairua (spirit/soul) and the mauri (life principal) according to Beattie’s informants in his book *Traditional Lifeways of the Southern Māori* they said that the mauri held the knowledge within the wairua of a person. Unlike wairua when a person dies it will go out of the body, but the mauri remains within the body until death, then it is diminished (1994).

Mākutu could be inflicted upon someone by a tohunga and was powerful enough to remove the mauri. Tohunga were called upon in difficult births to seek the offence and offer karakia (incantations) to make amends to the spirits. If the tohunga was successful the labour would progress and a healthy pēpi would be born. If the tohunga was not, the mana of the tohunga would be compromised and the wellbeing of the pēpi and mama in jeopardy.

Three types of birth were spoken about in Best’s (1929) writings and they all referred to the umbilical cord. Rauru (term for the section of umbilical cord nearest the placenta), so when a birth is termed Rauru Nui it means that the umbilical cord is large and
healthy. The baby has been born with no complications. If the birth was classed as Rauru whiria, this refers to the umbilical cord being tangled and suggests the birth was long and difficult. Rauru maruaitua indicated a tragedy that resulted in a stillbirth and potentially the mother near death (Mead, 2003b).
3.1 The Decline of Traditional Māori Birthing Practices

"Māori are relatively newcomers to the practice of medicalised birthing. With the advent of the 'urban drift', loss of extended whānau ties; Māori have lost touch with their tikanga Māori, lost traditional birthing practices, and quality whānau support, which nurtured good parenting skills from pre-conception, childhood through to adulthood, for male and female. This is tragic, and as my uncles would say, 'because within our ways of Birthing is our way of staying Māori'. The loss of traditional birthing practices could mean the loss of cultural identity" (Kupe-Wharehoka, 2000).

Prior to the European arrival to Aotearoa, Māori were physically very fit and relatively healthy although not always immune to disease and illhealth. The average life expectancy was 35 years of age, which is consistent with other parts of Europe at the same time (Kingi, 2005; World Resources Institution, 1998).

But fitness was no barrier to colonisation, land wars and the musket. Māori health became a concern shortly before 1837, exemplified by the alarming population decline. Although accurate statistics are not available it is known that the Māori population in the 1800's was around 150,000 (Kingi, 2005).

Māori began to move away from their own cultural practices in an effort to survive yet the overwhelming demand for more land for European settlement placed more pressure on those keeping the home fires burning (remaining on the Pā).

Land wars eventually led to the remaining 6.4 million hectares of land still owned by Māori to be placed under the management of the Native Land Court in 1862, Parliament then passed the Native Land Act in 1865. It soon became clear that the intention of the Land Court was to seek individual land title and dispose of customary title that gave ownership to all members of the tribe. Māori had to apply through court for a hearing to grant them a Certificate of Title to land they already owned. Over thirty years from the inception of the Native Land Court four million hectares of Māori land had been sold. According to historian Dr Ranginui Walker this law had "the most destructive and alienating effect on Māori people" (Walker, 1990, p.136).

The loss of cultural assets and treasures over time was exhausting and demoralising, making Māori vulnerable to change and majority rulings. The exposure to sexually
transmitted diseases such as gonorrhea and syphilis rendered large numbers of Māori women sterile. It is estimated that one in four Māori women may have been affected with sterility between the years of 1890 and 1910 (King, 1983; Makereti, 1938; Palmer, 2002; Prior, 1968; Walker, 1990).

Loss of life on a grand scale through epidemics such as: small pox, influenza and measles all played a role in the massive decline of the Māori population. At the turn of the Century the Māori population was less than 50,000. Pakeha population at the same time was over 600,000. Māori were considered at this point to be a dying race (Kingi, 2005; Walker, 1990).

Yet Māori resilience surprised many Pākehā at the time when the 1906 Census showed that Māori had managed to increase their population size by 10% and then doubled this percentage again in 1936, taking the Māori population to 82,326 (Walker, 1990).

Post World War II a greater number of Māori were lured by the opportunity for employment and to aid the war efforts in the cities while others were excited by what the big cities had to offer on a social level. The urban drift on the one hand exposed Māori to new opportunities yet at the same time created issues on the homefront over manāki (care and protection) of whānau and the cultural responsibilities that are required out by those living at the papakainga (home village). Who would carry out these cultural functions when whānau were leaving?

In 1951, Māori population stood at 115,740, 24% of Māori had moved to the towns and cities and the rate of rural to urban shift was said to be 1% per annum (Kupe-Wharehoka, 2000).

Missionary religious teachings and Western medicines and practitioners led many Māori away from their own spiritual beliefs. The passing by the General Assembly in 1907 of the Tohunga Suppression Act made it illegal for tohunga (māori specialists) to practice healing and rituals. Tohunga were imprisoned if found practising and this also contributed to Māori moving away from their own belief systems and towards that of the dominant culture who held the power.

Many non-Māori mistrusted the work of tohunga and aligned it with witchcraft, paganism and being evil. They criticised tohunga led practices, such as the immersion of
people into cold water to clear tapu and illness, the use of rongoa (māori medicines) and karakia (incantations) as being extremely inappropriate and a naïve practice to cure the many diseases being introduced into Aotearoa at this time (Pond, 1997).

Interestingly, Māori doctors and members of Parliament supported this Bill: Dr Maui Pomare, Te Rangi Hiroa (Peter Buck), James Carroll and Apirana Ngata to name a few. These Māori men were perceived as movers and shakers in the Parliament setting. They said they were eager to improve the sanitation for Māori and to achieve better standards of living (Pond, 1997). They too perhaps felt that tohunga could not compete with the Western medical knowledge and practices and therefore the best solution was to assimilate (Pomare, 1934). Consequently, with the passing of the Tohunga Suppression Act Bill, the training of tohunga also declined and many tohunga took their knowledge to their graves.

Māori lost these repositories of knowledge and teaching, for some the spiritual knowledge and customs that they once lived their lives by. The sense of isolation became more intense for those not wanting to assimilate to Western ways. Others happily integrated to Pākehā life styles and enjoyed the new western influences at the potential cost of future generations losing their language and understanding of cultural customs and rituals (Banks, 2000; Harte, 2001; Hungerford, 2008).

It appeared to be a combination of all of the above that had serious impact on the way Māori lived their lives, how they lived, where they lived and what cultural sacrifices occurred along the way. Māori health was integrated throughout all of the new legislations and bodies enforcing the legislations either within direct health related policies and laws or indirectly as a consequence of legislation oppression, land loss and impact of colonial practices.

In 1964 the Tohunga Suppression Act was repealed yet the damage had well and truly been done. The repeal did quell the Government’s disdain for rongoa Māori and the teaching of rongoa Māori in medical schools, placing it within medical degree examinations and as an option within medical research funding at this time (Pond, 1997).

The Midwives Act in 1904 formalised midwifery training and regulated their midwifery practices. State maternity hospitals were established to train midwifery students and
prepare them for their registration. These hospitals were later named the St Helens Hospitals (please refer to Chapter 4 for more detail). Initially this Act had minimal impact on wāhine Māori with only 17% birthing in maternity hospitals in comparison to 78% of European women in the 1930’s (of the 78%, 8% were birthing in St Helen’s Hospitals, 27% in public maternity hospitals and 43% in a mixture of private and public hospital settings). Prior to the mid 1920’s, 90% of Māori were living in rural areas and accessing maternity services was perhaps not a priority or a reality for many Māori at this time. Most preferred to stay at home and be attended by whānau (Gulliland & Pairman, 2010; Walker, 1990).

Those eager to retain their Māori values within their birthing experience were outcast economically as the Government started to coerce people by making maternity care free to those who registered with a doctor and birthed in hospital. This was achieved by making amendments to the Social Security Act 1938. Midwifery care was also free at this time but according to Gulliland and Pairman it was difficult for the midwife to compete against the social status of the Doctor and their ability to provide a popular anaesthetic drug commonly known as “twilight sleep”. The autonomy of the midwife alongside Māori birthing at home were seriously compromised (Gulliland & Pairman, 2010).

Registering births became another financial incentive, as some benefits were not accessible if you did not have your child’s birth registered. This was the case for the Maternity Benefit that was originally introduced by the Labour Government in 1939 to provide financial support and lure women to medical services. However, in 1963 with the passing of more legislation, having your birth registered became aligned with a woman’s eligibility to access this benefit. To get your birth registration you had to have a birth certificate authenticated by a registered midwife or doctor within a maternity hospital (Palmer, 2002).

By 1961, the urban drift had secured 40% of the Māori population. By the mid 1960’s wāhine Māori succumbed to the colonial medical processes with 95% of all Māori births occurring in hospital.

This is still a huge influence today, with many new mothers believing their first child must be birthed in hospital, like their mother and their grandmother. Turning the
thinking back to traditional birthing and feeling confident and strong in what knowledge lies within Māori cultural practices passed down from generation to generation will only occur if the knowledge remains, is articulated and is practised. Similar to the saying that Ngāi Tahu language experts express when stressing the importance of keeping te reo Ngāi Tahu alive for Ngāi Tahu whānau; *it takes one generation to lose a language, it will take three to gain it back*. This too can apply to all indigenous knowledge and specifically to traditional Māori birthing practices and customs (Barr, 2009; Harte, 2001; Walker, 1990).
3.2 Whakarāpopoto / Summary

This chapter recaptures what traditional birthing practices, rongoa and tikanga took place for both high ranked births and those not of Chiefly lines. Many birthing practices and rituals were similar all over Aotearoa, but the finer details did at times differ depending on dialect spoken, resources available and status.

Tapu and Noa graced over all conceptual and birthing arenas due to their intrinsic value implanted in all tikanga practices. Tapu and nca are intertwined in a ritual combination to protect the hapū wahine, spiritually raising the chances of survival of both herself and her pēpi.

Maurice Gray (2011) spoke of the transforming of the “hine” to the “wahine” post her first menstrual bleed. The uterus of a developing girl (hine) is seen to be a whare of pure energy (whare hihiri). Once menstruation begins, her whare hihiri evolves into a womb that is prepared for a pēpi and hence is now known as a whare tāngata.

Men played a significant role in birth. Some hapū preferred the men to be active outside of the birthing arena, preparing the kainga and food stocks for when the mother and child returned. However, for other hapū, men were the kaiwhakawhānau (birthers) or lead attendants, assisting their partners through labour. Male birthers were notorious, birthing not only their own but most of the babies in their kainga (village). Their knowledge gifted by their grandparents would then be duly gifted on to another chosen whānau member who showed a talent towards this particular mahi (work).

Once the pēpi had arrived the welcoming tikanga began to ensure the strength and courage was installed into every child. They were given every bit of effort to set them forth on their pathway to be resourceful to their hapū. It was believed that when a child understands their purpose and responsibility as transmitted to them in utero and post birth via the mediums of: karakia, oriori, waiata and taonga pūoro. The child grows with a strong knowledge platform, not just for individual gain but also more for the betterment of the whānau whānui (extended whānau).

Māori tikanga (customs) began to decline as Māori experienced their lands becoming appropriated, their cultural assets sold and death due to disease. The legislation continued to harper te iwi Māori by individualising land titles (Native Land Act 1865),
taking away customary titles and pitting Māori against each other in a bid to win back land or not to sell what they have left.

The drift from rural areas in New Zealand to the cities took place. Many Māori were lured to the cities by the carrot of opportunities within employment and others to be part of a new trend.

Although the Missionaries had by now been entrenched in New Zealand history for a decent period of time, they too had strong persuasion to encourage Māori to move away from their own spiritual beliefs towards the Christian faith.

The repositories of ancient knowledge and rituals, the tohunga, were legally stopped from practising their skills with the passing of the Tohunga Suppression Act (1907). Practising and training of other tohunga came to a halt in many areas or their mahi (work) became hidden to avoid risk of imprisonment.

Not all Māori rebelled the colonial changes and legal constraints. A number of Māori welcomed the colonisation, urbanisation and westernisation even if it was at the price for some replacing their own culture with another.

Traditional Māori birthing practices gave way to the Government’s financial incentives and free maternity services. In the 1960’s, 90% of all births occurred in hospital. By then, traditional Māori birthing practices were kept alive by small pockets of Māori in mainly rural communities and those adament to retain Māori tikanga. They were the last bastian. Many other Māori left home to birth in hospital and eventually the knowledge of birthing practices and rituals became vague memories of what once took place.

The next chapter takes a closer look at the hospitalisation of birth in Aotearoa. The transition out of the home, the demise of the lay midwives and kaiwhakawhānau, the formalisation of midwifery training and registration and the current reality for Māori midwives and Māori whānau eager to pursue traditional Māori birthing practices and rituals.
Chapter 4: Whānau Mai / Birth

4. When Birth left Home for Hospital.

Pregnancy and birthing for wāhine Māori in pre-colonial times was generally perceived as natural and healthy. For most wāhine Māori normal activities continued throughout the pregnancy. Māori birthers, male and female, were well known and well utilized within their hapū (subtribe). Their skills and knowledge passed down to them by their tuakana (seniors) and from them to the next generation. Procreation and sustainability of a hapū and iwi were very important to ancient Māori – it was strategically planned for survival. Those who aided in sustaining whakapapa (genealogy), such as kaiwhakawhānau (birthers) and tohunga (specialists) were held in the utmost regard (Best, 1975; Gray, 2010; Makereti, 1938; Walker, 1990).
With the arrival of European traders, sailors, whalers, missionaries, explorers and settlers came new technologies, new religions and new practices. It was only a matter of time before the ways of the incoming culture impacted on those already on the land.

For the early settlers arriving to reestablish themselves upon this new rugged land of promise; sustainability of self was also a key priority. They needed to grow a population and hence it was essential to place an importance on the wellbeing of the pregnant women and new babies. This was not always easy according to Maggie Banks (2000), author of *Home Birth Bound the Broken Weave*, who said that the European women appeared to struggle with pregnancy and childbirth. Banks said that due to the poor public sanitation, poor housing and vague water supplies in certain areas of the country, the women worked hard and often in difficult pioneering times. Consequently, for some early settler women, the discovery that they were pregnant may not have always been met with delight, but perhaps as more work upon an already arduous day.

Māori who had also been through a resettlement and learning the ways of the land generations before, knew their rohe (home areas) and surrounding landscape. It was a natural way of life to witness both birth and death for tamariki Māori. They were able to learn the practices, rituals and attitudes towards such events from their early years and then model their behaviour on this when their time came (Makereti, 1938; Palmer, 2002).

Jane Stojanovica, a registered midwife who researched the history of midwifery in NZ from 1904 to 1971 argued that even though the climate for the new settlers was challenging, their attitude towards birth was similar to Māori. Stojanovic reports that birth was accepted as a "natural part of a woman's role", childbirth was a family affair, often birthing at home with assistance given to the pregnant and labouring women by their immediate family and/or lay midwife. These midwives worked autonomously, were often married, and had often birthed many babies in their surrounding district (Stojanovic, 2010, p.53).

The European midwives in the late 1800's were known as handy women, lay midwives, monthly nurses or traditional midwives. They learnt their skills by attending births and being hands, like Māori birthers, or learnt their skills from other lay midwives. They
were well known and often birthed most of the babies in their community (Banks, 2000; Stojanovic, 2010).

In 1896, the Māori population reached it’s lowest of 42,113. Missionaries in New Zealand established small private hospitals primarily to address rising health concerns that were quickly annihilating the Māori population (Harte, 2001).

In 1900, New Zealand Government established the first Health Department. Alongside this organisation sat the Native schools, Native medical officers, Māori health nurses, district nurses and midwives, all providing services to attend to poor Māori health. This spurred the new Health Department to investigate ways to reduce Māori maternal and infant mortality. The Department believed that better hygiene practices and access to Western knowledge and medicines could be a solution. Key people within the Health Department alongside civil servants Grace Neill, Dr Duncan McGregor and the Premier at the time Richard Seddon, instigated and passed the 1904 Midwives Act (Banks, 2000; Donley, 1986; Exton, 2008; Gulliland & Pairman, 2010; Mein-Smith, 1986; Stojanovic, 2010).

This legislation changed the way both Māori and non-Māori birthed their babies in Aotearoa and placed midwifery into a medical realm and according to Jane Stojanovic, this then allowed for the "introduction of the nursing culture into midwifery by creating a nurse-midwife". Under the Nurses Registration Act in 1901 trained nurses could halve their midwifery training time down to 6 months to gain their midwifery registration and walk away with two qualifications. Stojanovic felt this move was another factor that aided an identity change of the midwife and allowed not only the medicalisation, but the nursification of midwives to occur too (Stojanovic, 2010).

The Midwives Act made it illegal to practice midwifery unless you had undertaken formal midwifery training in Government training schools located in state owned hospitals, later named St Helen’s Hospitals. The first St Helen’s hospitals opened in Wellington, Dunedin and Auckland with others around the country opening up through out the 1920’s.

In the 1920’s births were still taking place at home (65% of all New Zealand mothers birthed at home) or if not at home, women would attend the small un-licensed one-bed homes run by the local maternity nurse or midwife (Banks, 2000). Jane Stojanovic
wrote that there were private hospitals that functioned the same as the homes above, known as “lying in” hospitals. These were owned by doctors or midwives and were located in the urban areas. In 1920, 26% of births occurred in these hospitals and only 4% in St Helens hospitals (Banks, 2000; Exton, 2008; Stojanovic, 2010; Wassner, 1999).

At this time the trend to birth at home was fading and 58% of women were birthing in hospitals. This figure rose again in 1938 to 87% of births taking place in hospital (Banks, 2000; Hungerford, 2008).

Upon completion of the Midwifery training and meeting the new Midwifery regulations the next step in the legal process was to become listed on the Register for Midwives. Predominantly, registered midwives were in charge of the St Helen’s Hospitals and their targeted clientele were working men’s wives (Exton, 2008; Stojanovic, 2010).

The St Helens Hospitals practised a model of care that placed the women in the centre of all care from ante to postnatal, in the hospital and at home. Their midwives advocated for natural childbirth. This translated as no pain relief during labour and birth, except for the use of gas (nitrous oxide) and oxygen, otherwise known as “laughing gas”. It wasn’t long before the larger general hospitals based in the cities added maternity wings to provide yet another maternity service for families (Gulliland & Pairman, 2010; Stojanovic, 2010).

The St Helen’s Hospitals concept of encouraging women to birth baby’s naturally started to become unpopular with women when the hospitals in the larger centres began offering pain relief in the form of “twilight sleep”. This was a concoction of barbiturates, morphine and scopolamine that dulled both the pain and memory of childbirth. Later, the side affects of “twilight sleep” were addressed in research that revealed it depressed the baby’s central nervous system, making babies drowsy and seriously compromising their respiratory function (Banks, 2000; Donley, 1986; Webster, 2008).

By the mid 1930’s the Health Department had to relinquish their authority over the St Helen’s Hospitals to the Health Boards. The Health Boards endorsed the offering of “twilight sleep” as a standard midwifery practice for childbirth and hence made “twilight sleep” more available to women birthing in all hospitals (Gulliland & Pairman, 2010).
Despite all these medical offerings, Māori women were not birthing in hospitals and yet Māori women and their babies were dying at four times the rate of non-Māori due to post-natal complications (Aumua, 2010; Banks, 2000; Gulliland & Pairman, 2010; Harte, 2001; Mein-Smith, 1986).

In 1936, a Commission of Enquiry into Maternity Services took place in New Zealand. Hospital Boards, midwives, doctors and district nurses from around the Country contributed to the Enquiry. As a result, the commission acquired information confirming that maternity health needed to be addressed, and in particular, Māori maternal health should be actively encouraged to take place in hospitals with medical professionals in attendance. This was the Health Department's recommendation and they proceeded to make this a reality for the New Zealand community (Harte, 2001).

The New Zealand Health officials in 1937 did see the value of Te Whare Kohanga (traditional temporary birthing houses), often erected near fresh running water, as a positive practice towards healthy birthing experiences. Although, they struggled to perceive that the transition from the old ways of living to the dwellings Māori occupied in the larger towns and cities as being beneficial to Māori wellbeing and often wrote in medical reports that the hygiene in the Māori dwellings was very poor and the houses were repositories for infections (Riordan, 1950; Stewart & Tait, 1951).

By 1938, 87% of New Zealand births were in hospital. It also helped that the government made maternity services free with a fourteen-day stay in hospital under the Social Security Act passed in the same year. The Act presented another lure into the maternity services provided by public hospitals. So much so, that many private hospitals that had maternity service fees were forced to close by 1945 (Stojanovic, 2010).

**Anaesthesia**

The use of anaesthetics during labour and birth had a profound effect on how women began to perceive their births and how they should be treated. Jane Stojanovic says that at this point the control left the birthing women and went to those attending her. Labour changed from being normal to abnormal (Stojanovic, 2010).
Once one intervention became a standard practice, the doorway was ajar for others, such as forcep delivery. With more birthing interventions came increased infection rates, thus more hygiene techniques were put in place to reduce the risks. One of the biggest risks that the Health Department struggled to remove was puerperal septicaemia, a form of blood poisoning that developed post birth (Miller & Keane, 1983; Palmer, 2002).

Puerperal septicaemia had been an ongoing problem for NZ women since 1885 and contributed greatly to the mortality rate of both mother and child. These figures provided the impetus for the Health Department to move all births to hospital. Yet, hospitals were not void of these complications either. It was a debated issue that often resulted in the doctors blaming midwives for poor hygiene techniques. When in reality research highlighted an increase in sepsis connected more strongly with the greater use of intervention, such as vaginal examination and forceps deliveries often administrated by the medical fraternity (Banks, 2000; Donley, 1986; Hungerford, 2008; Mein-Smith, 1986).

Instead of investigating the real root of the puerperal sepsis problem in order to address it properly it became associated with birth and birth became associated with ill health and disease. In 1937, the Obstetric Society made statements that medicalised birth and termed it as a surgical operation, which in turn gave favour to pain relief being commonly used in labour and birth (Banks, 2000; Brackbill, Rice, & Young, 1984; Donley, 1986).

The hygiene regulations encompassed mandatory infection control and barrier nursing techniques; these are sterile nursing and medical techniques and practices that ultimately alienate contact between the midwife and labouring woman. Husbands and partners were removed through new regulations from the birthing arena and were often instructed to wait outside the delivery suite (Gulliland & Pairman, 2010).

It could be said, that in the move to hospitalise births, the role males once had in the birth experience was seriously compromised. Men and significant others continued to be placed outside the realm of pregnancy care, outside the realm of birth and outside the realm of whānau. This discord still lingers in births today, even after some gallant efforts to reclaim the role of men in pregnancy and birth and shrug off the old
institutional rules, encouragement from midwives, medical professionals and family are required to support men to take an active part in the birth of their children (Gulliland & Pairman, 2010; Harte, 2001; Rama, 2011).

Initially both non-Māori and Māori women resisted the call by the district nurses to go into hospital to birth. Valid excuses of no transport, phones or help at home deterred these women from taking the medical option. Stories of births occurring in transit to hospital are common of this era. However, over time hospital birth rates did rise (Harte, 2001).

In 1930, 68% of non-Māori women gave birth in hospital. By 1938 it had risen to 87%. In comparison in 1937, 16.8% of Māori births were registered in hospital. Ten years later birth rates in hospital for Māori climbed to 49.5% and in 1962 90% of all births took place in hospital. Researcher and author Helen Mountain Harte (2001) concluded that these figures are indicative of a fast change that took place from one cultural practice to another, even though Māori were reluctant initially to make this transition.

Another factor that provides additional insight to the character of our early midwives is that prior to the 1960's married women could not train to be a midwife. This was a huge contrast to the fact that most lay midwives in earlier times were married and had given birth themselves. The midwifery profession leading up to the late 1960's consisted of predominantly young unmarried women with no personal experience of childbirth. This is an important point when comprehending how difficult it must have been for all experienced mothers and, in particular wāhine Māori to birth in hospital with young non-Māori women telling them how to birth and what they must and must not do. At this time of birth transition from home to hospital, many of these Māori women had more often than not had already birthed many babies at home. Coming into hospital after having their previous babies birthed by mature lay midwives and/or male birthers, who had the respect and wisdom of their whānau and hapū (subtribe) must have been daunting and uncomfortable.

Helen Mountain Harte spoke to Māori women who had babies in the 1930's, for a project titled, Home Births to Hospital Births. Her findings generated through their birthing narratives highlight how patronising and domineering many of the hospital midwives
and doctors were at this time, leaving these wāhine Māori deeply saddened by their birthing memories even into their late 80’s and early 90’s (Harte, 2001).

Kuia 1

"...I had four at home. There are quite a few of us. I wasn’t the only one who had babies at home in those times. I don’t want to go to the hospital... They lift your feet up in the air ...In hospital you lay on your back and your legs are lifted up. That’s why I think it was so painful. And they’re prodding here and there...It’s not till afterwards that you think how embarrassing because it’s so painful" (Harte, 2001, p.94).

Kuia 3

"They took me to hospital at Whangarei. In the hospital, one of the sisters, one of the nurses, she said, she’s a sister, when I was going through the pains, and she said to me, “When I tell you to push, you push”. And I thought, “Oh well, push”. And then she said, “You push”. I pushed and then stopped you see. And then she slapped me for not pushing down you see. I said to her, “You wait till your turn comes and see if you are able to push”. I got wild with her you see. I didn’t like that about hospitals“ (Harte, 2001, p.96)

Another important point lies within the early training of midwives. The training given at this time to student midwives addressed the physical needs of the mother only. No interest or even awareness was applied to any other aspect of childbirth or any other member of the family. Māori culture bases their wellness on a holistic model, where physical wellness (tinana wellbeing) sits alongside wairua (spiritual wellbeing), whānau (family wellbeing) and hinengaro (mental wellbeing). Dr Mason Durie and colleagues have since developed a model to represent this concept, The Tapa Wha Model (1982). This health model acknowledges four key areas of a person’s wellbeing.

A model of a whare (house) is used to illustrate this health model. The four areas of health as mentioned above are likened to the pillars of a house, the key mainstays of a house. If any one of the pillars becomes unwell or unstable then it will have impact on the three other mainstays, implying that the house is unsteady. So when assessing a person’s health, the practitioner needs to look widely at all other areas that may be affected, not just what is being presented or diagnosed as the primary concern.
Durie’s model of care has been derived from old Māori values and is an example of how approach to care such as those provided in earlier midwifery, nursing and medical training can be culturally inappropriate and run the risk of non-compliance, poor care and escalating ill health (Morice, 2006).

Maternity care became fragmented into antenatal, labour and birth in the 1950’s and 60’s. Care was given to each of these phases in different areas of the hospital, as it still exists today. Now you have antenatal rooms, birthing rooms and post-natal rooms with neonatal care units that specialise in intensive care for sick babies. Parents of neonates can stay with their babies, but more often than not they are accommodated in another ward away from their child and the accommodation only provides for one member of the whānau. This is often difficult for whānau Māori (Māori families), who collectively care for their whānau member (Gulliland & Pairman, 2010).

The fragmentation of childbirth into clinical components and medicalising the approach, according to Karen Guilliland and Sally Pairman (2010), created barriers for women to perceive childbirth as natural and that they had the power to birth well. It also took the belief away from midwives in assisting the natural process of birth and the control of the women birthing. The result still lingers strongly in our maternity services and within the thinking of some of our current midwives.

"Midwives experienced birth as an interventionist and medicalised activity where doctor and/or the hospital directed the process" (Gulliland & Pairman, 2010).

From the mid 50’s newly formed organisations such as the: Homebirth Association, Parent’s Centre, La Leche League and others were established by mostly women advocating for a change in midwifery practices. These groups, together with midwives and a smaller number of doctors wanted a serious review of the routine pain management in labour, the strict hospital maternity care protocols and the lack of informed choice and consent in order to provide a better child birthing experience for women and their families.

The 1971 Nurses Act added more gusto to the gradual disempowerment of Midwifery Scope of Practice, by setting in law that a midwife could only work under the supervision of a doctor (Banks, 2000; Gulliland & Pairman, 2010; Stojanovic, 2010). It took another 20 years and numerous amendments to the original 1904 Midwives Act,
including combining it with the Nurses Act in 1925 to then become the Nurses and Midwives Act. Followed by more changes in the 1930's, 1945, 1957, 1962 and 1971. It was in the 70's that the management of the Nursing and Midwifery regulations fell upon the newly established Nursing Council of New Zealand (Gulliland & Pairman, 2010). The Council became responsible for the “protection and safety of women and babies during the childbirth process by providing mechanisms to ensure that midwives are competent and fit to practise” (Otago Polytechnic & Canterbury Polytechnic Institute of Technology, 2012).

The “maternity consumers”, mentioned above, such as Homebirth Association, Parent’s Centre and other similar groups, raised their concerns again in the early 1980’s, about increasing interventions into the birthing experience with modern technology. They expressed that the impact technology was having on childbirth practices within New Zealand’s maternity services further removed the voice of the pregnant women and her family in the birthing process (Gulliland & Pairman, 2010).

It took another 19 years of hard work from many midwives, associated health colleagues and the growing homebirth associations to encourage the next momentous change in New Zealand’s midwifery history. In 1990, an amendment to Section 54 of the 1977 Nurses Act was accepted to effectively reverse all the previous amendments allowing midwives once again to provide sole care and responsibility for a woman through pregnancy, birth and post birth (Gulliland & Pairman, 2010; Hungerford, 2008).

Altogether it took 86 years from the 1904 Midwives Act to the latest amendment in 1990 to recover some of what was initially intended with the former act. The most recent amendment gave birthing mothers and families more choice on who they could choose to assist them through childbirth and, for midwives, the ability to grow their own style of practice.
4.1 Māori in Midwifery

"To challenge maternity services to give long, thoughtful consideration as to whether their method of Practice is appropriate for the special and particular needs of some Māori whānau. To support our Māori midwives and encourage them to challenge themselves as to whether they too, are meeting the special and particular needs of some Māori whānau" (Kupe-Wharehoka, 2000).

The NZ College of Midwives (NZCOM) was established in 1989 to form an identity for the midwifery profession with the intention to promote and shape midwifery professionalism. The New Zealand College of Midwives sets and promotes midwifery Standards of Practice, the midwifery Code of Ethics and is also involved with midwifery education. The NZ College of Midwifery also define the Standards of Practice that provide an optimum level of practice that all midwives should be aspiring to within their delivery of care. NZCOM represents over 2800 members and has become recognised as the “voice” for student and registered midwives (New Zealand College of Midwives, 2008; Otago Polytechnic & Canterbury Polytechnic Institute of Technology, 2012).

In 1969, the New Zealand Nurses Association established the Midwives’ Section in order for midwives to be able to join the International Confederation of Midwives. The ICM gave New Zealand midwives a global connection to international activity around midwifery.

Following on from this initiative the representatives within the Midwives’ Section commenced a National Committee. The role of the National Committee was to develop national forums on midwifery issues in Aotearoa. Over the following years the Committee facilitated midwifery conferences, promoted midwifery to the general public and altogether grew a stronger “voice” for midwives (Gulliland & Pairman, 2010).

Towards the end of 1980 the National Committee members began to look more closely at the lack of Māori representation on the Committee. By 1991, the National Committee approached Irihapeti Ramsden, a prominent Māori spokeswoman on cultural safety within the nursing realm, on how best to consult with Māori in regards to midwifery (Gulliland & Pairman, 2010; Ramsden, 2002). This led to Mina Timutimu from the Council of Māori Nurses, being the first Māori representative to join the National
Midwifery committee. Mina, alongside Joan Donley, midwife, author and founding member, had a huge impact on the NZ College of Midwifery for the knowledge and wisdom they shared. This collaboration effectively opened the door for more Māori input into the approach and care provided by midwives to Māori whānau to ensure that equity in practice was maintained (Gulliland & Pairman, 2010).

Ngā Maia o Aotearoa me Te Waipounamu is a national Māori support network for Māori midwives, hapū wāhine and whānau. Ngā Maia o Aotearoa’s members include: midwives, students, educators and whānau and they have an active Board of Trustees, of which is currently chaired by Taua Aroha Reriti-Crofts. This collective embraces Kaumatua guidance and tautoko (support), and one of the initial visions of Ngā Maia, according to Ngā Maia member Janet Taiatini, was to look at traditional Māori birthing practices and tikanga (customs) and how best include this knowledge into current midwifery care (Taiatini, 2011).

Kaumatua Bunny McClean, who as a young child assisted his grandmother with traditional Māori birthing practices, supports the efforts of Ngā Maia and emphasised the need to include this knowledge within midwifery training.

"The way we were, tipuna were passionate about our old ways. These old ways should be part of the midwifery training. Translate te Ao Māori into clinical practice. Train practitioners to know traditional Māori birthing techniques...we’ve come a long way (with our midwifery training) but we have a way to go” (2011).

Ngā Maia has developed Māori gestational diabetes educational resources and has advised on other maternity resources. Ngā Maia provides a website with a directory of Māori midwives and links to supports and resources. They also have a vested interest in the recruitment of Māori midwifery students and the retention of Māori midwives within the workforce (Clarke, 2011).

Whānau Ora Minister Tariana Turia aptly said in her speech at an official engagement to open the new Ngā Maia offices in Hastings,

“Ngā Maia is about living and breathing our kaupapa – the unity of tīpuna, mātua and mokopuna, the precious bond of whakapapa; the connection between our sacred waters – our whenua; and our land, Papatūānuku, growth and creation” (2012).
Ngā Maia o Aotearoa honours the memorandum of understanding they have established with the New Zealand College of Midwives. Collaboratively they both work towards best practice in New Zealand midwifery by sharing knowledge that best meets the needs of hapū wāhine, pēpi and whānau (Ngā Maia o Aotearoa me Te Waipounamu, 2009).

Ngā Maia in partnership with NZCOM developed, under the guidance of their consultants Tungane and Henare Kani, cultural competencies titled, Turanga Kaupapa.

Turanga Kaupapa has been designed to assist midwives when working with whānau Māori. It is an integral part of the Midwifery Standards of Practice and is illustrated throughout the Midwives Handbook for Practice (2008). This handbook is produced by the New Zealand College of Midwives (Inc) and is a concise and essential reading for midwives and for the general public. The handbook defines what a midwife is, their scope of practice and the competencies midwives are expected to meet in order to be applicable to the Register of Midwives.

Within the Standards of Practice, Turanga Kaupapa provides guidance on how to approach each Standard from a Māori perspective and what may need to be included into the midwives scope of practice to ensure the midwife is meeting the needs of her Māori clients and their whānau. Although these cultural competencies have been developed for midwives working with whānau Māori, these competencies can sensitively applied to all midwifery partnerships (Gulliland & Pairman, 2010; New Zealand College of Midwives, 2008).

The obligations to the core Treaty of Waitangi principals are integrated throughout the NZ Midwives Handbook For Practice in particular within the Turanga Kaupapa supplements (New Zealand College of Midwives, 2008).

The Treaty of Waitangi signed in 1840 is a founding document between Māori and the Crown. It came about as a desire to establish some formality and order between tāngata whenua (local Māori people) and a growing European settlement. (Please see Appendix #5 Treaty of Waitangi)

In order to make the most of this growing population a Company was established by Edward Wakefield under the NZ Association. The Company purchased large portions of land from the Māori for very little and then sold it for huge profits to European gentry.
According to Ranginui Walker (1990), Wakefield replicated the English class structure by selling land to the upper class English. The land that was purchased surplus to the wants of the landowners would then be sold to entice the working class migrants to come to Aotearoa to provide the labour force required to develop the land such as: carpenters, blacksmiths and agricultural labourers. With no current regulations and price control of land purchase it was easy for the Company to continue to buy land.

On the 14th January New Zealand became a colony of New South Wales by the Order of Council and Captain Hobson arrived later that month to carry out the order. New Zealand was seen as a sovereign state and it was handed to Hobson to obtain consent by Māori to surrender their sovereignty to the British Crown. What was to be offered for this significant handover was “British protection, law and citizenship” (State Services Commission, 2006; Walker, 1990, p.90).

The Treaty of Waitangi was drafted and translated by Henry Williams while Hobson revised and made corrections. The outcome resulted in four English versions and one Māori version that interestingly didn’t match any of the English accounts. The Treaty and facilitators then went on a road tour of New Zealand seeking all signatures from all Chiefs.

Those discrepancies and the lack of adhering to the Treaty obligations by the British Crown have caused mortal grievances for te iwi Māori and continue to plague the consecutive NZ governments over land settlements and breaches of Treaty duties (Orange, 1987).

Nevertheless the fear felt by some Māori today if the Tiriti o Waitangi was not in place may far outweigh the huge issues we are all still working through. The NZ Government is still obligated to uphold the principals of Te Tiriti o Waitangi (Treaty of Waitangi). The principals of the Treaty of Waitangi have been placed within all Government organisations and institutions, as a benchmark of approach and service delivery. It would be fair to say still today many New Zealanders still grapple with it’s inclusion into the workforce environment and have difficulty relating the Treaty principals and general understanding of the Treaty of Waitangi within their work practices.
Treaty workshops were put in place and over time some organisations have managed to further define the implications of the Treaty within their work environment and policies (State Services Commission, 2006).

The challenge now, is to successfully sustain the key principals of the Treaty; partnership, protection and participation into the ethos of how New Zealanders work together for the betterment of a unique and exciting society.

Amber Clarke, (2011), Māori midwife, member of Ngā Maia o Aotearoa and Christchurch’s Māori Womens Welfare League, believes that most of the values in Te Ao Māori (the Māori world) are congruent with Best Practices in the current Midwifery Model. Clarke says there is an inherent expectation placed upon Māori within professions such as health, that Māori professionals have to do everything at 200%, because if they do not it has the potential to reflect negatively on all Māori.

"Māori midwives have to continually meet the needs of two worlds – Pakeha and Māori with their clients and also for themselves" (Clarke, 2011).

Herena Stone (2011) felt when she was a practicing midwife that at times it was difficult working with other colleagues who did not support and/or understand the needs of whānau Māori in midwifery. This she said made her feel lonely and vulnerable in some situations. She said it also made it difficult having to justify Māori practices and rituals to other midwives and health professionals within a New Zealand setting, when she had assumed this learning had to some degree already taken place.

Ultimately Māori midwives need to be safe in their midwifery practice on a physical and spiritual level. Safety comes through a clear understanding of their practice, their clients needs and where they sit within this relationship. Clarke (2011) also suggested that having kaumātua (elders) working with Māori midwives provides cultural guidance, maturity, wisdom and maintains a tuakana/teina (senior/junior, mentor/mentoree) relationship for Māori midwives.

Rotorua Midwife Janet Taiatini (2011) said the drive to include traditional Māori birthing practices and tikanga into maternity care needs to be driven by whānau not by Māori midwives.
"I have a professional responsibility to be safe in my practice and I have to record things and discuss with whānau the possible outcomes of their maternity requests."

Taiatini (2011) says whānau carry knowledge and it is important they share some of their knowledge pertaining to hapūtanga and birth to Pakeha midwives so that they can provide appropriate support to whānau Māori eager to action traditional Māori birthing practices into their birth plans.

Current consumer surveys indicate that three quarters of women are now registering with a midwife as their Lead Maternity Care (LMC). The opposite has occurred for obstetricians with a reduction of almost half their number in 2001. Their figures have dropped from 10.1% of women registering them as their LMC to 5.8%. These statistics provide a strong rationale for the need to work with all midwives to ensure they can access Māori birthing practices and ritual information, so they are at least familiar to with what these practices are and can therefore be of greater assistance to their Māori clients (Ministry of Health, 2010).

Christine Kenney graduated from Massey University, Palmerston North with a PhD in midwifery and is the first Māori scholar from Massey to be placed on the Dean's list of exceptional doctoral theses for her 2009 doctorate "Me aro ki te ha o Hineahuone - Women, midwives and miscarriage stories: Towards a contextually relevant research methodology". Kenney of Ngāti Toa Rangatira, Te Atiawa ki Whakarongotai and Ngāi Tahu believes that it is stated in NZ health legislation that midwives are required to assert Māori as tangata whenua (people of the land) and to affirm the principals of: partnership, protection and participation in the Treaty of Waitangi.

Keeney says apart from the incorporation of Turanga Kaupapa into midwifery professional competencies and standards of practice, she sees no insertions of any Māori world-view within the Midwifery partnership model as developed by the NZ College of Midwives.

Keeney has developed a new methodology titled, Te Whakamaramatanga (the enlightenment) that she believes provides more effectively for Māori within maternity care and general health. Te Whakamaramatanga, according to Kenney (2009), acknowledges the gaps and needs in midwifery regulations and education. She says that the NZ Health Strategy (Ministry of Health, 2000) and He Korowai Oranga: Māori Health
Strategy (Ministry of Health, 2002b) prioritised and validated that the wellbeing of Māori addressed the: spiritual, physical, cultural, emotional and social aspects of the individual within the whānau unit (Keeney, 2011). (See Appendix #2 He Korowai Oranga: Māori Health Strategy)

The Health Strategy made these areas key priorities in order to see a better health outcome for te Iwi Māori. Yet Keeney argues that the current midwifery partnership model and professional competencies do not perceive Māori as a equal partner, whom must be involved in all facets of midwifery discussions and especially those that are about establishing practice needs and requirements. Instead, Keeney says that the midwifery partnership model and competencies have been developed “within a Eurocentric framework” and therefore cannot be a valid model or competencies that will sit true for all (Keeney, 2011, p.124).

Midwives have to conform to a set of standards that incorporate principals of partnership, ethical and theoretical factors. (See Appendix #4a Midwifery Standards) Keeney found numerous examples of how these standards reflect a more individual approach to midwifery rather than a whānau (family) focus. In midwifery terms it means working with the whānau alongside the wāhine hapū.

Keeney also found that the midwifery philosophy of partnership developed by the Midwifery Council of NZ, who carry the role of legislation and registration also features within their four professional competencies. These competencies are designed to address the requirements of the Health Practitioner’s Competence Assurance Act (Ministry of Health, 2003). The first competency highlights that the midwife will work with the woman throughout her maternity experience in a partnership. The footnote to this competency further defines the term wahine to include a woman’s baby, partner and whānau. This footnote is repeated for the other three competencies (Keeney, 2011; New Zealand College of Midwives, 2008).

Keeney sees the placement of this definition in a footnote and not in the body of the competency as Euro-centric, stating that the Midwifery Council of New Zealand places their perspective on Competencies in the centre yet other perspectives are delegated to footnotes, implying they are secondary to the primary viewpoint (Keeney, 2011). (See Appendix #4b)
In Chapter 3, the role of the tāne (men) as birthers or attendants is highlighted. Tohunga (specialist) were mostly male, they provided the skills required for karakia (incantations), and post baby rituals, such as the tohi (birthing ritual) ceremony. Many male birthers and attendees were active throughout the labour and birth process. Some were known as kaiwhakawhānau, although other iwi had different terms used to describe their birth assistants. Yet Keeney says this term kaiwhakawhānau infers that the assistant’s role is to “facilitate the creation and development of whānau” (Keeney, 2011, p.126).

Keeney highlights that New Zealand still uses the term Midwife; this term is derived from an old English term “midwif” which means “with woman”. The Midwifery Council of NZ has never changed the midwife label to accommodate tāngata whenua or the potential of encouraging and training men as future birth assistants. Therefore, this thinking or approach could also be seen as maternally Euro-centric. Keeney describes this as a “linguistic strategy” designed to uphold the hierarchy of European midwifery, seeing this as the norm, which in turn has the demoralising affect of making Māori birthing practices invisible or of lesser value (Jenkins & Pihama, 2001; Kupenga­Wharehoka, 2000; Mihaere, 2011). This is also highlighted by a number of Māori midwives, who can not meet the needs of Māori whānau who have requested Māori birthing practices, for fear of going against their midwifery regulations and at the risk of losing their registration to practice (Rama, 2011; Tamati-Elliffe, 2011).

For Keeney, the lack of awareness of cultural knowledge and traditions is evident throughout Midwifery standards and regulations and that this can have a detrimental impact on Māori midwives who feel inferior to their European colleagues.

Keeney (2011) acknowledges the work of Ngā Maia o Aotearoa me Te Waipounamu (National Māori Midwife Collective) for the development of Turanga Kaupapa. Never the less she is disheartened that the principals of Turanga Kaupapa can only be located in the Midwives Handbook and not acknowledged in any underlying philosophies, which she says, can only be perceived as cultural tokenism.

Keeney wants to see culturally appropriate maternity care that can be read throughout midwifery principals and seen in the actions of all practising midwives. This Keeney says, would not only improve the Maternity service for all New Zealanders, it may turn
around the poor retention rate of Māori midwives and attract a higher number of Māori midwifery students (2011).

4.2 Current Reality for Māori Midwives and Midwifery Students in Aotearoa

Like in many other health sectors, the need for Māori staff far outweighs the supply. Māori midwives are too few and are in high demand (Broodkorn, 2010; Ministry of Health, 2002a). Alongside this reality Māori health workers appear to have an inherent passion to over commit themselves to their Māori community. Meaning they frequently work far and beyond their midwife role to ensure whānau needs are met. This outpouring of care and responsibility to whānau Māori and the wider Māori community inevitably leads to: stress, anxiety, ill health and “burn out”. Their passion is admirable but unfortunately not sustainable, especially when their own whānau need them (Moeke-Maxwell, 2007).

Herena Stone (2011) is an experienced midwife and nurse and although she enjoyed her work within midwifery and working with Māori and non-Māori clients, she relates to the difficulties some Māori midwives face. Being on-call 24/7 when working within your own community, she says, is both rewarding yet time consuming. When you live and surround yourself with your community then there is no “down time” and this can only be sustained for a finite period of time.

'I know my clients, they are part of my world...they saw me as part of their whānau and they were my whānau too" (Stone, 2011).

Margaret Broodkorn (2010) took a closer look at the recruitment statistics of Māori nurses and midwives working in the health arena and she concluded that although the numbers have improved marginally, there still needs to be “robust workforce planning and development” to meet the health needs of Māori (Broodkorn, 2010).

There are approximately 45,000 nurses and midwives with current New Zealand practising certificates. Of that figure, only 3035 are registered Māori nurses and midwives, with only 166 registered and currently practising Māori midwives, making up 6.4% of the total midwifery workforce.
According to the Ministry of Health’s Maternity Factsheet 2001 – 2010, the number of babies being born annually in New Zealand has increased by 15%. In 2010, there were 60,641 babies born, of that figure 12,412 were Māori and 33,347 were European, 6700 were Pacific Island, 6616 were Asian and 1566 were of other ethnic origin. Statistics New Zealand have recorded that our resident population sits at approximately 624,210 for Māori and 3,586,550 for European (2006).

Māori population figures highlight that Māori have had the greatest increase in birthrates from 8.9% in 2001 to 10.8% in 2010. Māori women have three live births to every woman in comparison to European women have two live births for every woman. Therefore, the Māori birthrate is higher than the national average and Māori women tend to give birth at a younger age than other women in New Zealand. The average age to give birth is 22 years for Māori women in comparison to European women who frequently birth older at 32 years of age. It was also highlighted that the younger mothers and higher birth rate is often associated with deprivation. Lower socio economic areas have higher numbers of younger mothers, birthing a greater number of babies (Ministry of Health, 2010).

Illustrating statistical data such as that provided here highlights the scenario of birthing patterns for the Māori population and consequently the areas that need to be addressed and planned for to ensure needs are met, education is provided and supports put in place for the wellbeing of the mother, pēpi, whānau and the community. The drive to recruit more Māori midwives is now more urgent than ever before in order to meet current and future needs of Māori whānau and their pēpi (Broodkorn, 2010; Durie, 2003; Ministry of Health, 2002a).

Recruitment of Māori midwifery students is a key focus for Ngā Maia o Aotearoa. Currently there are four main educational institutes with a few satellite programmes that offer the three-year Bachelor of Midwifery programme. One of their 2008 goals was to increase the number of Māori students by 50 per year meaning encouraging approximately 10 Māori midwifery students per school, per year. Ngā Maia found that Māori who may be interested in midwifery as a career hesitated at entering the training required due to the upheaval of their whānau to go to where the midwifery course was held for the study period of three years to achieve their Bachelor of Midwifery. Whānau
play a huge part in decision-making regarding enrolling in midwifery (Vaughn & Babbington, 2008).

Once Māori midwifery students have made it through and received their degree, then the next challenge is to retain them in the workforce. Alongside NZCOM, Ngā Maia o Aotearoa are assessing and discussing what can be done to improve the working conditions for midwives to encourage more Māori to become midwives (Vaughn & Babbington, 2008).

Ngā Maia o Aotearoa me Te Waipounamu is not the only rōpu (group) working towards recruitment of Māori midwifery students and retaining Māori midwives. There are a number of positive initiatives occurring in New Zealand, such as the University of Auckland’s Whakapiki Ake programme that promotes health careers to secondary students. The Hawkes Bay District Health Board have been influential to other District Health Boards with their incubator programme that nurtures young people’s passion for a potential career in the health arena by providing mentoring and/or role models within their own health sector to feed the interests of the tertiary students (Nursing and Allied Health Collection, 2010).

One of the latest Māori health workforce initiatives to assist with retention and recruitment of Māori health professionals is a national Māori nursing and midwifery workforce and clinical leaders development programme titled Ngā Manukura o Āpōpō. A speciality team within the Auckland District Health Board developed a programme in 2010, for registered Māori nurses and midwives to be conducted over a four-year period. The programme’s intent is to provide professional development and preparation for clinical leadership roles (Nursing and Allied Health Collection, 2010).

Grants and scholarships make up a key component of sustaining and encouraging Māori into midwifery and other health careers. There appears to be a good number of Māori scholarships available through a range of learning institutions and Māori Funding bodies such as Te Puni Kōkiri, Māori Education Trust and Te Tapuae o Rehua. All initiatives previously mentioned are positive steps towards growing the Māori midwifery workforce and are favourable solutions to address the shortfall of Māori midwives and midwifery students (Nursing and Allied Health Collection, 2010).
Some Māori midwives who are working both independently and/or with a maternity service are at ease working as Māori within these services, with Māori and non-Māori clientele. Others have developed their own ways of working that allows them to work safely within mainstream maternity services whilst meeting the cultural requests of whānau Māori. Some requests are more overt than others, for instance some Māori midwives have the support of their fellow midwives (both Māori and Pākehā) and are able to articulate how best to work with some Māori clients and their views and advice are accepted and supported within their organisation (Clarke, 2011; Rama, 2011).

For others, cultural practices are performed behind closed doors for fear of hospital staff not understanding and potentially disrespecting the tikanga and kawa, by walking in and/or talking over top or prioritising non-essential care over cultural practices. Māori midwives in these situations are aware there is a potential to be caught between meeting the needs of the whānau and compromising their registration requirements, including obeying hospital rules (Rama, 2011; Tamati-Elliffe, 2011).

As mentioned before, for some Māori midwives cultural needs and tikanga practices can be met without too much stress or change to the way they practice. Other midwives who are proud to be Māori may be at a level of learning that enables them to support traditional Māori birthing practices but would struggle to deliver these practices themselves. Often the whānau teaches the midwife what they have learnt or have been told. This can also be true for non-Māori midwives, some of whom are more familiar with traditional Māori birthing practices because previous clients have introduced these ideas to them before. Once Māori whānau become aware of which midwives are supportive of things Māori they tend to gravitate towards that particular midwife or collective of midwives (Clarke, 2011).

Midwife and Ngā Maia o Aotearoa BOT representative Amber Clark (2011) speaks about the confidence a Māori midwife requires to clearly communicate the needs of the whānau as articulated by the whānau, whilst in disagreement with another health professional. This can be isolating for a Māori midwife, especially if it is verbalising an intervention that is derived from Te Ao Māori (Māori world) that might not be understood nor valued by the other health professional.
Clarke said when working with whānau Māori it is sometimes placed upon the Māori midwife to take on additional responsibilities, such as karakia (incantations), assisting with natural resources to aid and facilitate the tying and cutting of the iho (umbilical cord) or the making of a whāriki or ipu whenua, to teach waiata and to do karanga (welcome call to the baby) to name a few (Rama, 2011; Tamati-Elliffe, 2011).

Support is needed for the Māori midwife to ensure she is safe and assisted with these extra responsibilities. The midwife also needs to decide if she feels confident, competent and comfortable to perform these practices and to be sure the whānau has given her the authority to do so. Seeking support in the form of ensuring the midwife has a tuakana/teina relationship established, be it with peers or those more senior, who act like mentors, aligning midwives with kaumātua to keep them safe and nurtured along their clinical pathway could be the bridge to ensure cultural practices are observed and all efforts to remain safe are also met (Clarke, 2011; Stone, 2011; Tamati-Elliffe, 2011).

There are a small number of Māori midwives who commenced their training with a desire to work predominantly with Māori whānau and are eager to incorporate traditional Māori birthing practices into their delivery of care (Papuni, 2010).

There are some Māori midwives who didn’t necessarily set out to do any of the above, but succumbed to the overwhelming interest from Māori whānau to return to ancestral practices, so have incorporated traditional Māori practices into their own midwifery delivery of care.
4.3 Whakarāpopoto / Summary

When birthing babies at home no longer became an option for women in Aotearoa towards the end of the 19th Century, a pathway for change and evolution was inevitable. Pākehā culture adapted to the hospitalisation of birth quicker than Māori women. Initially holding onto their cultural practices and rituals appeared important to Māori, but difficult to secure when their very being, te reo Māori, whenua, technologies, spiritual values for example, were being devalued in the face of colonisation.

Midwifery in New Zealand has also had many up's and down's in its desire to provide competent, knowledgeable professional midwives. The New Zealand College of Midwives aims to deliver quality care to all women, yet over the years has had to defend itself against the medical profession to stand-alone and be respected in their field of expertise.

Māori have a higher birthing rate than non-Māori, yet we have a low number of registered Māori midwives to cater for the needs of the whānau Māori. Attracting more Māori into the midwifery profession is one strategy, supporting and maintaining them in the industry is another. Providing an awareness of the dual role Māori midwives often deliver to their employer and within their communities may work towards relieving stress and burn out by putting strategies in place that include this external awareness of cultural commitments.

Although our hospitals have made some important political changes to their approach to Māori patients, Ngāi Tahu kaumatua Maurice Gray (2010) says the hospitals in his opinion still do not support the deep spiritual rituals of te iwi Māori in the birthing arena. To the ancient Māori, the upkeep and emphasis on spiritual wellbeing was crucial to the wellbeing of the whole whānau (family) (Gray, 2010).

Highlighting Māori models of health within education of midwifery students and in the delivery of maternity services may assist spiritual practices to be accepted and supported within health practices.

There are similarities and differences occurring between the current maternity care deliverables and how some Māori whānau want to birth their babies. The person in the middle of this is the midwife, who may or may not be Māori. The task is to find the
solution that meets the needs of the whānau Māori and can be safely addressed by either a Māori or non-Māori midwife. Arriving at an outcome that keeps all involved informed, safe and respected.

The next chapter explores the concepts, values and ideas portrayed in the 25-minute documentary, *lho – a cord between two worlds*. Exploring the many creative components that became woven into a short piece of work. The film provides an overview of traditional Māori birthing practices and rituals told through the birthing stories of four Māori whānau who were eager to revisit they ways of their tūpuna for their birthing experiences.
Chapter 5: Ko te Pēpi/ The Baby

5. The Making of “Iho – a cord between two worlds”.

The initial outline for the documentary involved one pregnant Māori women and her whānau as we followed her pregnancy and birth journey, exploring her use of traditional birthing practices. A panui (advertisement seeking hapū wāhine) was produced and circulated via hui (gathering of people) and word of mouth.

The response to the panui and talent drive was positive with four-hapū wāhine eager to find out about traditional Māori birthing practices and to be filmed throughout their pregnancy. The documentary outline had to change to accommodate the stories of not just one, but all the wāhine. Having more people to interview also allowed for more back up, in case one of the chosen wāhine were unable to continue filming.

The nature of filming an event like a birth means that things do not always go according to plan. Out of the original four-hapū wāhine, three had planned to have homebirths and one was eager to go into hospital. In reality all four wāhine had their babies in hospital and, for a number of factors beyond my control, none of their births were captured on film.
To produce a documentary about birth, but have no birth footage was frustrating and worrisome. The deadline for this project was looming and I was really fortunate that a young family agreed to allow me to film the birth of their second child at their home. The pressure to capture this birth was great, given that time was running out and the difficulties that could potentially come with this particular birth created more challenges.

The young family lived in the country on a beautiful lifestyle block. The mother was already a week overdue and they were planning a water birth. Their house was compact and the room they were birthing in was made smaller by large screens hoisted up around the birthing pool for privacy and to separate the living and eating space.

The main source of lighting in the birthing area was an altar of candles that had melted considerably before filming commenced. They were keen for their first-born aged three years to join them through the birthing process if he was awake. Given this knowledge a decision was made to use a small hand held digital camera to capture the birth, reducing both the focus on the camera and the risk of someone tripping over the tripod.

On the night of the birth the camera struggled to find focus in the low light and the steam rising from the water pool created a condensation on the camera lens that over time created a shimmering visual. Ideally, I would have set up a lighting rig that flooded light around the mother and the pool to reduce the camera gain. If time had been available, the camera would have been taken out of the steamy environment to decrease the lens fog, but given that her labour progressed quickly I was concerned I would miss her birth if I stepped out of the room.

The privilege of filming such an intimate and magic moment was an achievement in itself. To alter this process by creating an environment that suited filming was never a consideration. The filming needed to be approached respectfully, with minimal impact on the labouring wahine and her whānau.

As the labour progressed, the wahine climbed into the birthing pool, further reducing the ability to film. The night vision on the camera became the only hope of seeing any detail underwater. However, the night vision setting makes peoples’ eyes look wild and startled and all images have a green shade overlay.
There was a slight concern that this look might imply the wrong message to the viewers, as if there was an intrusion on a private moment. This was not the intent, but could be perceived as such. Post-production colour correction assisted to change the green tone to a blue to mirror the moana (ocean). The unintentional out of focus footage caused by the climate within the room worked, to the film’s favour. It allowed viewers a “veil” to view such intense and intimate moments such as that of the water birth. Too much detail may have made some viewers squeamish and inclined to look away. The “veil” also gave the family some privacy.

The choice of music and a narration for this particular piece highlighted the traditional use of water as a birthing aid. Māori delivered their babies in: creeks, rivers and rock pools or used the water to expel the whenua (placenta). So, from a near edit floor casualty, this piece of filming did eventuate as a successful and emotive segment in the finished product.

**Colours**

The colours within the film were drawn out and enhanced. They were used to create moods and metaphors. The yellow and green throughout the drama scenes were highlighted to reflect the native bush colours.

Red depicted the blood and the membranes of the uterus as highlighted in the scene of the baby being born at the beginning of the documentary and the colouring of the text in the opening titles.

The red, white and black colours were traditionally dominant colours seen on Māori wharenui (meeting house) and various village buildings.

The national Tino Rangatiratanga Flag, also known as the Māori Protest Flag, features the black, white and red designed by Linda Gunn, Hiraina Marsden and Jan Dobson Smith with slight alterations made by members of the group, Te Kawariki, a collective of Māori issue advocates (Harris, 2004; Te Kawariki, 1999).
Te Kawariki initiated a creative way to illustrate Treaty breaches through a flag making competition. The three female artists managed to encapsulate meaning with simplicity and strength. This flag was launched in 1990 during an organized hikoi (march) from Te Rerenga Wairua (Cape Reinga) to Waitangi for the commemorations of Waitangi (Harris, 2004; Te Kawariki, 1999).

![Tino Rangatiratanga Flag](www.perplexmenot.com/2019/07/pack-light/)

Walter Erstich from Te Kawariki says that the black on the flag represents potential and the period within the Māori creation story of the long period of darkness. This, within the context of Iho, reflects the period of conception – the potential of the kākano (sperm and egg) meeting, joining and beginning a new human life. It also represents the male element floating above like Ranginui (the sky father) (Erstich, 1990).

The white represents Te Ao Marama (the world of light) – this is the physical realm and like most cultures white is often associated with: purity, cleansing, peace, light and balance (Erstich, 1990; Ministry for Culture and Heritage, 2012).

The red represents Te Whei Ao, the realm of coming into being, it represents the earth floor, land, forest and Papatūānuku (earth mother) and all her virtues. In relation to Iho, the red could be perceived as the passage of birth from the seed to the puāwai (the blossoming, the fruits of the labour). Red is often associated with hard work, emotion, love, passion and the strength of wāhine and their ability to produce, provide and deliver through to the labour, and the release of the whenua. For the pēpi (baby), red represents their journey, their vision of emerging into another world, another phase and with the many sensory textures that come with Te Ao Marama (the human world)

The Tino Rangatiratanga flag features two prominent koru forms linked between the black and red - creating the space to solve, to settle and link. This could also be perceived, as the time that the baby is formed and grows within the uterus; in it’s purest and most magnificent form. The kōpū (womb) incubates and protects the child within the waitapu (sacred waters).

Using black, white and red as the primary text colours throughout Iho was an indirect way of supporting the above philosophy throughout the documentary.

**Drama**

Iho uses drama to illustrate traditional Māori birthing practices within two short sequences that begin and conclude the documentary. Producing drama within documentary with limited resources was very challenging. The decision to use an interpretation of how life was in Te Ao Tawhito (ancient world) for Māori rather than an exact reenactment allowed more creative freedom in the filming of the drama sequences.

![Figure 23. Young birth attendant sitting in the Whare Kohanga (actress Emere Leitch-Munroe). - Iho Drama Shoot (Henriquez, 2011).](image)

The costumes were made from old coffee sacks, wool and fibres from the harakeke (flax), tī kōuka (cabbage tree/cordyline australis) leaves and leaf butts. Local weaver
Roka Ngarimu-Cameron gifted a few dried leaves from a mountain lily. This particular lily only grows on our Southern mountains and was once used to craft garments for the Southern Māori. Roka suggested making the costumes simple and raw. She said that very few clothes would have been worn while a wahine is in labour but also on a practical level there was not enough time to raranga (weave) what was required for this shoot (Ngarimu-Cameron, 2011).

The birthing whare (house), Te Whare Kōhanga was made from raupo (bull rush), this is a traditional material used by Māori to make whare (houses) and mōkihi (temporary river boats). The raupo was collected in Hampden, North of Dunedin. A large amount of raupo was required. Once cut, it was then dried over wooden slats in a covered area, before it was eventually crafted into a Whare Kōhanga prop for filming. The kōrari (flax stalks) were also used to hold the raupo in place and to give it another layer of aesthetics. My ability to craft with raupo is attributed to the late Kelly Davis of Waihao, who frequently ventured to Tāmaki Makau-rau (Auckland) to facilitate mōkihi (temporary waka made from raupo) making wānaka (workshops) for Kāi Tahu whānau (Ngāi Tahu families) living in Auckland. Kelly, like many great teachers, threw the challenges out to the whānau to work together to solve problems. Whilst recreating these old waka mōkihi, we were able to understand and perhaps for the first time retrace our ancestral knowledge and peoples by learning what they did and how they
made these temporary water rafts. This was also the rationale behind the drama sequences that aimed to provide an insight into a world that had passed. The knowledge, albeit forgotten by many, still exists and was able to be woven into these sequences to give them authenticity.

Filming the birth in the drama was also challenging. I worked to capture the reality of a traditional birth, without using nudity. This preserved the dignity of the actresses and the modesty of the small film crew. The frequent use of mirimiri (massage) to all parts of the body, the use of steam pits to open and relax the perineum area and also the general assessment of a labouring wahine is more visible naked, but could be implied dramatically without nudity.

The heartbeat of the baby becomes prominent along with the redness of the screen and the sense of movement. The heartbeat is real not a constructed sound, but a privileged recording from a young woman in late pregnancy. This brief but authentic sound bite gave the drama truth and allowed the viewer to transition to the modern world.

Figure 25 and 26. Iho Drama Shoot a & b, outside scenes (Henriquez, 2011).
Transitioning Ihō from Te Ao Tawhito (the Ancient World) to Te Ao Hurihuri (The Changing World)

The topic of the documentary is then confronted with a transition of perspective. The objective view then becomes subjective as the camera becomes the baby traveling its pathway out of the birth canal and into an image of a contemporary mother and child preparing for the father to cut the umbilical cord using a pounamu blade.

A search of the many photos archived at the Alexander Turnbull Library on their Timelines website combined with my own personal collection provided all the images used in Ihō.

Two wānaka (workshops) were organized with selected experts in pottery and fibre, to increase the understanding of the participants in Ihō, of the traditional birthing practices of Māori.

The first workshop involved making an ipu whenua (a vessel that holds the afterbirth/placenta). Phylis Smith is a well-known Dunedin potter/artist of note and has worked with clay for many years. Phylis was able to teach the wāhine how to work with the clay. She asked the wāhine to bring a small handful of whenua (soil) from a place that was special to them. The soil was then added to the clay and blended in to make the bowl that would be used to house the placenta of their child or their relative’s pēpi.

The wāhine crafted their ipu whenua under the guidance of Phylis and were then encouraged to add their own personal style and adornments in the shape of discs that they could then place on the bowl or in with the whenua as a form of decoration or lid prior to burial.

*Figure 27 Small clay discs made for an ipu whenua (Samantha Thomas, 2011).*
Once completed the ipu whenua was then placed in the kiln for a very light firing so that they became firm enough to hold the whenua, but soft enough to decompose once buried.

![Figure 28 An ipu whenua ready to receive a whenua for burial (Samantha Thomas, 2011).](image)

Roka Ngarimu-Cameron, a well-known artist, weaver and teacher facilitated the second workshop. Her skill and knowledge about fibres is outstanding and she was able to share with this group of wāhine stories from her tūpuna (ancestors) about resources made and used during and post birth. They all made a taura whītau (muka cordage) to be used to tie the umbilical cord before it is severed.

Roka began her workshop with the wāhine standing amongst the pū harakeke – (flax garden) she started with a karakia (incantation) thanking Hine Te Iwa Iwa the goddess of harakeke, acknowledging her status and the gifts she has provided. Roka took them through the process of looking after the harakeke, cutting correctly and then how to remove the front and back sections of the harakeke leaf. The wāhine left the workshop with their taura whītau (muka cord) ready to add to their kete rauemi whānau (basket of birthing resources).

The filmed footage from this workshop was used throughout the documentary. The intention was never that the wāhine must use these resources, but that they were given an opportunity to learn to make them and had the option to use them in their birthing experience.

Harakeke (flax) was a dominant feature throughout the film. It’s pinnacle involvement with: labour, birth, medicine, clothing, resources and as a building material made harakeke relevant to include in various shots throughout Iho (Best, 1975; Ngamoke, 2011; Ngarimu-Cameron, 2011).
Iho has been made under a kaupapa Māori framework and features knowledge that has been lost to some, unknown to others and used by few. It was a treasure and a privilege to have access to this knowledge and filming the sharing of this knowledge was an added gift. Prior to filming, a karakia (incantation) and mihi (greeting) would be given by either the interviewer or the interviewee. Once filming had been completed, time would be taken to share a meal or a hot drink and biscuits. The time taken to wind down with the interviewees and to reflect on what had just been discussed allowed for both the filmmaker and interviewee to achieve a sense of closure on this part of the project.

**Filming a Caesarian Section**

Filming around one couple’s caesarian section highlighted a number of layers of cultural preparation between hospital staff, the whānau, the midwife and myself. The issues that needed to be discussed ranged from the filming in the hospital setting prior to surgery, during surgery and in recovery with pepi (baby). Hygiene requirements meant only the husband and the midwife could be in surgery during the caesarian section. However, permission was achieved for the filming prior and post surgery. The birth was captured through still images taken by the midwife. Post surgery, the couple and their new pepi were taken into a large single room and it as here that the whānau performed a number of traditional Māori practices and customs. These included the tying and recutting of the iho (umbilical cord), before wrapping their daughter in a korowai (cloak) made by the husband’s grandmother specifically for her grandchild and placing a pounamu (greenstone) pendant around her neck as a kaitiaki (guardian) to watch over her.

They conducted a short naming ceremony and sang to their pepi. The door to this room remained open and hospital staff came and went to do the necessary observations on the new mother. Others popped in, curious to see what was happening in this room.

In retrospect it was an unintentional yet proactive action to keep the doors open – this highlighted that the practices that were taking place were not to be hidden away behind closed doors nor were the whānau conducting these practices embarrassed if others saw. Being open and inclusive allowed others into the practices and kawa (customs) and took away the mystique and fear. The couple spoke at a later interview about the number of visiting staff who wanted to see the way the iho (umbilical cord) was tied
with the taura muka (flax fibre cord). All were curious to see what it looked like and how it was healing. All hospital staff expressed how well it gelled with the baby's own umbilical cord and how attractive it looked.

![Figure 29 A baby's pito with whita wha muka, Dunedin Hospital. (Hira Adlam, 2011). Reprinted with permission.](image)

**The Soundtrack**

The soundtrack for Iho comprised recorded music and waiata (songs) that were composed specifically for Iho. Moana Tipa is a talented artist and performer. She was selected for her mature voice to give width to the drama sequence and help this piece build up to the climax of birth. Over a period of months of emailing and exchanging thoughts and feelings of what Iho was trying to portray in this segment, the collaboration unfolded in the first and only recording session. After reading the documentary synopsis and getting a feeling for what was being created in the film, Moana came prepared with some kupu (words) that might work. A karanga mihi (welcoming call) was recorded and this became the beginning of the soundtrack for the opening drama piece. The karanga provided the emotional build up and pace required for this section of Iho.

From here I worked with sound engineer Dan Cox to provide the rest of the music loops that again added to the mood of the drama sequences. The music soundscape had to provide the depth of reverb and a haunting vibe that had intent to lure, but not to scare.
Dr Richard Nunns was able to share the return of the pūmotomoto (from the flute family) that when the heat and directed breath reached inside the belly of this instrument the result was raw and primal. We recorded Nunns playing the pūmotomoto for the soundtrack and filmed as he played to a hapū wahine and her unborn pēpi (baby).

Musicians and taonga pūoro performer Horomona Horo and Rodger Cunningham managed to fuse traditional Māori musical instruments with gentle contemporary acoustic and piano. These musical interludes worked well within Iho to carry the feelings portrayed in the visuals.

Nearing the completion of the film Moana Tipa's voice is heard again with another karanga (call) of a whakataukī (proverb).

"Ka pā te muri, ka tangi te toroa ki tōna kāika i waho i te moana"

This whakataukī (proverb) indicates a change of things to come and at these times we return to our turangawaewae (ancestral places) to seek solace and understanding (Te Runanga o Ngāi Tahu, 2001).

The hiphop waiata chosen to take the film into the credits was purposely placed at this point of the film to act like kai (food) after a more formal Māori ritual. Food nullifies the sacredness of what has just occurred or what has just been viewed, in order to move the viewer into the future. The hiphop genre and the words James Greenslade, also known as Maitreya, used in his hiphop track suited the vibe and the tone of which to leave the viewer with. A sound that was upbeat, political and contemporary.

"Aoraki is my mountain, Waimakariri is my river, struggle without end...” (Maitreya, 2008).

The last few words, “struggle without end” are from a book title written by Dr Ranginui Walker (1990), "Ka Whawhai Tonu Mātou Struggle without End". This is a poignant book outlining the history of Aotearoa from an Māori perspective and again this held many connections to what the film was also trying to achieve and the hurdles to overcome in the process of completing this task.
The overall learning achieved by creating a 25-minute documentary as a solo filmmaker was truly amazing. I learnt that although I can comfortably work independently on projects when it comes to making a documentary I prefer to work with a team of experts. I value the skills and input others can bring to the process and the product. I now have a far greater appreciation of each role within a production team and how important their roles are. I feel I have vastly improved my skills as director and communicator because I now understand much more about filming sequences and what is best to capture in the field rather than trying to achieve it in post-production.

It was an amazing journey that has not only aided me to communicate science to a wider audience, but to also learn the “tools” to communicate more effectively with, from the pen, the camera, the edit and the narration.
5.1 Whakarāpopoto / Summary

The creative component to this thesis provides an introduction to Traditional Māori Birthing Practices, by telling the story through the eyes of the director and others who have experience with these practices or who have a passion to find out more.

The making of "Iho - a cord between two worlds" gave knowledge to the thesis and the thesis to the film. The ideal would have been to have written the thesis first and then based the film on the knowledge learnt. Due to course requirements the film had to be completed prior to the thesis to meet a screening deadline.

Making a documentary to a time limit of 25 minutes is a challenge in itself, and therefore instead of being a film that told an in depth story of one whānau’s birthing experience, it dipped in and out of many peoples lives around selected themes. Both styles have merit and due to the richness of talent who shared their stories, the decision was made to use all.

Produced for an international audience "Iho - a cord between two worlds" triggers similarities, differences and perhaps cultural connections. Once the Premier of the film occurred the requests began to flow in from around the country to see the film. Initially the requests were put on hold to await the completion of the thesis but the eagerness of many encouraged me to release the film and allow it to take it's own journey.

The final chapter to this thesis looks at Māori Health Services, Māori initiatives and whānau collectives that continue to advocate for equality in health care. A number of health acts and strategies produced by the Ministry of Health promote the Articles of the Treaty of Waitangi by upholding the three key principals: Partnership, Protection and Participation. Traditional Māori knowledge and rongoa (medicines) are frequently mentioned alongside the intent for Māori to be part of all decision making processes when it comes to the development of health practices affecting all peoples.
Chapter 6: Kei te tupu ake / Growing Up

Figure 30. "Threshold" [Robyn Kahukiwa]. Reprinted with permission.


In the final chapter of this thesis it felt necessary to highlight some key organisations and services that have contributed to improving the wellbeing of Māori wāhine and their whānau. It is also important to address what Ministry of Health policies were in place that specifically related to addressing the cultural inequalities.

Māori Women’s Welfare League – Te Rōpu Wāhine Māori Toko i te Ora

The work of the Māori Women’s Welfare League continues today with annual conferences on a regional and national level and monthly meetings held at League branches around Aotearoa and overseas. Boasting a membership of over 3000 Māori wāhine.

Although still involved with Māori social, health and education issues, the focus for the League more recently has become more about family and community wellbeing (Brown, 2005).
When the Māori Women’s Welfare League formed in 1951, it provided the avenue for Māori women to be represented in Parliament. The League’s initial drive was to promote better understanding between Māori and European women and to form relationships with other women’s organisations (Brown, 2005; Māori Women’s Welfare League, 1993).

The Māori Women’s Welfare League continue to utilise their mana wāhine strength politically and socially to support Māori health and social service providers that are working on a range of projects for the benefit of the iwi whānui (community).

Whānau Ora

Whānau Ora takes the passion established by the MWWL for family wellness and addresses it on a political level. The Ministry o’ Health, Te Puni Kōkiri and the Ministry of Social Development have combined resources to drive a whānau centred approach for Māori wellbeing. Tariana Turia accepted the appointment as Minister for Whānau Ora. Turia outlines that health providers who have been awarded the Whānau Ora contracts need to be skilled in “Whānau interventions; have a wide network of services and programmes; possess brokerage experience and a commitment to whānau self-management and self-determination” (Turia, 2012).

Whānau Ora is a strategic tool for all government sectors, not just the health and disability sectors. This tool can be used to help services work collaboratively with whānau, iwi, Māori providers and Māori communities to improve health and reduce disparities between Māori and other New Zealanders (Te Puni Kōkiri, 2011).

Teresa Wall is the Deputy Director-General for Māori Health with the Ministry of Health and she see’s Whānau Ora as an opportunity for Māori providers to deliver services that work for Māori, but can also meet the needs for non-Māori. Wall highlighted that Whānau Ora is empowering whānau to have autonomy over their own wellbeing (Te Puni Kōkiri, 2011).

Māori midwives have spoken about the whānau instigating the want of traditional Māori birthing practices within their birthing plans. It feels more appropriate that the whānau drive this desire than Māori midwives (Taiatini, 2011). The Whānau Ora concept endorses this view and makes it more widely acceptable to hear the needs of whānau.
and place them in the centre of the care provided. It could also provide some guidance and substance to a midwives dilemma of meeting the needs of whānau and remaining within her midwifery registration boundaries. The ultimate goal is to remain safe within one’s midwifery practise but to also develop a process that allows for midwives registration boundaries to have movement that can safely accommodate cultural values and practices.

**Homebirth Association**

“Reclaiming the tikanga protocols and practices of my foremothers was the most empowering act of tino rangatiratanga (self determination) possible. Both my grandmothers have home birthed 14 children each in the 1940’s, but now only 1% of Māori are homebirthing” (Waerea, 2011).

Charissa Waerea’s quote came from her article titled, *Tikanga Whānau*, which featured in the *Tummy Talk* magazine (2011). The article reflected Charissa’s own birthing experience utilizing traditional Māori birthing practices with her youngest child at home. She stressed a concern for the low percentage of Māori women choosing home birth. Interestingly, in the 2011 Maternity Consumer Satisfaction Survey conducted by the Ministry of Health, Māori appeared most dissatisfied with their overall maternity experience in hospital. Yet the transition back to birthing at home does not appear to be a choice readily taken up by Māori women at present.

The rate of homebirth appears to be on the increase but accurate statistics are difficult to obtain due to poor data collection in the past. Homebirth figures rely on the Ministry of Health’s “Homebirths Fee and Services” that midwives claim from. What it doesn’t distinguish is whether the homebirths were planned or not and whether the birth actually took place in the home or upon transfer to another facility. The figure that often gets quoted is approximately 7% of all births are a planned home birth (Home Birth Aotearoa).

The formation of the Auckland Home Birth Association in 1978 was instigated by a group of Auckland parents who had their babies at home. It didn’t take long before a number of branches were established all over Aotearoa. The initial role of this group
involved the application of political pressure towards obstetricians that refused to allow other alternatives to hospital births be acknowledged or accepted.

In 1980, a National Home Birthing Association formed and alongside applying political pressure to obstetricians who were negative towards birthing options outside of the hospital, the Home Birth Association ran home birth support groups and offered natural childbirth antenatal classes (Donley, 1986).

The Home Birth Association and it’s many branches around Aotearoa still support families to have homebirths and have shown great support for home birth midwives working with Māori whānau wanting to use traditional Māori birthing practices and customs within their birth plans.

**Other Family Services**

There are a number of services directly involved with whānau wellbeing and who are making advances in their approach to cultural differences and needs. Alongside Māori midwives are non-Māori midwives who are championing the desires of whānau Māori to incorporate te reo Māori (Māori language), tikanga Māori (Māori customs) and practices into the birth experience of their clients. There are also services that have an impact indirectly on the encouragement and revitalization of traditional Māori pathways such as the Māori Education providers like: Te Kōhanga Reo Trust, Kura Kaupapa, Whare Wānanga, Māori Health Providers, Marae, Hui, Wānanga Reo and our living repositories such as our Kaumatua (elders) that provide guidance and knowledge about the old ways.

**6.1 Cultural Safety**

One way to encourage more traditional practices into mainstream health and medical services is to understand cultural safety and why this may aid sustaining wellbeing across the cultures (Ellis, 1998). The concept of cultural safety evolved from a personal and professional journey for nurse and author, the late Irihapeti Ramsden.

Irihapeti was known as one of the pioneers of cultural safety in New Zealand. She became advisor to the Nursing Council in the 1980’s to address issues around attracting
and maintaining Māori nursing students, addressing Māori health disparities and negative experiences Māori were reporting in the hospital setting.

Ramsden worked alongside other Māori and Pākehā to formalize a cultural safety programme that would be introduced into nursing programmes and tested in state final nursing exams. Although, this was a mammoth task to develop and introduce, the groundwork had already been laid by a number of nursing schools that had implemented Māori health papers and employed Māori staff. Cultural Safety programmes became known as, Kawa Whakaruruhau, and this became incorporated into the nursing curriculum in 1992 (O’Connor, 2004).

Cultural safety according to Ramsden (2002) is about "human sameness and human differences" (p. 178). Trinh Minh-ha (1989) portrays cultural safety as the formation of trust. Only when trust has been established can differences be revealed, discussed and negotiated.

"Understanding is required of history and social function of racism and the colonial process. It also requires a critical analysis of existing social, political and cultural structures and the physical, mental and spiritual and social outcomes for people who are different" (Trinh-T, 1989, p.110)(p. 110).

Cultural safety in a health setting targets the employees understanding of their own worldview and how this impacts on the way they practice. It also allows the consumer to inform the health provider whether their service is culturally safe or not for them to use (Day, 2012; Ellis, 1998).

Cultural safety has morphed into the Registered Nurses Competency requirements amongst many other nursing competencies. The concern now is that after the struggle to get cultural awareness and cultural safety acknowledged and actioned within varying health settings – has it lost it’s oomph? Have we become complacent in activating policies or addressing the competencies unless prompted to?

Cultural safety runs the risk of becoming redundant if it is only activated in a reactive situation rather than being integrated proactively into health training, professional development and all health practices.
6.2 Te Tiriti o Waitangi and Hauora Māori

172 years post the signing of the Tiriti o Waitangi in 1840 we have seen numerous publications addressing the history of the Treaty, the impact of the Treaty, the grief and gains of the Treaty and so forth. We frequently hear about the Waitangi Tribunal Hearings and their recommendations with never a dull response from the Government. We have witnessed a good number of settled claims and we know there is a list of Iwi claims waiting to be processed (King, 1992; State Services Commission, 2006).

Aotearoa has come a long way on many levels with addressing past grievances between Māori and Pākehā, and finding solutions collaboratively to move into the future, primarily as a bicultural nation (Orange, 1987; State Services Commission, 2006; Ward, 1999).

It is said that the discrepancies between the Māori and the English versions of the Tiriti were seen by some historians as intentional, to gain advantage for the early settlers in Aotearoa. Others say that perhaps the perspective at the time was not malicious but that to view the “spirit” of the Treaty was to improve relationships between Māori and European settlers, in order for all to live more harmoniously on the same land.

It appears leading up to the composing of the Treaty and during the gathering of signatures from Māori chiefs, that the struggles felt then at this stage of the Treaty timeline had less of an impact in comparison to what eventuated post Treaty signing (King, 2003; State Services Commission, 2006).

The actions of the early Governor’s after the signing of the Treaty adjusted laws, such as the New Zealand Constitution Act in 1852, to suit the needs of the settlers rather than the Treaty partners, te Iwi Māori, created a growing anxiety between Māori and Pākehā. Māori could see the power shifting dramatically and dangerously towards the settlers and this deterred positive race relationships.

The 1860’s did nothing to rectify the situation and perhaps for many iwi today, drove an unmoveable wedge between Māori and Pākehā when the use of armed forces to coerce land purchases occurred, alongside land confiscation and the suppression of any autonomous Māori groupings. These events encouraged racial unease and are the basis
of many Treaty Settlement claims today (King, 2003; State Services Commission, 2006; Walker, 1990).

In order to find some clarity in the rights of te iwi Māori currently is important to look at the policies in place and in particular the rights as laid out in the Tiriti o Waitangi under Article 2, that guaranteed tino rangatiratanga over lands, villages and all property or treasures. For many Māori the term treasure not only includes things of the tangible realm, such as whakapapa, te reo Māori, waiata and hauora but also treasures more ethereal such as wairua, tikanga, pakiwaitara and karakia. Collectively these all contribute to the holistic wellbeing of Māori (Rimene, et al., 1998; State Services Commission, 2006).

In Article 3, the Crown assured Māori would have the Queen’s protection and the same rights as British subjects. The quantity of poor health statistics for Māori health is a sad reflection of the state of Māori wellbeing on a national and international level. When we observe the health statistics such as lung cancer for Māori women, diabetes, cardiac problems, stroke incidents and the rate of suicide amongst young Māori men, it is difficult to comprehend just how this happened so fast in a land of plenty.

Māori health and social services are making huge steps with the assistance of government funding to work with Māori in the community to provide education, health care and social services that address whānau wellbeing within a cultural context. Mainstream health promotion services, to varying degrees, are also employing Māori staff, focusing on Māori health issues and creating health resources more suited to the Māori community.

Finding the bridges to include traditional Māori birthing practices and rituals into all maternity services and training of all health professionals will require more effort and research into the content taught and the delivery of this knowledge. But, once in place, what can then be offered to all New Zealander's is a bicultural service that more closely reflects what was stated in Article 2 and 3 of the Tiriti o Waitangi advocating protection of all Māori peoples.
6.3 Health Policies and Hauora Māori

He Korowai Māori Health Strategy

Throughout the publications produced by the Ministries of the Government and in particular the Ministry of Health, there are clear priorities to commit to the relationship between Crown and Māori under the Tiriti o Waitangi and uphold the key principals of: Partnership, Participation and Protection. The Government is also obligated to reducing health inequalities between Māori and other New Zealanders.

The Māori Health Strategy titled, He Korowai (2002) supplied a strategic framework for the public health sector to utilise collectively to improve the Māori health status. It also provided another proactive step towards addressing the inequalities and pressing Māori health concerns.

"The strategy supports tāngata whenua led development resulting in the achievement of tino rangatiratanga and ultimately the promise of a healthy nation" (Ministry of Health, 2002b).

He Korowai highlights the importance of recognizing that hauora for Māori can be influenced by the whānau as well as the individual and to view hauora Māori not just by the physical ailments but within their social context (Ministry of Health, 2002b).

In regards to traditional Māori birthing practices He Korowai provides the documentation that supports the inclusion of Māori knowledge into mainstream services. It says in He Korowai that this strategy will:

"Affirm Māori Approaches by supporting Māori holistic models and wellness approaches to health and disability" (Ministry of Health, 2002b).

It will also achieve this kaupapa by supporting Māori in their desire to improve their own health. He Korowai acknowledges that Māori need to be autonomous in addressing their health concerns in order for health initiatives to be successful.

He Korowai Māori Health Strategy is implemented through Whakatātaka Tuatahi Māori Health Plan 2002 -2005 that has since been updated for the period of 2006-2011 (Ministry of Health, 2002b).
Whakatātaka Tuatahi and Tuarua Māori Health Plans

The initial goal of the Māori Health Plan - Whakatātaka Tuatahi was to aid District Health Boards to make their services accessible and appropriate for Māori. District Health Boards are required to assess the barriers that Māori feel exist within the mainstream health services and one of those areas of interest outlined in He Korowai was addressing whether the service was *culturally appropriate*.

Whakatātaka is divided into four pathways:

1) Development of whānau, hapū, iwi and Māori communities
2) Māori Participation in the Health and Disability sector
3) Effective Health and Disability Services
4) Working Across Sectors (Ministry of Health, 2002b)

Pathway One addresses the Crown’s desire to work collaboratively with whānau, hapū and iwi Māori to find out what is needed to improve hauora Māori. This includes accepting a Māori world view on health by recognizing the value and interest Māori have with their own models of hauora including traditional healing.

“Māori want to be able to express themselves as Māori in Aotearoa. This pathway supports whānau (including tohunga, kaumātua, Māori healers, health specialists and researchers) to develop services that reflect Māori cultural values. Therefore extending opportunities for health services to practice Māori views of health and healing (while recognizing diversity of whānau) will be fostered in order to progress whānau ora outcomes” (Ministry of Health, 2002b).

The Ministry of Health indicated that it will support the health sector include Māori cultural values in the planning, delivery and funding of health services.

Traditional healing is also recognized under Pathway One of the Whakatātaka Tautahi Māori Health Plan and is further updated in the Māori Health Plan Tuarua. It says Māori traditional healing is based on indigenous knowledge that embraces the Māori world. The Ministry of Health alongside other key stakeholders in health will continue to support Māori traditional healing practices (Ministry of Health, 2002b).
It was noted within the third Whakatātaka Tuatahi Pathway (Effective Health and Disability Services), that emphasis is placed upon whānau receiving culturally appropriate health and disability services to improve whānau ora and reduce inequalities.

Whakatātaka Tuarua (2006 – 2011) builds upon what was laid out in the initial Māori Health Plan and has also added further development of District Health Board activities involving Māori health and improving the quality of services provided by Māori Health providers.

Whakatātaka Tuarua also indicated that there is a high proportion of Māori using mainstream services and that a large amount of health and disability funding goes to these services. Therefore, there is an obligation from these mainstream services to cater appropriately for Māori and work towards improving Māori health.

Suggesting that traditional Māori birthing practices and rituals could be included into the options available within our mainstream and community maternity services is not beyond what the Government and more specifically the Ministry of Health have already stated they are committed to.

*The New Zealand Public Health and Disability Act 2000*

Alongside the Māori Health Strategy and the Māori Health Plans lies the New Zealand Public Health and Disability Act (2000) this Act sets out the overall objective of improving the health of the population and reducing the inequalities for Māori. The Act informs the District Health Boards and all other health providers what their responsibilities are to the public, and in this case to the Māori community. This ensures that Māori health needs are acknowledged and actioned accordingly and that Māori are given the opportunities to participate in health services and are to be part of the decision making at all levels of management (Ministry of Health, 2000).

*The New Zealand Health Strategy 2000*

The New Zealand Health Strategy (2000) again reflects the need throughout the strategy to improve Māori health by setting specific goals such as reducing the inequalities and assisting Māori development within health by growing the ability for Māori to
participate in all levels of the health sector and "enabling the Māori community to identify and provide for their own health needs" (Ministry of Health, 2000).

This Strategy outlines seven fundamental principles and one of those principals highlights the relationship between Māori and the Crown under the Tiriti o Waitangi. Again the three key principals extracted to illustrate the special relationship are: Participation at all levels, Partnership and Protection.

6.4 Rebirthing traditional Māori birthing practices and customs.

“I believe that the colonization process has impacted on traditional birthing practices and mātauranga Māori and has delivered a dependency mindset. The revitalization of mātauranga Māori and practices of our forebears will have the potential of reclaiming the birth process” (Taiatini, 2009).

Learning about traditional Māori birthing practices and customs isn’t as forthcoming as many Māori whānau would like. It does require, still today, a bit of effort and energy to locate literature, find Māori midwives and due to the small number of registered Māori midwives many localities are unable to provide Māori midwives. This reality forces whānau to find non-Māori midwives in their community who are supportive of cultural practices. Midwives who are eager to teach and or facilitate Māori learning around components of traditional Māori birthing practices are already providing this to their communities and clients. Workshops on mirimiri (massage), making ipu whenua (placenta pots), making taura muka or muka whitau (cordage for the tying of the umbilical cord), rongoa hapūtanga (pregnancy medicines) and mātauranga hapūtanga (Māori pregnancy knowledge) are being held but not in all locations. Awhitia and Manu’eu also run wānanga predominantly in the Auckland area for hapū wahine and their whānau, combining both Māori and Hawaiian knowledge around pregnancy and birth. The Huria Management Trust run Hei Tiki Pumau workshops to foster and preserve traditional Māori birthing practices in Tauranga, Te Ha Ora in Whakatane also run Kaupapa Māori antenatal classes and there are other initiatives
similar to those mentioned. Ngā Maia o Aotearoa me Te Waipounamu also offer a website to inform the public of specific events relating to hapūtanga and whānau ora, aswell as a national Māori midwives database.

Unfortunately there are too few wānanga (workshops) or information portals about traditional Māori birthing practices thus far. The positive is that they are occurring. The more information that can be produced about this take (subject), the greater the interest and then it is this interest that inspires more funding, more wānanga and more publications.

6.5 Future Planning

Raeleen de Joux (2002) conducted a survey with Māori women in the Canterbury and West Coast of the South Island to identify possible reasons that prevented these Māori wāhine from attending antenatal classes. The results showed that many of the study participants did not feel the need to attend antenatal classes because they said friends and relatives provided the information they needed. Many stated that they found the antenatal classes culturally inappropriate and they would have liked the class to be more informal and the focus to be directed towards a normal birth.

What they did say would entice them to attend antenatal classes were the opportunity to meet other whānau Māori, share experiences, learn from older women and hear about traditional Māori birthing practices. The latter being a strong point for many of the women interviewed, stressing the need to include traditional practices and customs such as mirimiri (massage), karakia (incantations), the tapu state of hapūtanga, karanga (call), whāngai ū (breast feeding) and to ensure that spiritual wellbeing was respected and acknowledged.

De Joux supports the statements made by the survey participants, but also feels that Māori women would gain from accessing information on pregnancy and parenting and attending antenatal care. The key according to De Joux is in the delivery of care and information, “enhance Māori concepts” and that stress the importance of “protecting whakapapa” alongside other realities that are prevalent with Māori women, such as: young mothers, smoking, alcohol and drugs, mothers with many children, mothers with no adult support and mothers living away from their tūrangawaewae (tribal locations).
A Maternity Consumer Satisfaction survey conducted in 2011 by Nielsen NZ aimed at assessing women's perceptions of maternity services. The results would then allow the Ministry of Health to measure how well current policies are doing and to also inform future maternity planning.

Although nine years later the Maternity Consumer Satisfaction survey results around antenatal services were similar to the outcomes of De Joux’s survey. On a mainstream level the survey raised a need to improve antenatal services for the New Zealand community. Māori have low attendance at antenatal classes but overall the women said in the survey that they did not feel this service was meeting their interest or needs.

3000 women who had live births answered the Maternity Consumer Satisfaction survey, 51% said they were very satisfied with their maternity care and 27% said they were quite satisfied. Interestingly, the majority of women who said they were very satisfied were those who had a planned homebirth (78%) and 65% said they were happy with their service because they received more than 8 post-natal visits.

On the whole the survey indicated that apart from the antenatal services the current maternity system is working well for most, but what was also clear in these results is that it is not working well for Māori. Many said they were “very dissatisfied” with the overall service (Ministry of Health, 2011). With all the health policies and strategies in place there still appears to be discrepancies that are not being met. It is disheartening, and it appears not to be an easy dilemma to solve.

Māori Population

New Zealand’s Māori population is 643,977. Current overall population of New Zealand is at 4,439,546 (Statistics New Zealand, 2006).

The Māori population is increasing more rapidly than the European population of New Zealand. Māori have a birth rate of three live births to every woman. The National average is two live births to every woman (Ministry of Health, 2011).

In Mason Durie’s book titled, Launching Māori Futures, he wrote about the foreseeable increase in the Māori population by the year 2051. Saying that Māori population will almost double in size to 22% of the New Zealand population with a huge proportion of
this figure being children. There is also a trend for the older population of Māori over 65 to also grow in size. So we have a growing number of tamariki (children) and an older generation living longer. Currently the life expectancy of a Māori male is 70 years, five years short of the European male life expectancy. Māori women have a life expectancy of 79 years and European women on average live a few years longer to 83 years (2003).

Durie has highlighted these demographics to stress the need to plan ahead, to be proactive about the future health needs of Māori (2003). Good health is strongly linked to how well people, specifically Māori, can adapt to their current environment (Durie, 2003, p.161).

In the past Māori have been able to adapt and grow their knowledge and customs around their natural environment for their wellbeing. But today Māori not only live in the natural world but also the changing world with advancing technologies that allow people to have interaction with: cosmic, oceanic and potentially virtual worlds. These will all have an impact on human development says Durie and although the natural environment will remain special to te iwi Māori there is a very real risk that Māori may struggle with adapting to their changing worlds and this could have a serious impact on their health (Durie, 1998; Marsden, 1992, 2003; Rimene, et al., 1998; L. Smith, 1999; Walker, 1990).

Durie states in order to make significant changes to the chronic diseases that plague Māoridom at present the same application that our ancestors deployed upon their arrival to these shores in order to survive and provoke a careful approach to their new world is required. They did this through the laws of tapu (sacred) and noa (common) (2003). (Refer to chapter three for information on tapu and noa)

Durie (2003) advocates that if strong Māori figures in today's society endorsed tapu and noa concepts that pertained to the world we currently live in this could give Māori a centre point or sense of place within their Ao (world, current reality), in order that they can safely navigate around it. This alone may have a far greater impact on the health of te iwi Māori than the many fragmented approaches that are currently in place (Manihera, et al., 1992; Marsden, 2003).

"Cultural identity is considered to be a critical prerequisite for good health" (Durie, 2003, p. 162).
Like all natural cycles we have reached the beginning again. This thesis, like any journey, gathered taonga (treasures) along the way in terms of people and knowledge, it resurfaced old knowledge, it highlighted practices still being used to varying degrees around Aotearoa today and there appears to be a ground swell of people interested in natural and indigenous practices as an alternative to the medical birthing models.

The intention of this thesis is not to force traditional Māori birthing practices upon all peoples. The intention is to draw some attention to knowledge that has always existed in this country and is still relevant today. To make a start at gathering all the fragments on this topic together into one body of work, yet to know that this is only the beginning of a repository of knowledge to be shared with and added to by other researchers, writers, midwives, kaimahi hauora (Māori health workers) and anyone interested in the survival of indigenous birthing knowledge.

In the course of completing my Masters in Science Communication I have had a child who is now 2 years old, witnessed two other births and have been around numerous other wāhine hapū. I have also attended funerals and tangi of close relatives.
When my Uncle passed away recently he was able to tell the whānau that he had spoken to his papa and his son previously deceased and from this conversation he knew it was time for him to leave this physical realm. When he passed away his 5-year-old mokopuna (grandchild) commented on his skin and how it looked as smooth as a pēpi (baby). Gone were the wrinkles, the stress, the pain and the fear of perhaps death, pain and loss combined. There are physical and scientific reasons for the skin to be like this, but I like more so the metaphorical reference to his skin returning to its baby state to highlight the concept of rebirth.

The tikanga (ritual) process that takes place during tangi assist the spiritual form of the tūpāpaku (corpse) to return to Hawaiki via Cape Reinga, but it also provides a healing process for those who remain in the physical realm. It allows for grief and loss to be expressed. It allows for laughter and enjoyment of memories and gifts that a person has shared with those around them. It ultimately allows us to grieve and celebrate at the same time with the support of whānau and friends.

It is an open process everyone can come to the tangi; all cultures and all relationships. It has a beginning and an end and then a follow up with the hura kōhatu (unveiling) of the headstone. Then those deceased are acknowledged in all formal and informal processes within the karanga (call) during pōwhiri (welcome) and whaikōrero (speeches) in acknowledgement of our whakapapa (genealogy) and thus orally Māori acknowledge the continuum of life in all forms (Karetu, 1992; Marsden, 1992; Mead, 2003b; Ministry of Health, 2011).

Maurice Gray said he was intrigued how Māori have managed to sustain certain tikanga such as death rituals around tangi, but have not been able to the same extent keep tikanga around conception and birth. Why did Māori not succumb to the Western death rituals like we did with our birthing practices? Perhaps, he suggested that until the balance of life and death is returned the wellbeing of te iwi Māori will always be at stake (Gray, 2010).

The theme of *restoring balance* became evident throughout the research process for this thesis. Restoring balance was mentioned in a number of research interviews in various configurations, for example Pereme Porter and Blondie Ngamoke (2011) spoke of the need for tāne (Māori men) and wāhine (Māori women) to remember the values they
both provide within the whānau structure. The wāhine carried the whakapapa within her whare tangata (womb) and the tane provided the care and protection required, keeping the whakapapa alive. The various roles between tāne and wāhine are not to be compared and critiqued but to be seen in a balance of energies and skills. Likened to the role of Papatūānuku (Earth mother) and Rakinui (Sky Father), they both had an important role to play in creation and core Māori values that aided the survival of te iwi Māori.

Discussions around context of restoration were also raised. Blending the old world with the new world may hinder the re-introduction of traditional Māori birthing practices and customs due to the social conditioning some have undergone with the implication that Western practices lead the way to a better life and that new technologies are better than old and outdated ones. First time mothers are often socialized and pressured into believing they need to birth in hospital for fear of birth complications. The negative is emphasized rather than the reality that birth is a wellbeing component of life and not an illness.

Yet, the current world is where most of us take our centre point from and to bring back traditional knowledge into a technology driven world can be daunting and difficult for some to comprehend within their birthing experience, not only for the immediate whānau but also for whānau whānui (wider family) and friends. Choosing some traditional birthing practices and rituals alongside other Western and/or other cultural practices is about having autonomy and choice. What isn’t available at present is an abundant resource of health professionals who can educate families about traditional Māori birthing practices and customs and then also support the whānau to action these options. But that should not be a reason to not work on this option and make it a reality.

The Ministry of Health have produced a number of Health Plans and Strategies that have guided services within the health sector to acknowledge holistic Māori models of health. Within these Māori models of health, the spiritual domain is prioritised, regardless if the ill health that led Māori to a health service is of a physical nature.

Whānau Ora as a strategic health tool places the Māori whānau in the middle of all actions. Similar to assessing and addressing the spiritual realm, the whānau realm needs also to be looked at when working with the individual. It may not be appropriate
to all Māori but to include it in Health Plans appears to be better approach than not including them at all. Like the offering of traditional Māori birthing practices as an option for all whānau. These choices need not to be taken up, but it does need to be offered.

“To support, encourage and educate non-Maori parents to hold true to their beliefs and values too. To gently remind middle class New Zealand who are the majority that one size does not fit all” (Kupe-Wharehoka, 2000).

Māori and Pākehā relationships also need to find a balance. Sir Tipene O’Regan once said that Māori need to get out of the grieving stage, in regards to land loss and the impact of colonisation and Pākehā need to stop fearing Māori, in terms of what might happen if Māori were given autonomy in all things that concern them (O’Regan, 1997). If the Treaty of Waitangi was truly understood and honoured by all New Zealanders, as it is written in numerous documents about the three key principals of Partnership, Participation and Protection, could this nation achieve equity for both Māori and Pākehā?

In order to rebalance the scales to improve equality for all, it may appear to many New Zealanders that Māori are getting the upper hand, the advantages and therefore the proactive health initiatives could potentially be perceived as not being fair or right. Will the appropriate education be given around this potential scenario and then even so how will New Zealand comprehend the adjustment of power and acceptance of a true bicultural community?

This thesis serves as the kākano (seed) to a larger body of work, in the form of a future doctorate to seek greater Māori knowledge around: conception, pregnancy and birth. The intent would be to travel to Marae around Aotearoa to screen the film, “Iho – a cord between two worlds” as a methodology tool in order to aid memory and to stimulate discussions around the given take (subject matter). I would then be able to gather more hapū specific information that can contribute to what is already known. Knowledge sourced from this research journey could then be produced into easy to read, easy to access pamphlets or DVD’s free to whānau.

Therefore the final restoration of balance lies within this conclusion that also represents the beginning. A rebirthing of knowledge that is unique to Aotearoa and represents
exciting opportunities within our health sectors that will have a positive influence with other Government Ministries.

I believe there is a place for the inclusion of Māori health practices such as traditional Māori birthing practices and customs within both clinical and community health settings, within health training establishments and professional development initiatives, not only for midwifery focus health professionals but also for general medical services. I also believe that it is important that information on Māori knowledge is learnt and supported throughout the health continuum, not only for the betterment of te iwi Māori but for all who would like to access indigenous practices and particular practices unique to Aotearoa.

This is an exciting opportunity for New Zealand health providers to embrace mātauranga Māori within their service philosophies and practices, to action te Tiriti o Waitangi and Ministry of Health policies and strategies already in place; and to ultimately provide a dynamic and innovative step forward into the future of cultural health care and reducing inequalities.

I will leave my closing statement to my whānauka (relative) Maurice Gray, who said this to me as I was leaving his whare in Christchurch as a gentle reminder (as our elders do) for me to stay true to the kaupapa of this research,

"Hopefully your work won't just be in the medical context, but in a social, cultural and spiritual context as well...to raise the consciousness and awareness of our people, to consider what was, that could become again in a new form, that holds the essence of who we are" (Gray, 2010).
#1 He Kura Pounamu (Some precious people)

Teone Taare Tikao

Teone is my great grandfather, father to my grandfather George Tikao, who is the father of my father Robert Tikao. Teone was known as one of the last surviving tohunga of the South Island. He studied under the two remaining tohunga on the Banks Peninsula Koroko and Tuauau for 10 years before they died. Although Teone was prevented from finishing his training as a tohunga he went on to gather as much knowledge as he could from the elders living on the Peninsula at the time. Teone and his second wife had eight children and fostered a number of children from other relatives. Shortly before Teone’s father died he asked his son to take on his mantle as rangatira of the Irakehu hapū. Teone accepted and consequently became involved in tribal matters locally and nationally. This political interest eventually saw Teone being elected as Chairperson on the 1893 Māori Federated Assembly, whose primary incentive was Kotahitanga. Kotahitanga is a concept that sought “Māori jurisdiction over Māori matters”.

Teone passed away in 1927 aged 77 years, he is buried next to his wife in the urupā at Rapaki, Banks Peninsula and his wisdom and knowledge is still revered by his descendants today (Beattie, 1990).

Maurice Gray

Maurice Gray is another valued whānauka to me. He is frequently involved with advising our whānau on reo Māori and tikaka issues. He is also often called in to lead ceremonies for our whānau and the Horomaka collective. Maurice was gifted knowledge of birthing traditions and practices by his Aunty Erena Raukura Gillies (Taua Fan).

When I approached Maurice Gray to assist me with knowledge specific to our own hapū and whānau he provided such rich and personal information that this interview session was both overwhelming and rewarding.
Huata Holmes

Huata is another whānauka based in Otepoti. He was raised between the mainland and the Tīti Islands. He speaks an old Southern dialect that intrigues and challenges many Kāi Tahu. His knowledge of fertility, birth and birth practices is enlightening and specific to his hapū and whānau. Huata was able through his kōrero transcend time and take me back into the world of his childhood and beyond to gain a clearer understanding why practices were done and what considerations were taken at this time.

Huata was also a strong advocate for the documentary, “Iho – a cord between two worlds”. He stood by me at crucial times and supplied wisdom and guidance that gave me the encouragement and the strength to continue down this pathway.

Kukupa Tirikatene

Kukupa is the son of Sir Eruera and Ruti Matekino Tirikatene. He is of Kāi Tahu, Kāti Māmoe, Waitaha and Ngāti Pahauwera o Te Rūpu Tūhonohono o Kahungunu. Kukupa has been involved in education for many years teaching te reo Māori. Kukupa recently spent two years as resident Kaumatua for the long-term Kāi Tahu exhibition, “Mō Mātou” at Te Papa in Wellington. Post this position Kukupa returned to Auckland to take up the Kaiākau position at Manukau Institute of Technology’s Tari Mātauranga Māori.

My initial involvement with Kukupa began with the Kāi Tahu Taurahere Roopu based in Auckland. This is a support roopu (group) for Kāi Tahu whānau living in Auckland. Kukupa became my te reo Māori pou (support pillar) helping me with my journey of learning te reo Māori and guiding me on tikanga issues. He is a gracious, humble leader who is a poet and gifted composer. Kukupa translated the creation story I had given to him to read for the documentary, not only did he read and translate it, but he also wrote his interpretation of the words and story I had given him. This interpretation has been included into the Appendix of this thesis (See Appendix #7).
Bunny McClean

Bunny of Tūhoe lineage has a long and enduring involvement working within the mental health sector. Bunny was raised for the first seven years of his life alongside his grandmother. A period of his life he loved and fondly recalls what his grandmother did for her people within the realms of birth, death and looking after those suffering with mental illness. Bunny recalls the many births he attended as his grandmothers little assistant carrying her bags, fetching the hot water and whāriki (birthing mats) to birth the baby upon. Bunny now resides in Invercargill with his wife and commutes to Dunedin to work at Te Oranga Tonu Tanga (Māori Mental Health Service) as the Kaumātua/Māori Advisor.

I interviewed Bunny at the beginning of this research project and Bunny knew the taputanga (sacredness) of our kōrero and honoured it by commencing his kōrero with a karakia tīmata and a karakia mutunga (opening and closing prayer). It felt right that this kaupapa was not always led by myself, but also by my interviewees.

Awhitia Mihaere

Awhitia has learnt much of her knowledge around healing, koomirimiri and rongoa from her grandfather Whati Wiremu Mihaere of Ngāti Maniapoto and her grandmother Lena Ngete Reweti Hamiora Ne Paewai. Lena would prepare the wāhine with rongoa pre and post pēpi and would waiata (sing) oriori mokopuna to welcome the pēpi into the world. Wiremu was a midwife in the Dannevirke area and Awhitia honours the skills that both grandparents have passed on to her.

Awhitia has also worked under the late Hohepa Delamere, a well-known Māori traditional healer based in Waitakere City, Auckland. From his teachings and her own expansive knowledge Awhitia continued to practice after his sad passing in recent years. Awhitia works alongside her partner Manu’eu, delivering powerful workshops combining Manu’eu’s Hawaiian knowledge of traditional birthing practices with traditions from this whenua (land – Aotearoa).

Awhitia and Manu’eu work with hapū wāhine and their whānau teaching: hula, mirimiri (massage), positioning, pain relief, spiritual cleansing, and support the partners and whānau tautoko of the hapū wāhine. Awhitia and Manu’eu spoke to me about what
knowledge they share to participants and clients about traditional Māori and Hawaiian birthing practices.

Noi Hudson

Noi is one of the last living descendants to be born at Rotorua’s Whakarewarewa Pā. She reflects on her birth story as told to her by her late Uncle, as it was he who assisted Noi’s mother to birth Noi. Noi, herself has rich memories of her childhood at the Pā and witnessing life and death as a common occurrence. Living on a Pā, Noi said, allowed her to be part of other people’s experiences. Watching women labour and birth were examples of just one of those experiences. Consequently Noi was able to give me knowledge around Pā life in Rotorua and her own birth experience. Noi shifted to the South Island when she was very young to pursue her nursing training and has remained here ever since. Noi resides in Dunedin and she is a “super” kuia on countless committees and organisations. Contributing significantly to the Dunedin community.

Pereme Porter

Pereme Porter of Ngāti Kahu has been for a number of years the Kaumatua for both Northshore and Waitakere Hospital. Although recently retired to enjoy life with his extended whānau he is still asked to fulfil Kaumatua roles for many community events/functions. Pereme was interviewed for the documentary and prior to the filming supplied information via phone conversations whilst arranging a trip to Auckland to film him. Pereme’s role as a young man, with birthing rituals was shared with humour and integrity. He explained what his elders asked of him, how he initially perceived his role and how he learnt to utterly respect the mahi he did. Pereme opened my mind to practices I didn’t know existed in Aotearoa and was able to explain it in such a way that I could comprehend. Pereme was emotive and this was inspiring. He provided a visual doorway to transgress back to a time of our tūpuna.

Herena Stone

Herena was a midwife in the Christchurch area for a long period of time. She worked predominantly with Māori whānau before venturing over to Australia working as a midwife in aboriginal communities there. Herena wanted a change in career and studied to be a lawyer. She has had many years working as a solicitor with Te Runanga o
Ngāi Tahu, then Herena did a stint in commercial law and more recently her interests lie with criminal law. Her latest law arena, Herena said, is dealing with the people and aligns more closely with her midwifery background.

Herena is a whānauka from Rapaki and shared her experiences as a Māori midwife and also what she had learnt from her grandfather in Te Reinga, who admitted much later in his life about his mahi as a kaiwhakawhānau (birther) within his rohe (area) and what this entailed. I have used both Herena’s own journey and what her grandfather shared with her in this thesis.

**Brian Allingham**

Brian Allingham is a Pākehā archaeologist in the South Island who has worked closely with Ngāi Tahu for many years on a number of archaeology projects. He raised with me the connection between whakapapa, iho and rock art and suggested I look into it. I was eager to include this whakāro into this thesis under an Art and Birth Chapter, but due to time constraints to complete this I decided to place this Chapter into my eventual PhD and concentrate on the information thus far. We remain in touch and are both keen to keep discussing and researching this topic and grow more knowledge around birth representation in art by tūpuna Māori and contemporary Māori artists.

**Rakahurihia Ngarimu-Cameron**

Roka of Te Whānau ā Apānui, Whakatōhea, Ngāti Awa, Te Arawa, Tūwharetoa and Ngāti Airihi descent is a well-known fibre artist and teacher. Roka has spent years using her knowledge to assist youth and students around Aotearoa learn the art of weaving. Roka facilitated a wanaka (workshop) that I had arranged so that I could film hapū wāhine learning to make whitau muka (a thin cord of prepared flax) to tie the umbilical cord post birth.

The participants of this workshop learnt how to prepare a whitau muka and see other resources Roka has made and continues to teach others to make, such as a wahakura (babies sleeping basket), ipu whenua, pīkau (backpāck that can be used to carry babies in) and whariki (birth mats).

During this workshop and in an interview post workshop Roka shared birthing practices she had learnt from her Te Whānau ā Apānui mother in law Te Raita Ngamoki. Te Raita
was the daughter of Hannah Trevan and tohunga and kaiwhakawhānau Pāora Kingi Delamere. Pāora performed many of the births in the Whitianga area right up until the passing of the 1904 Midwives Act.

**Aroha Reriti Crofts**

Taua Aroha is the current Chair of Ngā Maia o Aotearoa Me Te Waipounamu, she is also a past National President of the Māori Women's Welfare League in 1990. In 1993, she was awarded a CBE for her services to Māori and the community. I met with Aroha to look specifically at the role and history of Ngā Maia o Aotearoa. Through the work Aroha has and still does within the Māori health sector and being a member on a number of Boards has assisted Aroha to gain experience and knowledge on Māori health. Māori health workers for guidance and support also frequently seek out Taua Aroha. She is a valued member not only within her own whānau but her iwi whānui (wider community).

**Janet Taiatini**

Janet is an Māori midwife in Rotorua after practising for many years in South Auckland. Janet produced a research paper on *Rongoa Māori Use in Hapūtanga* towards her Bachelor Degree in Iwi Environmental Management at Te Wananga o Aotearoa, Waiariki. This paper and the interview I was able to have with Janet has informed this thesis greatly. Janet has also been very supportive throughout the filming and writing of this thesis encouraging me to keep going and providing references that may be useful to my research. I have appreciated greatly the advice and guidance by practising Māori midwives as to where to head for information, what they believe is relevant to whānau Māori and practising Māori midwives from a thesis such as this. Janet was one of those special acquaintances.

**Amber Clarke**

Amber affiliates to Kā Tahu and is an Independent Māori midwife predominantly involved with rakatahi (youth) in the Christchurch area and carry out locum work around Aotearoa. Amber is also a kaiako (lecturer) at Christchurch Institute of Technology School of Midwifery, as well as completing post-graduate studies on Māori ways of breathing wellness and iwi development. Amber is a Board member of Ngā
Maia o Aotearoa me Te Waipounamu and is an active member of the Māori Women’s Welfare League in Otautahi. Amber was able to give me a wide perspective on the current reality for her as an Māori midwife in Otautahi and further afield and the work and development of Ngā Maia o Aotearoa. Amber is passionate about mātauranga Māori and the role that our Taua and Poua play in preserving this knowledge and guidance they give to help the younger generations deliver traditional practices and rituals in today’s context. I enjoyed listening to Amber she is relatable, intelligent, stunning and a fabulous midwife.

**Nanny Bella Morrell**

I was told to call Nanny Bella because she had an interesting story to tell about her own mother. I was intrigued and had an enjoyable interview with Bella about her life and her memories of birth, her own and those of her mother. Although Bella’s stories were slightly outside the timeframe I had pitched my research at (prior to 1930), I still learnt from Bella how, in her whānau, some of the traditional Māori birthing practices still existed albeit in using slightly modernised resources such as a flagon box instead of a paeruru (birth aid), the concept was the same, karakia (incantations) and birthing at home.

Reverend Bella Morrell is part of the Kahui Wahine ki Te Waipounamu a women’s group formed from members of the South Island Anglican Māori Church, a branch of the National Kahui Wahine Movement in Aotearoa. Nanny Bella also works with the Chaplancy Services at both the Dunedin and Wakari Hospitals.

**Tungane Kani**

Tungane Kani is a Māori midwife in Gisbourne. She is an active member of Ngā Maia o Aotearoa and alongside her husband Henare they developed the Turanga Kaupapa, which is a set of guidelines for cultural competence for Midwives as set out in the Midwives Handbook for Practice. I met Tungane in Christchurch while she was attending a National Midwives Committee Meeting. Tungane talked me through her own style of practice that has been moulded by the knowledge she gained from her kuia and mentor from Wairoa and also other significant elders in Gisbourne who have shared various birthing practices and rituals with her over the course of her own pregnancy.
and birthing experience and those of whānau. She now shares this through her own midwifery practice to the whānau she works with.

**Joanne Rama**

Joanne of Tainui and Ngāti Apakura iwi resides in Auckland. I was told about Joanne through a friend who had Joanne as her midwife and could not speak more highly of her. I then met Joanne when I filmed her for the documentary, Iho. Joanne is a passionate ex-midwife and strong advocate for Māori birthing practices. Joanne brought the passion to the documentary and was brave enough to speak her truths, the good things and the not so good things that happened for herself and other Māori colleagues throughout her career in midwifery.

Due to poor health and frustrated with trying to fit within a midwifery model that did not match Joanne's own model of wellbeing, she decided not to practise as a registered midwife but to be an active supporter at births. This way she maintained her integrity and was able to take part in home births of those who requested her presence.

**Leisa Aumua**

It was in response to an advertisement I had placed in Te Pānui Rūnaka – a Ngāi Tahu tribal monthly newsletter, that the mother of Leisa Aumua connected with me to tell me about her daughter's interest in traditional Māori birthing practices.

I rang Leisa in Waiouru and we had an interview over the phone that I transcribed and later checked with her. Leisa is a stunning Māori artist who weaves her interest and knowledge around traditional Māori birthing practices into her art works.

Leisa shared with me her own birthing experiences that involved karakia, kaitiaki, manāki, ipu whenua, wairua, working with Pākehā midwives and doctors and ways she had incorporated old Māori birthing knowledge into her own birth experiences.

Leisa was able to clearly articulate what she had learnt, what she still wanted to know and what she feels her children have gained from being born immersed in tikanga Māori and using the old ways. Leisa's birthing experiences were very rich and I really enjoyed and felt humbled to hear another Kāi Tahu wahine share her birth journey.
Priscilla Cowie

Priscilla is a dear friend and stunning contemporary artist. Priscilla is of Ngāti Kahu, Ngā Puhi and Kāi Tahu affiliations. She resides with her whānau in Pines Beach, Christchurch. Priscilla paints and designs on commission. Throughout the years she has painted series of work themed around wāhine including: whāngai ŭ (breastfeeding), hapūtanga, kuia, tamariki and landscapes. Priscilla drew the image of the pēpi that I have used in the documentary “Iho – a cord between two worlds”, on the Iho promotion postcard and thermally printed onto the DVD.

Robyn Kahukiwa

I have always admired Robyn Kahukiwa’s powerful paintings of wāhine toa (warriors). Her paintings not only reflected the wāhine rongonui (famous) in mythology but the strength of wāhine to birth and carry the generations. I approached Robyn at the beginning of this research project to see if I could incorporate some of her images into both the documentary and the thesis. I was surprised and also humbled that she agreed to support both the documentary and the thesis by supplying her images free of charge. Robyn is of Ngāti Porou, Te Aitanga a Hauiti, Ngati Hau, Ngāti Konohi and Whānau-a-Ruataupare. She is a self-taught painter illustrator, author and wonderful mother and grandmother.

Rua McCallum

Rua is a wahine in the community whom I have a great deal of respect for. She is a hard worker, determined, creative, resourceful and honourable. Her journey of academic study links with mine and I was fortunate enough to utilise her knowledge during my Masters as my Cultural Advisor and mentor. It was important to have that Cultural connection to ensure I was working in the collective and not as an individual and that the kaupapa Māori focus was maintained throughout the thesis process. I felt on this take (subject) I could only be supported and kept in line by someone wearing the same lens.
Dr Brigit Mirfin-Veitch

Brigit is the Director of the Donald Beasley Institute, which promotes research and education in the field of intellectual disability. Brigit has given both moral support and guidance on completing my Masters thesis, plus has allowed me to work on my thesis in my office at the Institute in the weekends. This meant a lot to have a quiet space away from a busy household. Brigit has written and published books, articles, chapters and academic papers relating to her research around intellectual disability and her current focus is on the experiences of parents who have intellectual disabilities. Brigit gave me constructive feedback towards the latter stages of writing this thesis and given her busy schedule I was very grateful for the time she took to do this. Brigit is an inspiring role model and I feel very lucky to have her as a colleague and a friend.

Professor Jean Fleming

I was lucky or cheeky enough to ask Jean to be my Supervisor (given that Jean normally works with Popularising Science or Writing Students). So I was thrilled when she agreed and has been on this journey of research with me since I began. Jean knew when to place the pressure on and when to release it. She understood me, a mature student, raising children and working full-time, struggling with the challenges that come with thesis work and knowing when to tell me to “move on” or to “relax”.

Jean is a Professor of Science Communication at the Centre for Science Communication and the Department of Anatomy, University of Otago. Jean has received numerous accolades for her tireless commitment to popularising science and with her research on molecular and cellular ovarian biology. In 2011, Jean was elected as a Companion of the Royal Society of New Zealand in recognition of her leadership and contribution to science in New Zealand. That aside, Jean is also a mother and her own experiences and interest in birth and traditional Māori birthing knowledge assisted me to pursue such a large and challenging topic.
#2 He Korowai Oranga Māori Health Strategy 2002 (Segments)
See Next Page.
Emphasising whānau health and wellbeing

The overall aim of He Korowai Oranga is whānau ora: Maori families supported to achieve their maximum health and wellbeing.

Whānau (kia, koroua, pakeke, rangatahi and tamaiti) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively.

The use of the term whānau in this document is not limited to traditional definitions but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for themselves who their whānau is.

Outcomes sought for whānau

The outcomes sought for whānau include:

- whānau experience physical, spiritual, mental and emotional health and have control over their own destinies
- whānau members live longer and enjoy a better quality of life
- whānau members (including those with disabilities) participate in te ao Maori and wider New Zealand society.

These outcomes are more likely where:

- whānau are cohesive, nurturing and safe
- whānau are able to give and receive support
- whānau have a secure identity, high self-esteem, confidence and pride
- whānau have the necessary physical, social and economic means to participate fully and to provide for their own needs
- whānau live, work and play in safe and supportive environments.

He Korowai Oranga asks the health and disability sectors to recognise the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms.
Whānau ora is a strategic tool for the health and disability sector, as well as for other government sectors, to assist them to work together with iwi, Māori providers and Māori communities and whānau to increase the life span of Māori, improve their health and quality of life, and reduce disparities with other New Zealanders.

He Korowai Oranga: setting a new direction for Māori health

He Korowai Oranga sets a new direction for Māori health development over the next 10 years, building on the gains made over the past decade.

Committed to the Treaty of Waitangi

The Government is committed to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi. The principles of Partnership, Participation and Protection (derived from the Royal Commission on Social Policy) will continue to underpin that relationship, and are threaded throughout He Korowai Oranga.

**Partnership**

Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services

**Participation**

Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services

**Protection**

Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices

Improving Māori health and reducing inequalities

As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. This is not acceptable. The Government and the Ministry of Health have made it a key priority to reduce health inequalities that affect Māori.

If Māori are to live longer, have healthier lives, and fulfil their potential to participate in New Zealand society, then the factors that cause inequalities in health need to be addressed.
The factors that lead to poor health status are complex. Across New Zealand, people with lower incomes suffer more ill health, but Māori whānau at all educational, occupational and income levels have poorer health status than non-Māori. The challenge is for New Zealand to identify and address the factors that cause inequalities.

Addressing these issues requires other sectors as well as the health sector to understand the impact of their activities on health, and for the whole of the government sector to work with Māori to address these issues.

The New Zealand Health Strategy and the New Zealand Disability Strategy

The New Zealand Health Strategy and the New Zealand Disability Strategy are the Government’s platform for action on health and disability, including Māori health. The strategies’ principles, goals, objectives, action and service priorities for improving the health and disability of New Zealanders are all relevant to improving Māori health.

He Korowai Oranga expands the principles and objectives for Māori in both strategies and takes them to the next stage by providing more detail on how Māori health objectives will be achieved. At the same time, He Korowai Oranga exists in its own right.

He Korowai Oranga also sets the direction for Māori health in other service or population-group strategies, including the Primary Health Care Strategy, the Health of Older People Strategy and the Public Health Strategy.

He Korowai Oranga: kaupapa

The kaupapa (purpose) behind He Korowai Oranga is twofold.

Affirming Māori approaches: The strategy strongly supports Māori holistic models and wellness approaches to health and disability. It will also tautoko, or support, Māori in their desire to improve their own health.

He Korowai Oranga seeks to support Māori-led initiatives to improve the health of whānau, hapū and iwi. The strategy recognises that the desire of Māori to have control over their future direction is a strong motivation for Māori to seek their own solutions and to manage their own services.

Improving Māori outcomes: Achieving this will mean a gradual reorientation of the way that Māori health and disability services are planned, funded and delivered in New Zealand. Government, District Health Boards (DHBs) and the health and disability sector will continue to have a responsibility to deliver improved health services for Māori, which will improve Māori outcomes.
He Korowai Oranga: a living strategy

He Korowai Oranga is a living strategy, which will continue to be refined and evaluated over time to address the needs of whānau, hapū, iwi and Māori communities.

A separate Māori Health Action Plan, Whakatāka, accompanies He Korowai Oranga. The plan outlines the first two to three years of implementation and specifies the rules, responsibilities, performance expectations, measures and initiatives for achieving the strategy. Whakatāka will be regularly updated to take into account progress towards the strategy.

The structure

In setting out to achieve whanau ora, He Korowai Oranga has two broad directions which acknowledge the partnership between Māori and the Crown. Within the context of these two broad directions, three key themes are woven throughout the strategy. Finally, four pathways set out how whanau ora will be achieved.

He Korowai Oranga works like this.

Each part of He Korowai Oranga is explained in the following sections.
Three key threads

Three key threads, or themes, are woven throughout the strategy.

Rangatiratanga

He Korowai Oranga acknowledges whānau, hapū, iwi and Māori aspirations for rangatiratanga to have control over the direction and shape of their own institutions, communities and development as a people.

Involving iwi in decision making as representatives and as partners ensures that new directions fit with the wider development goals. Continuing Māori provider development and Māori workforce development allows health initiatives to contribute to whānau, hapū, iwi and Māori community initiatives. These aims are in the New Zealand Public Health and Disability Act 2000.

The Government has also supported moves to strengthen the capability of Māori communities to develop initiatives that meet their needs across the social, cultural and economic sectors. These initiatives will begin to drive changes for the health and disability sector.

Building on the gains

He Korowai Oranga builds on the considerable gains already made in Māori health.

Past policies have established a base for gains in Māori and whānau ora outcomes, service uptake and Māori participation throughout the health and disability sector. Major gains in Māori provider and workforce development have strengthened Māori infrastructure and leadership.

Māori Development Organisations (MDOs) have, for example, emerged alongside Māori co-funding organisations (MAPOs) and Māori provider and professional organisations, to play a critical role in the effective delivery of health and disability services for Māori.

The Ministry of Health, DHBs, and other health and disability agencies have a responsibility to maintain these gains and to build on them.
Reducing inequalities

Reducing inequalities in health and disability outcomes and improving access to services is a thread that weaves throughout this strategy. In implementing service changes, it is critical that the changes are assessed to ensure that they will contribute to reducing inequalities and not increase inequalities.

These disparities in health status reflect broader socioeconomic inequalities experienced by Māori and create a challenge for the Government, the health sector and other sectors.

Reducing inequalities in health also requires a focus on identifying priorities where a difference can be made. Population health objectives have been identified. DHBs will need to assess the health needs of their region (recognising that Māori may have different needs), identify service coverage and areas that need to be strengthened or modified over time.
Pathways for action

Within the context of the two broad directions and the three threads outlined, four pathways for action specify how the aim of improved whānau ora is to be achieved. These pathways are not mutually exclusive but are intended to work as an integrated whole. Whakatātaka sets out specific expectations of Crown agencies for each of the pathways over the next two to three years.

Te Ara Tuatahi - Pathway One
Development of whānau, hapū, iwi and Māori communities
The Crown will work collaboratively with whānau, hapū and iwi and Māori communities to identify what is needed to encourage health as well as prevent or treat disease. This includes supporting whānau development and participation in both te ao Māori and wider New Zealand society, to improve health and wellbeing.

Te Ara Tuarua - Pathway Two
Māori participation in the health and disability sector
The goal is active participation by Māori at all levels of the health and disability sector in decision-making, planning, development and delivery of health and disability services. This pathway supports Māori provider and workforce development.

Te Ara Tuatoru - Pathway Three
Effective health and disability services
This pathway aims to ensure that whānau receive timely, high-quality, effective and culturally appropriate health and disability services to improve whānau ora and reduce inequalities.

Te Ara Tuawha - Pathway Four
Working across sectors
This pathway directs the health and disability sectors to take a leadership role across the whole of government and its agencies to achieve the aim of whānau ora by addressing the broad determinants of health.
Inequalities in health

Making a difference: reducing inequalities for all New Zealanders, including Māori and Pacific peoples

To improve the overall health of New Zealanders, particular attention must be paid to those with the poorest health. Many complex factors lead to poor health status. The impact of those factors is particularly evident amongst Māori and Pacific peoples and has resulted in disparities in Māori and Pacific peoples’ health status.

Addressing health inequalities is a major priority requiring ongoing commitment across the sector. The most effective means to reduce disparities will focus on:

- intersectoral approaches
- use of prevention strategies, with a population health focus
- building on existing initiatives
- modifying behaviour and lifestyle risk factors through appropriately tailored policies and programmes
- improved delivery of treatment services through mainstream enhancement and provider development.

The Government has given priority to reducing the disparities in social and economic outcomes for all New Zealanders, including Māori and Pacific peoples, and an intersectoral work programme is in place to ensure identifiable progress is made over the next three years to reduce those inequalities.

In order to design policies and programmes to reduce inequalities for all New Zealanders, including Māori and Pacific peoples, the Ministry of Health and District Health Boards will:

- identify community-driven initiatives that are achieving results or that have the potential to do so
- identify ways they can respond to communities’ needs and interests
- advise communities and provide them with information to help them meet their needs and fulfil their interests
- help communities to access the optimum mix of resources to achieve their own goals

The Government has given priority to reducing the disparities in social and economic outcomes for all New Zealanders, including Māori and Pacific peoples, and an intersectoral work programme is in place to ensure identifiable progress is made over the next three years to reduce those inequalities. In order to design policies and programmes to reduce inequalities for all New Zealanders, including Māori and Pacific peoples, the Ministry of Health and District Health Boards will:

- identify community-driven initiatives that are achieving results or that have the potential to do so
- identify ways they can respond to communities’ needs and interests
- advise communities and provide them with information to help them meet their needs and fulfil their interests
- help communities to access the optimum mix of resources to achieve their own goals
• adapt policies, programmes and funding to support successful community initiatives
• implement programmes to reduce health inequalities
• liaise with other government agencies on a national and local basis to build more co-ordinated policies and programmes
• support provision of by Māori for Māori services
• support ‘by Pacific for Pacific’ initiatives
• focus on results.

Chapter 3:
Fundamental Principles, Goals and Objectives

This section adopts a principles, goals and objectives framework. Each of the areas is discussed separately below. For definitions of terms used see the Glossary.

Principles

The New Zealand Health Strategy is based on seven underlying principles that the Government sees as fundamental. Those principles are to be applied across the sector and be reflected in any new strategies or developments.

Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi.

Good health and wellbeing for all New Zealanders throughout their lives.
An improvement in health status of those currently disadvantaged.
Collaborative health promotion and disease and injury prevention by all sectors.
Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
A high-performing system in which people have confidence.
Active involvement of consumers and communities at all levels.

Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi - The New Zealand Health Strategy 7

This principle recognises that the Treaty of Waitangi is New Zealand’s founding document and the Government is committed to fulfilling its obligations as a Treaty partner. This special relationship is ongoing and is based on the underlying premise that Māori should continue to live in Aotearoa as Māori. The nature of this relationship has been confirmed through interpretations of the Treaty of Waitangi, which stem from decisions of the Waitangi Tribunal, the Court of Appeal and the Privy Council.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

Māori should be able to define and provide for their own priorities for health and be encouraged to develop the capacity for delivery of services to their communities. This needs to be balanced by the Crown’s duty to govern on behalf of the total population.
To date, the relationship between Māori and the Crown in the health and disability sector has been based on three key principles:
• participation at all levels
• partnership in service delivery
• protection and improvement of Māori health status.

Not only is it important to improve Māori health status, but other goals based on concepts of equity, partnership, and economic and cultural security must also be achieved.

**Good health and wellbeing for all New Zealanders throughout their lives**

This principle reflects the sector’s clear focus on good health and wellbeing. This applies at both the individual level (for example, with treatment services) and the community level (for example, with health promotion services), and that continues throughout people’s lives. The Government recognises that good health and wellbeing rely on a range of factors, many of which are outside the health sector. The sector must, therefore, seek to move towards more intersectoral ways of working to ensure these linkages can be made, both centrally and locally.

**An improvement in health status of those currently disadvantaged**

This principle identifies the opportunity for health improvement within the population. The benefits of health improvements are not shared equally by all sectors of society. An increase in effort is needed to address the low health status of groups with low socioeconomic status, including Māori and Pacific peoples, and people with serious mental illness.

**Collaborative health promotion and disease and injury prevention by all sectors**

This principle reflects the Government’s desire to have a health system that promotes good health and ‘wellness’ as well as treating illness. Many of the illnesses affecting the New Zealand population are potentially preventable, and we need to do better at addressing all the determinants of health.

**Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay**

This principle reflects the fact that fairness is a fundamental value for most New Zealanders, and the health sector must ensure that New Zealanders with similar health conditions are able to achieve similar outcomes.

**Māori advancement in health**

Improvements in Māori health status are critical, given that Māori, on average, have the poorest health status of any group in New Zealand. The Government has acknowledged the importance of prioritising Māori health gain and development by identifying a need to reduce and eventually eliminate health inequalities that negatively affect Māori.

Working towards reducing inequalities will involve government departments and agencies working co-operatively across sectors, community engagement, and community development.
The progress of achievements since the mid-1980s must continue. Some examples include:

- growth and upskilling of Māori providers
- expansion of the Māori workforce at all levels of the health sector
- enhancement of mainstream providers’ ability to meet Māori needs and expectations
- increased Māori participation at all levels of the public health sector.

A Māori Health Strategy will be available by June 2001 (see Appendix 2 for more details) and will provide the details unable to be captured within the New Zealand Health Strategy.

Reducing inequalities for Māori in the short to medium term includes, but is not limited to:

- attention on addressing He Pūtahitanga Hōu objectives relating to rangatahi health, disability support services and alcohol and drug services
- improving the quality and effectiveness of health promotion and education programmes targeted at Māori
- forming effective partnerships at all levels under the Treaty of Waitangi
- enhancement of mainstream providers
- increased Māori participation at all levels of the public health sector
- improving an established matrix of relationships vertically and horizontally throughout the health sector
- increased participation and involvement of Māori health providers across the health sector
- improved mental health services to Māori, which take into account Māori healing
- an increased number of Māori in the health workforce, particularly in mental health
- promotion of smoking cessation programmes
- increased resources for Māori health providers delivering sexual and reproductive health services.

Existing Māori health gain priority areas will continue to receive attention. The eight priority areas are:

- immunisation
- hearing
- smoking cessation
- diabetes
- asthma
- mental health
- oral health
- injury prevention.
#4 a) The Standards of Midwifery Practice

Cited from: Midwives Handbook for Practice – New Zealand College of Midwives (Inc)

See Next Page.
The midwife works in partnership with the woman.

Criteria
The midwife:

- recognises individual and shared responsibilities
- facilitates open interactive communication and negotiates choices and decisions
- shares relevant information within the partnership
- identifies her midwifery philosophy and Code of Practice, and freely shares this information with the woman
- acknowledges and respects different ways of knowing
- is culturally safe
- recognises contribution of both partners
- recognises that continuity of care enhances partnership

Turanga Kaupapa

Whakapapa

- The wāhine and her whānau is acknowledged.

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8 Cultural Safety and Nursing Education in Aotearoa and Te Waiwhetū
Standard Two

The midwife upholds each woman’s right to free and informed choice and consent throughout the childbirth experience.

Criteria
The midwife:

• shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices

• facilitates the decision-making process without coercion

• negotiates her role as care-giver and clearly identifies mutual responsibilities

• develops a plan for midwifery care together with the woman

• respects the decisions made by the woman, even when these decisions are contrary to her own belief

• respects the woman’s right to decline treatments or procedures

• clearly states when her professional judgement is in conflict with the decision or plans of the woman

• discusses with the woman, and colleagues as necessary, in an effort to find mutually satisfying solutions

• attends when requested by the woman in situations where no other health professional is available

• documents decisions and her midwifery actions

Turanga Kaupapa

Karakia

• The wahine and her whānau may use karakia
Standard Three

The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Criteria
The midwife:

• collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman.
• collects information using all sources in consultation with the woman.
• collects information which includes:
  personal and family/whānau details
  physical, psychological, emotional wellbeing
  cultural and spiritual dimensions
  physical, social and cultural environment.
• acknowledges the individual nature of each woman's pregnancy in her assessments and documentation.
• documents her assessments and uses them as the basis for on-going midwifery practice.

Turanga Kaupapa

Whanaungatanga

• The wahine and her whānau may involve others in her birthing programme
Standard Four

The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.

Criteria
The midwife:

- reviews and updates records at each professional contact with the woman
- ensures information is legible, signed and dated at each entry
- makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman’s knowledge and consent
- ensures confidentiality of information and stores records in line with current legislation

Turanga Kaupapa

Te Reo Maori

- The wahine and her whānau may speak Te Reo Maori
Standard Six

Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.

Criteria
The midwife:

• plans midwifery actions on the basis of current and reliable knowledge and in accordance with Acts, Regulations and relevant policies
• ensures assessment is on-going and modifies the midwifery plan accordingly
• ensures potentially life threatening situations take priority
• demonstrates competency to act effectively in any maternity emergency situation
• identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate
• works collaboratively with other health professionals and community groups as necessary
• has the responsibility to refer to the appropriate health professional when she has reached the limit of her expertise
• can continue providing midwifery care in situations where medical skills are required if this is appropriate
• demonstrates awareness of her own health status and seeks support to ensure optimum care for the woman is maintained
• has easy access to appropriate emergency equipment
• acknowledges every interaction with the woman as a teaching/learning opportunity

Turanga Kaupapa

Hau Ora
• The physical, spiritual, emotional and mental wellbeing of the wahine and her whānau is promoted and maintained
The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.

Criteria

The midwife:

- recognises that she is an autonomous practitioner, regardless of setting, and is accountable for her practice
- clearly documents her decisions and professional actions
- records her practice outcomes and makes them freely available
- ensures relevant information is available to the woman
- ensures women are aware of avenues for complaints and mechanisms for review
- ensures her practice is based on relevant and recent research
- in situations where another dimension of care is needed, ensures negotiation takes place with other care providers to clarify who has the responsibility for the care
- documents any misjudgement of practice and initiates restorative actions
- recognises own learning needs and finds opportunities to have these met
- reflects on practice
- seeks to maintain and improve the policies and quality of service in the organisation or agencies in which she works
- identifies processes for ensuring midwife back-up, access and support to other colleagues as necessary
- is a member of the New Zealand College of Midwives

Turanga Kaupapa

Tikanga Whenua

- Maintains the continuous relationship to land, life and nourishment; and the knowledge and support of kaumatua and whānau is available
#4 b) Competencies for Entry to the Register of Midwives

**Cited from:** Midwives Handbook for Practice - New Zealand College of Midwives (Inc)

See Next Page.

## Competencies for Entry to the Register of Midwives

The Competencies for Entry to the Register of Midwives provide detail of the skills, knowledge and attitudes expected of a midwife to work within the Midwifery Scope of Practice. Where the Midwifery Scope of Practice provides the broad boundaries of midwifery practice, the competencies provide the detail of how a registered midwife is expected to practise and what she is expected to be capable of doing. By defining the minimum competence standards for registration as a midwife in New Zealand the Midwifery Council has established the minimum standard that all midwives are expected to maintain in their ongoing midwifery practice.

**Competency One**

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

**Explanation**

The word midwife has an inherent meaning of being "with woman". The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early parenthood. The midwifery relationship enhances the health and well-being of the woman wahine, the baby tamaiti and their family whānau. The onus is on the midwife to create a functional partnership. The balance of 'power' within the partnership fluctuates but it is always understood that the woman has control over her own experience.
Competency Two

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

Explanations
The competent midwife integrates knowledge and understanding, personal, professional and clinical skills within a legal and ethical framework.

The actions of the midwife are directed towards a safe and satisfying outcome.

The midwife utilises midwifery skills that facilitate the physiological processes of childbirth and balances these with the judicious use of intervention when appropriate.

Competency Three

"The midwife promotes practices that enhance the health of the woman/wahine and her family/whānau and which encourage their participation in her health care."

Explanations
Midwifery is a primary health service in that it recognises childbirth as significant and normal life event. The midwife is therefore responsible for supporting this process through health promotion, education and information sharing, across all settings.

Competency Four

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

Explanations
As a member of the midwifery profession the midwife has responsibilities to the profession. The midwife must have the skills to recognise when midwifery practice is safe and satisfactory to the woman/wahine and her family/whānau.
# The HDC Code of Health and Disability Services Consumers' Rights
Regulation 1996


1. Consumers have Rights and Providers have Duties:

1) Every consumer has the rights in this Code.

2) Every provider is subject to the duties in this Code.

3) Every provider must take action to -
   a) Inform consumers of their rights; and
   b) Enable consumers to exercise their rights.

2. Rights of Consumers and Duties of Providers:

The rights of consumers and the duties of providers under this Code are as follows:

**RIGHT 1**
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.

2) Every consumer has the right to have his or her privacy respected.

3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

**RIGHT 2**
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

**RIGHT 3**
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

**RIGHT 4**
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

**RIGHT 5  
Right to Effective Communication**

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

**RIGHT 6  
Right to be Fully Informed**

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -

   a) An explanation of his or her condition; and

   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

   c) Advice of the estimated time within which the services will be provided; and

   d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and

   e) Any other information required by legal, professional, ethical, and other relevant standards; and

   f) The results of tests; and

   g) The results of procedures.

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -

   a) The identity and qualifications of the provider; and

   b) The recommendation of the provider; and

   c) How to obtain an opinion from another provider; and

   d) The results of research.

4) Every consumer has the right to receive, on request, a written summary of information provided.

**RIGHT 7**

*Right to Make an Informed Choice and Give Informed Consent*

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -

   a) It is in the best interests of the consumer; and

   b) Reasonable steps have been taken to ascertain the views of the consumer; and

   c) Either, -

      i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

      ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.
6) Where informed consent to a health care procedure is required, it must be in writing if -
   a) The consumer is to participate in any research; or
   b) The procedure is experimental; or
   c) The consumer will be under general anaesthetic; or
   d) There is a significant risk of adverse effects on the consumer.

7) Every consumer has the right to refuse services and to withdraw consent to services.

8) Every consumer has the right to express a preference as to who will provide services and
   have that preference met where practicable.

9) Every consumer has the right to make a decision about the return or disposal of any body
   parts or bodily substances removed or obtained in the course of a health care procedure.

10) No body part or bodily substance removed or obtained in the course of a health care
    procedure may be stored, preserved, or used otherwise than
        (a) with the informed consent of the consumer; or (b) For the purposes of research that
            has received the approval of an ethics committee; or c) For the purposes of 1 or more
            of the following activities, being activities that are each undertaken to assure or
            improve the quality of services:
                (i) a professionally recognised quality assurance programme:
                (ii) an external audit of services:
                (iii) an external evaluation of services.

   **RIGHT 8**
   **Right to Support**

   Every consumer has the right to have one or more support persons of his or her choice
   present, except where safety may be compromised or another consumer's rights may be
   unreasonably infringed.

   **RIGHT 9**
   **Rights in Respect of Teaching or Research**

   The rights in this Code extend to those occasions when a consumer is participating in, or it is
   proposed that a consumer participate in, teaching or research.

   **RIGHT 10**
   **Right to Complain**

1) Every consumer has the right to complain about a provider in any form appropriate to the
   consumer.
2) Every consumer may make a complaint to -
   a) The individual or individuals who provided the services complained of; and
   b) Any person authorised to receive complaints about that provider; and
   c) Any other appropriate person, including -
      i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner.

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -
   a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -
      i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner; and
   c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and
   d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -
   a) Decide whether the provider -
      i. Accepts that the complaint is justified; or
      ii. Does not accept that the complaint is justified; or
b) If it decides that more time is needed to investigate the complaint, -

i. Determine how much additional time is needed; and

ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -

a) The reasons for the decision; and

b) Any actions the provider proposes to take; and

c) Any appeal procedure the provider has in place.

3. Provider Compliance

A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

The onus is on the provider to prove it took reasonable actions.

For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4. Definitions

In this Code,

"Advance directive" means a written or oral directive-

(a) By which a consumer makes a choice about a possible future health care procedure; and

(b) That is intended to be effective only when he or she is not competent:

"Choice" means a decision-

(a) To receive services:

(b) To refuse services:

(c) To withdraw consent to services:

"Consumer" means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer:

"Discrimination" means discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993:

"Duties" includes duties and obligations corresponding to the rights in this Code

"Ethics committee" means an ethics committee -
(a) established by, or appointed under, an enactment; or
(b) approved by the Director-General of Health.

"Exploitation" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence:

"Optimise the quality of life" means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances:

"Privacy" means all matters of privacy in respect of the consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates:

"Provider" means a health care provider or disability services provider:

"Research" means health research or disability research:

"Rights" includes rights corresponding to the duties in this Code:

"Services" means health services, or disability services, or both; and includes health care procedures:

"Teaching" includes training of providers.

5. Other Enactments

Nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6. Other Rights

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.
The Treaty of Waitangi signed in 1840 is a founding document between Māori and the Crown. It came about as a desire to establish some formality and order between tangata whenua (local Māori people) and a growing European settlement.

It is important to understand the proceedings surrounding the signing of the Treaty of Waitangi as it still creates confusion and misunderstanding for many people today.

Missionaries George Clarke and Henry Williams called the British Government to intervene by asking for a Governor to come to New Zealand alongside military support. Meanwhile, more migrants were arriving to begin their new life in New Zealand.

In order to make the most of this growing population a Company was established by Edward Wakefield under the NZ Association. The Company purchased large portions of land from the Māori for pittance and then sold it for huge profits to European gentry. According to Ranginui Walker (1990), Wakefield replicated the English class structure by selling land to the upper class English. The land that was purchased surplus to the wants of the landowners would then be sold to entice the working class migrants to come to Aotearoa to provide the labour force required to develop the land such as: carpenters, blacksmiths and agricultural labourers. With no current regulations and price control of land purchase it was easy for the Company to continue to buy land.

On the 14th January New Zealand became a colony of New South Wales by the Order of Council and Captain Hobson arrived later that month to carry out the order. New Zealand was seen as a sovereign state and it was handed to Hobson to obtain consent by Māori to surrender their sovereignty to the British Crown. What was to be offered for this significant handover was “British protection, law and citizenship” (Walker, 1990, p.90, States Service Commission, 2005)

The Treaty of Waitangi was drafted and translated by Henry Williams while Hobson revised and made corrections. The outcome resulted in four English and one Māori versions that didn’t match any of the English accounts. The Treaty and facilitators then went on a road tour of New Zealand seeking all signatures from all Chiefs.
Flawed with major discrepancies between the Māori and English version and delivered with reassurances that the Treaty was put in place to protect Māori and to safeguard the possession of their lands, 540 Māori chiefs did concede and placed their signature upon it.

The Principals of the Treaty of Waitangi


See next page.

The Principles of the Treaty of Waitangi

The Treaty of Waitangi is considered to be an important source of the New Zealand constitution, however the formal legal position is that the Treaty has legally enforceable effect only when referred to in legislation. At the present time the Treaty of Waitangi is referred to in 62 separate Acts of Parliament. Most statutes have no reference to the Treaty, and most of the ones that do relate either to natural resources and environmental legislation, or to such Māori-specific parts of the law as Māori land law.

Most of these legislative references are not to the Treaty text but rather to the "principles" of the Treaty. This is because the two texts of the Treaty have led to different understandings, and because of the need to apply the Treaty to present-day circumstances and issues. Treaty principles interpret the Treaty as a whole, its intention and its spirit. In the 1994 Broadcasting Assets case (p. 513), Lord Woolf described the principles as "the underlying mutual obligations and responsibilities the Treaty places on the parties. They reflect the intention of the Treaty as a whole and include, but are not confined to, the express terms of the Treaty."

Examples of references to Treaty principles in legislation include section 6 of the Treaty of Waitangi Act 1975, which gives the Waitangi Tribunal jurisdiction to inquire into claims that actions or omissions of the Crown are "inconsistent" with "the principles of the Treaty of Waitangi". Section 9 of the State Owned Enterprises Act 1986 states that "nothing in this Act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi". To take yet another example, section 4 of the Crown Minerals Act 1991 states that the Act "shall be so interpreted and administered as to give effect to the principles of the Treaty of Waitangi".

There are many other examples. There is considerable variety in wording: in some statutes an obligation to comply with the Treaty is phrased positively, in others negatively.

Given the tendency to refer to the "principles" of the Treaty rather than to the Treaty text, it has become necessary for the Courts and the Waitangi Tribunal to work out what those principles are. The most important discussion of this issue by the Courts is found in the judgment of the Court of Appeal in New Zealand Māori Council v Attorney-General, [1987] 1 NZLR 641. In this case, Court of Appeal President Cooke said that the task of interpretation "should not be approached with the austerity of tabulated legalism" and that a "broad, unquibbling and practical interpretation" was necessary (p. 661).

In the same case, Justice Richardson noted that "regrettably, but reflecting the limited dialogue there has been on the Treaty, it cannot yet be said that there is broad agreement as to what those principles are" (p. 673).

The Court of Appeal emphasised that there were two core principles. These were "partnership" and "active protection". President Cooke said that "the Treaty signified a partnership between races, and it is in this concept that the answer to the present case has to be found" (p. 664).

Both the Courts and the Waitangi Tribunal have determined that the principle of partnership includes the obligation on both parties to act reasonably, honourably and in good faith. The Courts have found that Treaty partnership does not necessarily describe a relationship where the partners share national resources equally. The Courts have also found that an aspect of the obligation to act in good faith is a duty to make informed decisions through consultation (although the duty to consult is not absolute). The Waitangi Tribunal has emphasised the value and
utility of consultation in upholding and strengthening the Treaty partnership.

Also mentioned in the case was a principle of "redress of grievances", which, however, "is not justiciable in the Courts" (Justice Somers, at p. 693). The principle of redress was seen to arise from the partnership principle, and reflects the Crown’s duty to take active and positive steps to redress Treaty breaches. It entails a fair and reasonable recognition and recompense for wrongdoing.

As to "active protection", President Cooke observed that "the duty of the Crown is not merely passive but extends to active protection of Māori people in the use of their lands and waters to the fullest extent practicable". This principle is located in the fundamental exchange recorded in the Treaty — the cession of sovereignty for the promise to respect Māori authority over their own affairs and protect their resource rights; or, in the Māori text, the giving up of kawanatanga for the guarantee of tino rangatiratanga. This is sometimes described as the principle of reciprocity.

Since 1987, the Courts and the Waitangi Tribunal have developed a number of more detailed principles but the concepts of "partnership" and "active protection" have remained dominant. For a detailed list of the principles that have been developed see "He Tirohanga o Kawa ki te Tiriti o Waitangi: A Guide to the Principles of the Treaty of Waitangi", Te Punī Kōkiri, Wellington, 2001 (http://www.tpk.govt.nz/publications).
I think to understand the Māori, one needs to examine and appreciate the various concepts which govern and determine his life style. The first concept, naturally enough, is the Māori attitude to the creation of all things, including man.

The Māori believed that in the beginning there was one supreme being, Io. From Io came his creation Korekore (nothingness). From the many forms of nothingness came Te Pō, or the night. There are many forms of night. From the night, came the light or, starting with the first form, Te Ata the dawn, progressing to Te Aomārama, the fullest light of Day, then to Whaitua, space.

From space there was Māku, moisture who was male, and Mahorua nui a rangi, the great expanse of Heauen, who was female. Then came Rangi, the sky father and Papa, the earth mother.

Rangi and Papa had many children, but, because of their strong love for one another they were in a permanent embrace, thus stifling their children and life. Their children decided to part them by force. It fell to Tanemahuta, the God of the forests to part them. With a major effort he accomplished this feat. Rangi became the sky, Papa became the earth and all the children became the elements of nature.

Tane mated with many beings, but failed to produce a human being. He went to his father, Rangi, to see if he could help, but his father said that the sky is the realm of life hereafter while the earth is the realm of fate. Tane realises he can give the spiritual component, while the physical must be derived from the earth. He forms earth in the shape of a woman and breathes the breath of life into her, this creating the human species.

The second concept is kinship. It can be seen from the creation, that there is a strong bond or relationship connecting nature, and man with nga atua, the gods. It extends to tribe with tribe, hapu with hapu, family with family, individual with family. Tangata whenua, man of the land is an extension of this. It means a person's right, through his foothold traced by genealogy, or, as modified to suit present day, attainment.

In the early times, there were no policemen, as such. Control was maintained by Tapu and Noa. These two concepts go hand in hand. Both are mental attitudes towards the relationships one has with the conduct towards various things or happenings. For human instance, the flower of the kiakia plant is said to be tapu for human consumption, that is humans cannot eat it during this period, for a certain part of the year. This part of the year is left for the rats. If you were to have a look at the flower during the year, the picking of the flower is said to be Noa, that is, it is permissible to take it, you will find not one flower touched by rats.

At a certain time of the year it is Tapu to get food from the sea. This ensured that the seafood was not over fished.

Mana is the concept where a person gets his prestige from nga atua, the gods. What does this mean? There are seventy two atua, all elements of nature, so it is showing respect nature in its widest sense with the underlining theme of to help now, is to insure sustainability. This is likened to whakapapa, family tree. At some stage we stem from others, who came first the chicken or the egg. He also acquires prestige through his success in life.
#8 “Eyes Half Shut” by Kelly Tikao

This is a fictional story that incorporates a Māori belief associated with birth and death. It intrigued the author when she heard her mother in law comment on a recent tangi (funeral) she had attended and that tūpapaku’s (deceased) eyes were slightly open. From this short conversation the author wrote the following story to highlight how old beliefs can still be very relevant and of concern for some Māori whānau.

“I wish they’d stop that wailing”, my mother moaned.

“Mum!” I replied crossly. I wish that you’d stop insisting on coming to tangi and then embarrassing me with your loud and naive comments.

“It just seems so dramatic Maia, that’s all” mum added, knowing I was getting pissed off.

“They’ve got every right to be dramatic mum, not only is Koro dead, but his eyes aren’t quite shut. For Māori this can be seen as a tohu. I pause because I could see mum’s wrinkles gathering on her forehead. ‘Like a sign mum, that Koro will claim someone close’.

This hushed my mother for a brief moment before she insisted that I elaborate on what exactly claiming someone meant. I explained it means that someone within the whanau will die and be taken with Koro to his grave. That did it, no more questions from mum and I felt her shudder at the weight of what I’d just told her.

That night the wharenui was a chorus of snoring and farting as people lay in cosy rows around Koro’s coffin. I needed a mimi, so I manoeuvred myself out of my sleeping bag, over dreaming bodies and out to the toilets.

The adrenalin surged through my heart and made it beat way too fast and way too loud. I could see fresh blood spots in my knickers. I held my pregnant puku and with the deafening sound of my heart in my ears I sat on the loo feeling very lonely and scared. The night wind danced through the toilet louver window down my back.
and bum. I stood up, folded some toilet paper into my knickers and went back to bed, praying that my baby was OK.

I glanced at Koro in his coffin, cold and waxy. I am his oldest grandchild and we used to be close when I was little. Then dad got a job in Christchurch and the whanau shifted to the South Island. I didn’t realise at the time, but this was a really sad day for Koro.

I climbed back into my sleeping bag and worried about my baby. I closed my eyes and there, at the end of my mattress stood Koro, his hands reaching towards my stomach and his eyes pleading into mine.

“No Koro, you will not take my first born”, I said in silence. But this did not stop Koro from appearing throughout the night, or from me begging him to go away. I hugged my belly tight and cried. I felt my uterus quiver, contract and heave.

I woke mum up early and asked her to take me to the local hospital. Tired emergency staff, keen to get home after a long night of Saturday drunkards, dealt with me quickly. I repeated my obstetrics history to junior house surgeons, then again to the registrar before I was eventually taken to radiography to await an ultrasound.

I was handed an over-washed hospital gown with too few material tags to barely cover the front of my body. I was then told to lie down on the cold, skinny trolley bed in the ultrasound room. Exhausted I tried to calm myself by closing my eyes and thinking positively. No sooner had I done this that Koro appeared again, his outreached hands were getting closer to my belly.

Mum had left the room, desperate for a cuppa. A sterile lab-coated radiographer entered the room, saw that I was distressed, but chose to say nothing. I knew she couldn’t see Koro, but I hated her lack of communication. She plastered ultrasound goo on my stomach and then apologised insincerely about how cold the gel was.

Mum came in carrying her cup of tea in a polystyrene cup. “I couldn’t find a teaspoon anywhere, the hospitals must be in a bad state if you have to bring your own cutlery in”. She looked up, took in my sadness and immediately pulled a chair up beside the bed and held my hand.
The radiographer placed the ultrasound probe onto my stomach. Koro’s hands were now delving into my uterus. I yelled at Koro to stop through angry frightened tears. The doors flung open and two black figures burst into the room. They were wailing loudly. My mother moaned. Between the sobs my Aunty Missy and Nanny Rose announced that Uncle Bill had just died.

Koro withdrew his hands, looked with intense sadness into my eyes, turned and walked away. The radiographer hushed the commotion with her words, “Baby is alive and well”.

My son Manuhaia, was born 4 months later, after a very quick and intense labour. He was as eager as I was to have him in this world.

“He’s got an interesting birthmark on his chest don’t you think Maia, I suppose it’ll fade ay?” mum said.

Koro may not have got his first-born great moko but he has left his mark. I did a mihi to my Koro and my Uncle Bill, leant down and kissed my son’s birthmark.
Ngā Pukapuka Whakamārama / References


