Mā te wāhine, mā te whenua, ka ngaro te tangata
Wāhine and whānau experiences informing the maternal-infant health care system

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Abstract

Māori (Indigenous people of Aotearoa New Zealand) whānau (family) are experiencing the harm or loss of their baby more often than Pākehā (non-Māori) whānau. Compared to Pākehā babies, Māori babies are twice as likely to have a potentially preventable death. In addition to death, Māori babies are admitted to a neonatal intensive care unit or special care neonatal unit more often. Arguably, these health disparities are a manifestation of how the current maternal-infant health care system is failing Māori whānau.

This research aimed to address this failure and questioned whether or not the maternal-infant health care system was delivering culturally responsive care for whānau following the harm or loss of their baby; and if not, can we learn from the lived realities of whānau and mātauranga Māori (Māori knowledge) to propose positive, culturally responsive systemic change(s). To carry out the research, a Kaupapa Māori (by Māori, for Māori) methodology, named Te Pūkenga Mātauranga, was developed following a consultation journey with key informants. Ten whānau who had experienced the harm or loss of their baby shared their stories through kōrero (conversational interview).

The shared stories and experiences were collated and the findings are expressed as a journey through the maternal-infant health care system: beginning from hapūtanga (pregnancy) to whānautanga (labour and delivery) to piripoho (immediately following birth), and onāianei (current time). All ten whānau entered the maternal-infant health care system at an unexpected time, and under unanticipated circumstances. It was found that when they were made to enter in this manner, the system was incompatible in delivering culturally responsive care. To offer a solution, a nuanced framework of health care, named Te Hā o Whānau, is suggested. The name was chosen to mean whānau voices leading maternity care in Aotearoa New Zealand. Thus, the framework builds upon the whānau experiences and Te Tiriti o Waitangi/the Treaty of Waitangi to offer tikanga Māori (Māori cultural practices) guidelines that could enable the maternal-infant health care system facilitating a culturally responsive environment that allows whānau to thrive as Māori following the harm of loss of their baby.
He Mihi

This thesis is a reflection of the aroha and generosity demonstrated by the wāhine and whānau that shared their experiences with me. I am in awe of these strong and courageous wāhine and whānau. Thank you for sharing your journey with me.

This PhD project has been a journey for me, one that has had many highs and some lows. I could not have made it here to the end without the korowai manaaki which I have been cloaked with throughout the entire journey. I would like to take this opportunity to give thanks and appreciation for each and every ‘thread’ of this korowai.

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Wāhanga Tuatahi

Te Kore

*Kua takoto te mānuka.*

*The leaves of the mānuka tree have been laid.*

Laying down mānuka tree leaves is symbolic of setting a wero (challenge) to those willing to accept. The challenge laid out before this research project is reducing the stark infant health disparities between Māori and non-Māori in Aotearoa New Zealand. The reasons behind these disparities are relatively unknown although evidence that the disparities exist is widely documented. This research project accepted this wero and aimed to contribute towards finding out why these disparities exist, and what we can do to bring about positive change.

Te Kore means the void, and is where all potential is derived (Marsden, 2003). Understanding this, it is fitting that the research project, and the wero it encompasses, is introduced and developed in this wāhanga (section).

Chapter 1 – Ko wai au?
Chapter 2 – He aha tēnei kaupapa?
Chapter 3 – Te Whare Tangata me Whakawhānau
Chapter 4 – Whakatuanui ā-mātauranga
Chapter 1: Ko wai au?

7th of July, 1993. It is a date that is forever etched into my mind, as it is etched forever into my skin. That was the day that our whānau (family) lost a precious taonga (treasure). Kiri Maria Stevenson, my first cousin who I considered my sister, passed away as a young child. The memories I have of Kiri are vivid (including all the growling's she would give me when I cried the house down - “Shuuuuut up Kendall!”), and I carry them with me every day. Kiri was a special girl who loved to sing and had a sense of humour that was beyond her years. Even in her last days, she would endure her pain and make us all laugh and smile with her cheeky nature. My father and Kiri had a particularly tight bond, as he became another caregiver for her to help his brother and sister-in-law, my uncle and aunty. Because of this, I was blessed to grow up with Kiri, alongside her two sisters and one brother. Through her passing, I have experienced the indescribable hurt of losing a part of our whakapapa and all her potential. This potential included having my tuakana (older sibling) guide me through life.

As a whānau, Kiri remains an integral part of our lives and we often talk about how she would have been involved in the dynamic of our whānau. We firmly believe that she has shaped a bit of who we are today. The lessons that Kiri taught me include always finding positivity in life, even amongst all adversities; and to care for, nurture and cherish whānau and their wellbeing. These lessons were particularly established when Kiri passed as I was determined to care for my Dad, aunty, uncle and cousins. This personal journey is difficult for me to share but I have come to realise through this PhD journey, that it is what underpins who I am today and my aspirations for improving whānau health.

As time has progressed, the inherent drive of wanting to nurture, care for, and enhance the livelihood of my whānau has remained within me and grown to extend to whānau outside of my own. It has become my aim to work with whānau to help them find positivity through their adversities and support them to strengthen their whānau wellbeing. Through whānau-centered research, it is my goal to work with whānau to understand how we can improve the provision of health care, in ways that are appropriate for Māori, so that fewer whānau will go through the pain of losing a child as we did. If loss is experienced, I want to help them find positivity again. As my beautiful and inspirational Mama, Kiri’s mum, shares “it’s never a bad idea to improve another person’s or people’s lives, especially when it is a child that is sick…when you put yourself out there to do that, you have to experience and see other people’s pain…but to us, who have and continue to empathise with others because of our loss
…you receive always the greater gift when giving because there is more joy in giving than receiving.” I stand by this philosophy and will endeavor to forever honour Kiri and contribute towards improving the wellbeing of whānau.

This thesis is for you, my Nan and Kiri.

Figure 1. Nan with Kiri. Photo taken January, 2018.
1.1 Pepeha

I te taha o tōku Pāpā,
Ko Pūtauaki me Kaputerangi ngā maunga
Ko Te Oriini me Rangitaiki ngā awa
Ko Mātaatua te waka
Ko Ngāti Awa te iwi
Ko Ngāi Taiwhakaeaa II, Ngāi Rangihouhiri me Pahipoto ngā hapū
Ko Te Paroa me Kokohinau ngā marae
Ko Taiwhakaeaa me Oruataupare ngā tūpuna whare
Ko Toanatini me Waipunarangi ngā wharekai
I te taha o tōku Māmā,
Ko Tikorangi me Emiemei ngā maunga
Ko Karatia me Waitiki me Pupuke ngā awa
Ko Kurahaupō me Mātaatua ngā waka
Ko Ngāti Kuri ki Ngātaki me Ngā Puhi ki Whangaroa ngā iwi
Ko Pohotiare me Ngāti Uru ngā hapū
Ko Te Reo Mihi ki Te Hapua me Huia, Te Tahawai, Paparore ngā marae
Ko Moetangi te urūpā
Ko Parengarenga te wahapū
Ko Whangaroa te moana
Ko Martin Stevenson rāua ko Bella Whitinui ōku mātua
Ko Kendall Stevenson tōku ingoa.

The pepeha (expression of genealogy) above expresses my whakapapa (layers of descendants) and acknowledges who I am and where I am from. Having this understanding connects me to Papatūānuku, our Earth Mother, where I am forever nurtured and bound to her through whakapapa. Being aware of my whakapapa and cultural identity also provides the platform necessary to carry out culturally responsive research with whānau through a Kaupapa Māori lens (personal communication, Areta Koopu, 2015). With this background knowledge of my whānau and whakapapa, I welcome you, the reader, to this thesis.

A glossary of the Māori terms used throughout the thesis is provided in Appendix A.
1.2 Setting the scene

I identify as a Māori (Indigenous people of Aotearoa New Zealand) wahine (woman) with whakapapa to three iwi (tribe/s) in Aotearoa New Zealand: Ngāti Awa in the Bay of Plenty region, and Ngāti Kuri and Ngā Puhi ki Whangaroa in the Far North. I was born and raised in the small rural town of Kaitaia, which has a high proportion of Māori in its population. I have been brought up with the knowledge of where I whakapapa to and how to behave according to Māori tikanga (customs, practices) that is customary in my iwi. For example, I grew up in coastal areas, so I was taught the importance of always respecting Tangaroa, atua (deity) of the sea and fish. Tangaroa is a male atua and Hinemoana (ocean maid) is the female element that maintains balance with Tangaroa (Mikaere, 2017). I have learnt to always show respect by reciting karakia (prayer) before entering the water and always giving thanks for any food that we gathered.

While it is relatively widely known that Tangaroa is the god of the sea, it is less known that he is also responsible for fresh water, including inland awa (rivers). This makes sense if one examines the activities of some marine life that live in the ocean but travel to fresh water streams to breed and lay eggs. I have been taught that Hinemoana provides us with waitai (salt water) and Tangaroa with wai māori (fresh water) and waitai. This is inclusive of te taiao (the environment) as well as the human body, as we are made up of both fresh water and salt water (personal communication, Tukaha Milne, 2016). We consume fresh water and excrete salt water through sweat and tears. The whakataukī (proverb) ‘Ko au te awa, ko te awa ko au’, meaning ‘I am the river, the river is me’ highlights how these atua (deities) are a part of us. In hapū māmā (pregnant women) this is particularly important because the amniotic fluids that flow between mother and child through the whenua (placenta) is representative of these flowing rivers and our connection with Tangaroa and Hinemoana (personal communication, Tukaha Milne, 2016). This connection outlines how Tangaroa and Hinemoana are significant atua (deities) in all water systems in te ao Māori (the Māori world)\(^2\).

As the introduction to this chapter has indicated, a pivotal memory I have growing up was being collectively raised by my whānau, which extended further than my nuclear family to include grandparents, uncles, aunties and cousins. This collective bond was strengthened by Kiri’s illness and eventual death, and while this was a deeply sad time it is also a time I treasure dearly. It was during this time that I learnt

\(^2\) Please note that while this is the knowledge that I hold, there are differing views regarding atuatanga within te ao Māori because different hapū and iwi have different creation narratives.
my whakapapa, including knowledge of my tūpuna (ancestors), wāhi tapu (sacred sites) and tikanga congruent within my tūrangawaewae (home place) because our whānau were always together. Today, as our whānau grows with the addition of new babies, I have the responsibility, as an older cousin and aunty, of passing on this mātauranga Māori (Māori knowledge) so as to sustain the process of taonga tuku iho (treasures handed down) to the younger generations.

Since the loss of my cousin at a young age, an inherent passion of improving health outcomes for whānau has been instilled within me. Even at a young age, Kīrī’s passing lifted the naïve veil that I was somewhat ‘protected’ under as I began to notice differences in health outcomes between Māori and non-Māori. I remember asking my Nana why we would always go to tangi (funerals) when some of my “other mates” (who were Pākehā) had not seen a dead body yet. Upon reflection today, I understand that these tangi were a manifestation of the disparities between Māori and non-Māori whānau. As I grew older, these disparities became more recognisable.

Carrying these experiences from my upbringing with me, I was fortunate to cross paths with influential Māori researchers (particularly Whaea Moe Milne and Dr Anne-Marie Jackson) who opened my eyes to this thing called research. They, along with others, have been instrumental in forging a path of Māori health research for me that aligned with my aspirations of caring for, nurturing and strengthening whānau wellbeing. Addressing the disparities between Māori and non-Māori, particularly for our Māori babies and youth, are where my research interests lie. Utilising mātauranga (Māori knowledge) and kaupapa (plans) that are Māori are central to my Māori health research journey. Throughout this journey, I have found it tika (correct) to undertake strengths-based research in collaboration with whānau and the community. Strengths-based research in this respect is about repositioning Māori in a positive manner. This contrasts with deficit-based research, which holds Māori as the problem in need of ‘fixing’ (Ormand, Cram & Carter, 2006). The strengths-based approach is about positive representations of whānau, as well as a structural analysis of the systems that prevent whānau achieving wellbeing. Abiding by this strengths-based tikanga allows me to work closely with whānau and communities to deliver whānau-led research that informs positive changes within the health care system that may strengthen whānau wellbeing. It is this background that led to the development of this research project.

1.3 Thesis structure

This is a Kaupapa Māori research project, which is explained further in subsequent chapters. Briefly, this means the research is by Māori, for Māori, and with
Māori, and is grounded in and informed by mātauranga Māori. This allows strengths-based research that promotes Māori interests and repositions Māori positively within Aotearoa through system transformation.

The thesis encompasses four wāhanga, Te Kore, Te Pō, Te Whaiao and Te Ao Marama. These four wāhanga represent a creation narrative in Te Ao Māori, namely the movement from darkness to light. This movement starts with the world of the void or nothingness (Te Kore), then moves to the world of the endless nights or darkness (Te Pō), through to the glimmer of light (Te Whaiao). From here, the final movement is through to the world of light and becoming (Te Ao Marama). This thesis follows the same movement, with the journey signifying two important transitions that are central to this research. The first transition is the movement from nothing to light, which signifies the movement from unknowing to enlightenment. The second movement represents a child’s conception and development in the womb, through to the birth and life in the world. As Ani Mikaere (2003, p. 16) shares, “the progression from Te Kore, through Te Pō and on to Te Ao Marama is an ongoing cycle of conception, development within the womb, and birth”. Te Whaiao describes the stage of the birth where the baby’s head enters the birth canal; that is, the stage before entering the world of light.

Within each wāhanga are the chapters relevant for that realm. Wāhanga Tuatahi: Te Kore includes the tīmatanga (introductory) chapters that introduce the reader to the research project and to myself. Included also are Chapters Three and Four, which explore literature around Kaupapa Māori and Te Whare Tangata (maternities). Te Kore also explores the impact of Pākehā ontology becoming the main body of knowledge and the ensuing trauma this has caused. Wāhanga Tuarua: Te Pō includes the research methodology and methods chapter. In this chapter, the research methodology, Te Pūkenga Mātauranga, which was developed following a consultation journey with key informants, is shared. Wāhanga Tuatoru: Te Whaiao includes chapters that share the findings that emerged from the whānau experiences. These experiences are collated and reflected upon as a whānau³ (birth and family) journey. There are four chapters in this wāhanga and each explores findings pertinent to the phase of the whānau journey: Hapūtanga (Pregnancy), Whānautanga (labour and delivery), Piripoho (postnatal), Onāianei (current). Wāhanga Tuawhā: Te Ao Marama is the final section and includes the discussion chapter and where the knowledge gained is transformed into actionable practices that can contribute to the maternal-infant health care system becoming more culturally responsive for whānau. It is in this

³ The dual meaning of whānau as birth and family will be further explained in the following chapter.
section where a tikanga-based framework of health care, named Te Hā o Whānau, is developed and shared to suggest how the health care system can become a culturally responsive partner for whānau following adverse events. The thesis is also concluded here, covering aspects of limitations and strengths, as well as outlining future research suggestions.

This thesis structure aligns with my being a Māori researcher operating in a non-Māori academic institution. In this position, I have faced a number of challenges throughout my PhD journey to find balance in both Māori and non-Māori worlds. Such challenges include explaining particular tikanga (for example, providing koha [gift] to participants or informants) to funding bodies as valid and necessary practices for the research project. Writing this thesis was another challenge as I often struggled to separate out ideas and themes for the format required of an academic thesis. Although these challenges have been present, I have been fortunate to have the guidance and support of my three supervisors, Dr. Sara Filoche, Dr. Fiona Cram, and Professor Beverley Lawton. These three have supported me to develop a thesis structure that privileges whānau and whakawhānau to whakamana (give prestige to) mātauranga Māori and the ten whānau who participated in this research project.

1.4 Chapter Summary

This chapter has provided insight into my whakapapa and upbringing. Understanding where I am from, and the history that shapes who I am today, are vital fabrications of my whakapapa. This is important knowledge as it shapes the strengths-based and whānau-oriented research position I adhere to in this research project. The next chapter discusses the research kaupapa.
Chapter 2: He aha tēnei kaupapa?

This chapter outlines the research kaupapa (idea; plan) and the context within which it resides. The research questions and aims are also shared before a discussion of the significance of and rationale for the project. First, I would like to explain the title of the project, as that indicates how the research kaupapa has been shaped. Mā te wāhine, mā te whenua, ka ngaro te tangata is a whakataukī (proverb; significant saying) that I have used to name this project. If translated, it means that without women and land, the people will perish. However, this whakataukī signified more to me than its direct translation. The word whenua carries two meanings: land and placenta. I read the whakataukī as indicating the value and significance of wāhine (women) as mothers and life-providers through whenua (childbirth). Another interpretation could be that we are connected with our land and wāhine as a mother is to a child in womb. Therefore, this special bond must be protected and nurtured. In these interpretations, it may be recognised how revered wāhine and childbirth are in te ao Māori (the Māori world). However, this knowledge has been marginalised and overlooked through colonial processes that have shifted Aotearoa towards being more New Zealand. Today, Māori wāhine and their babies face higher rates of morbidity and mortality than non-Māori (Perinatal and Maternal Mortality Review Committee, 2018). I wanted to learn how we can address these disparities from wāhine and whānau who experienced the harm or loss of their baby. Abiding by the whakataukī that has named this project, the research kaupapa has been shaped to give voice to wāhine and whenua in order to protect the health of our tangata (people).

2.1 Aotearoa New Zealand context

To begin, the chapter will outline contextual aspects of Aotearoa New Zealand that are relevant to this research kaupapa. Firstly, the importance of whānau in Aotearoa New Zealand is discussed. Secondly, the founding document of Aotearoa New Zealand, Te Tiriti o Waitangi/The Treaty of Waitangi is briefly outlined. Thirdly, the maternal-infant health care system is detailed.

The example shared of my upbringing is a reflection of the collective structure of whānau within Māori culture. Whānau is the core of Māori society (Pihama, Cram & Walker, 2002). He Korowai Oranga: Māori Health Strategy explains, “as a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively” (Ministry of Health, 2002, p. 1). Pivotal within whānau are children (Mikaere, 2003). Childbirth and infants are often treasured by whānau, as children are the ones who carry whakapapa forward and fulfill the
demands of the past (Mitcalfe, 1974; Kahukiwa & Potiki, 1999). This is demonstrated in the whakataukī:

‘He kai poutaka me kinkini atu, he kai poutaka me horehore atu, mā te tamaiti te iho’ (pinch off a bit of the potted bird, peel off a bit of the potted bird, but the inside is for the child – save the best for the child). (Tupara, 2017)

This whakataukī speaks of how the children were, and remain to be, cherished and collectively cared for to ensure their wellbeing because they represent the continuation of the whānau, hapū and iwi (Tupara, 2017). Birth and women are also highly revered in te ao Māori. The importance of birth and women as whare tangata (house of humanity) is demonstrated through their centrality across creation narratives within Māori worldviews (Mikaere, 2003). These creation narratives will be further explained in the next chapter. Being prominent in Māori cosmology is evidence that women and children and their health have always been held in high regard within te ao Māori and are a significant contributing factor to whānau wellbeing (Mikaere, 2003; Marsden, 2003).

From a Māori perspective, wellbeing is holistic and includes spiritual, mental and physical dimensions (Mark & Lyons, 2010; Cram, Smith & Johnstone, 2003). This view of wellbeing is based on Māori cultural beliefs, values and traditions that have been passed down through generations (Mark & Lyons, 2010). As Māori Marsden (2003) explains “the Māori approach to life is holistic. There is no sharp division between culture, society and their institutions…. Māori avoid the disjunction between the secular and spiritual, the compartmentalisation and isolation of one institution from another” (p. 33). Thus, wellness to Māori means the harmonious balance between all aspects of their holistic nature. It is more than simply the wellness of the physical body. For this holistic view of life and wellbeing to function, maintaining balance with whānau, hapū, iwi, and within oneself was, and is, paramount (Mikaere, 2003). This is because having balance ensures the continued integrity of the collective.

This balance remains an important feature for those who identify as Māori. Yet events have occurred throughout the history of Aotearoa New Zealand that have influenced the balance of Māori. One major event was the arrival of Europeans to Aotearoa New Zealand, and the signing of Te Tiriti o Waitangi/the Treaty of Waitangi.

### 2.1.1 Te Tiriti o Waitangi/Treaty of Waitangi

Today, Aotearoa New Zealand is recognised as a bi-cultural nation, and Te Tiriti o Waitangi/the Treaty of Waitangi is the founding document of this country that was signed between Māori and Pākehā (non-Māori) in 1840. Te Tiriti/The Treaty is made up of three Articles, and was written in two languages: English and Te Reo Māori.
The two texts created the Treaty of Waitangi, and te Tiriti o Waitangi respectively. Approximately only 500 Māori chiefs, 12 of whom included women, signed te Tiriti/the Treaty (Orange, 2004). Notably though, the majority of Māori chiefs who signed, had signed te Tiriti which is considerably different to the Treaty. The difference between the two texts is explored below. Te Tiriti/The Treaty was signed with the intention of promoting a partnership between Māori and Pākehā. As such the Crown has the obligation to support Māori as a willing and cooperative partner (Waitangi Tribunal, 2004). However, since the signing, there have been minimal efforts by the Crown to form an equal partnership with Māori. This has resulted in Māori being immersed in the enduring struggle of retaining their tino rangatiratanga within the realms of their own country.

The first and second articles of the treaty incorporated the points that Britain wanted to secure- that the chiefs give up their sovereignty, that Britain would have the right to exercise power and authority, and that Britain would take complete control over the purchasing of land from Māori and on-selling to settlers. The third article offered the Māori people protection and all the rights and privileges of British subjects with the requirement of loyalty to the Crown (Orange, 2004). An English missionary, Henry Williams, and his son translated the treaty into te reo Māori on 4 Feb 1840 (two days before it was signed), and although they were comfortable speakers of the Māori language, they were not experienced translators. This resulted in the imprecise translation of the English text. The wording in the Māori translation was ambiguous and vague on crucial points, such as sovereignty and giving control over the land. The implication of this ambiguity influenced how Māori understood what they were signing and agreeing to in Te Tiriti. Below outlines the different meanings stipulated in each article between the two texts:
• Article 1: By the Treaty in English, Māori leaders gave the Queen ‘all the rights and powers of sovereignty’ over their territories. By Te Tiriti, Māori gave the Queen ‘te kawanatanga katoa’ - the complete governance or government over their lands (Orange, 2004).

• Article 2: By the Treaty in English, Māori leaders and people, collectively and individually, were confined in and guaranteed ‘exclusive and undisturbed possession of their lands and estates, forests, fisheries and other properties’. By Te Tiriti, they were confined and guaranteed ‘te tino rangatiratanga’ - the unqualified exercise of their chieftainship over their lands, villages and all their treasures (Orange, 2004).

• Article 3: The Treaty in English extended to the Māori the Queen's protection and all the rights and privileges of British subjects (Orange, 2004). This was translated with reasonable accuracy.

Williams may have deliberately chosen terms to hide the transfer of sovereignty to Britain to encourage Māori to sign the treaty, or may have simply done the best he could to translate. Regardless, as a result of the erroneous translation, Māori held the understanding that signing the Treaty would allow Britain to have governance over New Zealand, likened to an overcasting shadow, but the chiefs would continue to have rangatiratanga over their land, resources and people (Maaka & Fleras, 2005). Therefore, Māori never signed to losing their tino rangatiratanga because “Māori signatories understood the Treaty as guaranteeing their rights to tino rangatiratanga (chiefly autonomy); sovereignty over their individual lands, property, treasures and resources; and ōrietetanga: comparative status with British citizens” (Kenney, 2011, p. 124).

The meanings of these three articles is “that the Crown has the right to govern, Māori kin groups have the right to own and manage collective assets and Māori individuals have the same rights and responsibilities as non-Māori New Zealanders” (Wyeth, Derret, Hokowhitu, Hall & Langley, 2010, p. 305). Yet, it is noticeable how the ambiguous meanings behind the Treaty often makes it difficult to apply in contemporary society. For this reason, the principles that inform the Treaty are more often referred to today. The definition of the treaty principles as understood by the courts and Waitangi Tribunal are that the “principles interpret the Treaty as a whole, including its underlying meaning, intention and spirit, to provide further understanding of the expectations of signatories” (Waitangi Tribunal, 2017). There are numerous principles, and each have some contention surrounding them. As this thesis
progresses, three of the treaty principles—Protection, Partnership, and Participation—are outlined.

The next contextual aspect relevant for this research kaupapa is the maternity health care services that exist in Aotearoa New Zealand.

2.1.2 Maternity Services in Aotearoa New Zealand

The general health care system in Aotearoa New Zealand is made up of numerous levels (adapted from Ferlie & Shortall, 2001). It comprises of:

1. The individual level (for example, patients)
2. The frontline health practitioners (for example, General practitioners (GPs), nurses, midwives)
3. The organisations and institutions (for example, hospitals and clinics)
4. The environment (for example the funding bodies, and the regulatory bodies such as policies and frameworks).

These numerous levels are illustrated below in Figure 2. As the figure depicts, the outer most level is the environment, and I recognise this as being how health care is often delivered from a top-down approach. This means that the power resides with the funding bodies and policymakers to inform how health care is delivered to patients. I recognise this as being problematic in Aotearoa New Zealand because Māori, particularly whānau, often do not have input into how the health care system environment is shaped. Thus, having no say in how health care is designed and delivered to them.
Figure 2. The ‘top-down’ levels of the health care system (adapted from Ferlie & Shortall, 2001).
This project is specifically concerned with whānau journeys through the maternal-infant health care system. It may not be common practice to acknowledge the maternity health care system as being the maternal-infant health care system; however, in this project, I wanted to encourage the link between maternal and infant rather than differentiating the two belonging to two different systems (i.e. maternity and neonatal). The goal of the health care services needs to be delivered in a continuum, whereby both mother and baby are cared for under a seamless service. Thus, the maternal-infant health care system is the systemic research context for this project and is what is referred to throughout the thesis.

Aotearoa New Zealand is considered to have a unique maternity system because it is largely midwifery led, and most maternity services are free to all eligible women (Makowharemahihi et al., 2014). The primary maternity care model is provided under Section 88 of the New Zealand Public Health & Disability Act 2000, and has the objectives of:

- Providing safe maternity services that are informed by evidence, and based on partnership, information and choice.
- Recognising that pregnancy and childbirth is a normal stage of life for most women.
- Providing the women with care from a Lead Maternity Carer (LMC) who is responsible for assessing the woman’s needs and appropriately planning her care and her baby’s care.
- Facilitating the provision of any additional care for the woman and/or baby that may be required.

Maternity services are provided by a range of health practitioners, including obstetricians, midwives, general practitioners (GPs), radiologists, and medical specialists. A lead maternity carer (LMC) provides care throughout a woman’s pregnancy, and then up until baby is around six weeks old. Independent community-based midwives are the most common LMC accessed by pregnant women. Of the midwifery workforce, 5.6% of midwives identified as Māori in 2014 (Ministry of Health, 2016). Midwifery in Aotearoa New Zealand has its own regulatory body named the Midwifery Council of New Zealand, as well as professional organisation named New Zealand College of Midwives (NZCOM), and a national collective organisation of Māori midwives named Ngā Maia (Grigg & Tracy, 2013). Ngā Maia has made significant contributions towards delivering culturally responsive midwifery care for hapū wāhine (pregnant women) in Aotearoa New Zealand. In particular, Ngā Maia developed a set of guidelines, named Tūranga Kaupapa, in 2006 to provide cultural competency in
midwifery care. Tūranga Kaupapa are applicable for all midwives working in Aotearoa New Zealand, and they have been formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives. The guidelines are as follows:

- **Whakapapa:** Acknowledge the wahine and her whānau
- **Karakia:** The wahine and her whānau may use karakia
- **Whanaungatanga:** The wahine and her whānau may involve others in her birthing programme
- **Te Reo Māori:** The wahine and her whānau may speak Te Reo Māori
- **Mana:** The dignity of the wahine, her whānau, the midwife and others involved is maintained
- **Hau Ora:** The physical, spiritual, emotional and mental wellbeing of the wahine and her whānau is promoted and maintained
- **Tikanga Whenua:** Maintain the continuous relationship to land, life and nourishment; and the knowledge and support of kaumātua (elders) and whānau is available
- **Te Whare Tangata:** The wahine is acknowledged, protected, nurtured and respected as Te Whare Tangata (the “House of the People”)
- **Mokopuna:** The mokopuna is unique, cared for and inherits the future, a healthy environment, wai ū and whānau
- **Manaakitanga:** The midwife is a key person with a clear role and shares with the wahine and her whānau the goal of a safe, healthy, birthing outcome (New Zealand College of Midwives, 2018).

These guidelines provide standards of practice for midwives operating in Aotearoa New Zealand.

When it comes to birthing, there are a variety of options available for women in Aotearoa New Zealand. For wahine who have pregnancies with no complications, the option to birth at home or in a small, primary maternity unit (often known as birthing centres) is available. These women will be usually attended to by their LMC and use less pain relief than those who birth in hospitals (Ministry of Health, 2018). The option to birth in hospitals are also provided to women in Aotearoa New Zealand, and this option may become a requirement if complications are present throughout the pregnancy.

There are differing levels of medical care within the maternal-infant health care system. Primary care centres/hospitals are usually the first entry point into the health care system, as this is where we present to when we become symptomatic. Birthing centres are also classified as primary maternity units (Ministry of Health, 2018).
Secondary care is provided when the primary care refers women on for more specialised care. In respect to the maternal-infant health care system, secondary care is usually delivered by hospitals that have access to obstetricians and Special Care Baby Units (SCBU). Tertiary care is the most specialised care, containing specialists with particular expertise. For example, the Neonatal Intensive Care Units (NICU) are specialised care facilities and are considered to be tertiary care for babies. Due to tertiary care being highly specialised and specific, there are fewer tertiary care hospitals in Aotearoa New Zealand.

Each District Health Board (DHB) also has a set of culturally competent guidelines named Tikanga Best Practices. Health care practitioners operating within hospitals in Aotearoa New Zealand are expected to deliver culturally competent care that is guided by their Best Tikanga Practice. To offer an insight, some examples of tikanga best practice guidelines that are within the Bay of Plenty DHB include:

- Karakia: whānau and patients will be verbally offered a karakia at all times.
- Whānau will be actively encouraged, included and supported by staff to be involved in aspects of care and decision making.
- Staff will be flexible with visiting hours and consider a whānau member staying overnight.
- During all initial encounters, staff will introduce themselves.
- Staff will ensure whānau are aware of accommodation services.
- Staff will notify appropriate Māori staff.
- Request and explanation of consent must be obtained before touching anywhere on the patient’s body (Bay of Plenty DHB, no date).

### 2.2 Building a case for research

Evidence is increasingly suggesting that the first 1000 days of life, starting from pregnancy, are crucial in determining health outcomes, both short and long term, for children (Blaiklock & Kiro, 2015; Mantell, Craig, Stewart, Ekeroma & Mitchell, 2004). A child’s early years of life begin with the pregnant mother, therefore, ensuring her wellbeing assists in constructing the foundation and scaffolding for the child’s lifelong wellbeing. As explained by Blaiklock and Kiro (2015), children “have one chance for normal development...their experiences have lifelong consequences for individuals and their contributions to society” (p. 191). For pregnant wāhine (women) Māori and their babies, social and health disadvantages contribute to poor health outcomes during the first years of life of their tamariki (child/ren). These social determinants of health include poverty and barriers to access issues (Children’s commission, 2017;
Craig, Anderson, Jackson & Jackson, 2012). As of 2015, 15% of the Aotearoa New Zealand population identified as Māori (Statistics New Zealand, 2016). Yet, Māori people continue to be overrepresented in poor health indicators. These poor health statistics are a representation of how Māori health is not being protected, which is a direct breach of te Tiriti o Waitangi/the Treaty of Waitangi’s principle of protection. Too many Māori babies are dying or experiencing poor health following birth. It is an unwelcome truth that “too many die young, suffer avoidable illnesses and injuries, and live in unnecessarily difficult circumstances” (Blaiklock & Kiro, 2015, p. 188). Reports from the Perinatal Mortality and Morbidity Review Committee (PMMRC) inform us that compared to non-Māori babies, Māori babies are twice as likely to have a potentially preventable perinatal death (PMMRC, 2016). In 2014, 22% of Māori perinatal deaths were potentially avoidable (PMMRC, 2016). In addition to death, Māori babies are more likely to be born preterm (born before 37 weeks gestation) (Mantell, Craig et al, 2004; Ministry of Health, 2017). Māori have a higher rate of preterm birth (8.1% in comparison to the overall rate of 7.4%) (PMMRC, 2016), which results in a greater need for Māori babies being admitted to a neonatal intensive care unit or special care neonatal unit to receive care. Post-term (greater than 42 weeks gestation) deliveries of Māori women are also increasing, which increases the risk of perinatal morbidity and mortality (PMMRC, 2017). These high rates of infant mortality and morbidity represent a disruption to whakapapa that can cause immense distress for whānau (Blaiklock & Kiro, 2015). The loss of a child also disrupts the balance of whānau wellbeing because it represents a breakdown in whakapapa that is often unexpected and unplanned (Mikaere, 2003).

There is also the issue of access to health care services for Māori. Cram (2014) explains that Māori often have poor health outcomes because they face significant financial and logistical barriers when accessing health care. Examples of barriers faced by Māori include the lack of access to information and services, negative past experiences, and cost (Ratima & Crengle, 2013). The cost of accessing care can be higher for whānau who live rurally because of the greater distance they are required to travel to health care centres. The Hapu Ora report confirms that access to care inequalities exist for Māori pregnant women, and that they often report lower satisfaction within the health care system (Moewaka Barnes, Barnes, Baxter, Crengle, Pihama, Ratima & Robson, 2013). ‘Access’ encompasses availability of services, accessibility of services (as in, can I get there?), appropriateness and quality of

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4 There are variations of defining the time period that pertains to perinatal. However, the World Health Organisation defines the perinatal period commencing at 22 completed weeks of gestation and ends seven completed days after birth (World Health Organisation, 2018).
services (Cram, 2014). The provision of equitable access to health care services is paramount for ensuring Māori health and wellbeing (Cram, 2014). Current access issues are compounded by the reality that Māori are more likely to live in households without Internet or phone connections, and without motor vehicle access (Ministry of Health, 2017). Whānau facing these barriers often cannot access the required primary care their infants require, potentially leading to further health disparities for their tamariki (Ministry of Health, Annual Data Explorer 2016/17). Barriers to accessing care that enhance the health disparities for their tamariki include: having their registered primary care medical center not available within 24 hours, the cost of the GP visit being unaffordable, lack of child care, and a lack of transport. In severe cases where they may need after-hours service, Māori children are over 5 times more likely than non-Māori children to experience this unmet need because of a lack of transport (Ministry of Health, Annual Data Explorer 2016/17). Past negative experiences with services and health care practitioners also acts as a barrier to access to culturally appropriate care. Offering services that are culturally appropriate is just as important as making the services affordable and accessible because people may not be willing to access those services if they are deemed culturally inappropriate (Cram & Smith, 2003).

These events can contribute to poor infant health, which returns to the idea of disrupting the balance of whānau wellbeing and particularly whakapapa if the baby dies.

What underlies the access issues and what contributes to causing health disparities needs to be challenged. The voices of whānau who go through the harm or loss of their baby often go unrepresented because there is limited research that offers the opportunity for whānau to share their lived realities. This is evident in the limited literature available in this field. As stipulated under Section 88, maternity services are to be built upon a partnership, information and choice. Yet, this seems to be lacking as whānau have few opportunities to voice their experiences with maternity services. This project is an attempt to correct that shortfall by framing the research from a strengths-based perspective and explore the lived realities of whānau who had experienced a disrupted whakawhānau (childbirth) imaginary that resulted in the unanticipated harm or loss of their baby. There is a current knowledge gap in this area because too often research is delivered from a deficit base that only focuses on the negative health outcomes without providing actionable alternatives.

I have used the term ‘Imaginary’ to conceptualise the perceptions held by wāhine and their whānau of whakawhānau and motherhood. I believe imaginaries is a term that connects with the mana and essence of indigenous space, values, identity and ideas. Imaginaries has also been a term used in other indigenous research (Bond,
Foley & Askew, 2016). It is used throughout the thesis as the lived realities of the whānau experiences are explored. It is not the intention of the research to explain the situation parents found themselves in, but rather to provide an opportunity for whānau to share their stories and explore their experiences of enduring the harm or loss of their baby.

2.3 Research project context

Ten wāhine and their whānau were involved with the study, from the areas of Te Tai Tokerau (Northland) and Te Moana-a Toi (Bay of Plenty). These locations were chosen because they are where I whakapapa to and are where I consider my ūkaipō (nurturing places) to be. I valued researching in the areas I whakapapa to because it allowed me the opportunity to research with my people and for my people. Te Tai Tokerau and Te Moana-a Toi are also both highly Māori populated areas with a large proportion of the population being aged 0-4 years (40% of Bay of Plenty DHB\(^5\) population and 52% of Northland DHB). To provide further context for the project, a brief outline of each region is provided below.

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\(^5\) DHB is an abbreviation for District Health Board. District health boards in New Zealand are organisations established by the New Zealand Public Health and Disability Act 2000, responsible for ensuring the provision of health and disability services to populations within a defined geographical area (Ministry of Health, 2017).
2.3.1 Te Tai Tokerau (Northland)

Figure 3. Map of Te Tai Tokerau (Northland). Source: Adapted from Google images, 2018.

Te Tai Tokerau is the northern most region of Aotearoa New Zealand, with an estimated population of 151,692, which is inclusive of 44,928 who identify as Māori (Census, 2013). Te Tai Tokerau extends from the tip of the Northland Peninsula to a small town near Auckland named Wellsford. There are over twelve iwi within Te Tai Tokerau, indicating the large representation of Māori in the region. I whakapapa to the majority of iwi in Te Tai Tokerau and was born and raised in Kaitaia, which is a town of roughly 5,000 people in the Far North district of Te Tai Tokerau.

Te Tai Tokerau is recognised as having a poor health status in comparison to other regions of the country, and, is marked by high levels of deprivation. The number of women birthing in Tai Tokerau who are Māori is also higher than other regions (www.northlanddhhb.org.nz). On average, 1386 Māori infants were born per year during 2009-2013, making up 60% of all live births within the Northland DHB region. Of that
rate, approximately 10% of babies born in Northland DHB were admitted to SCBU, which is a secondary level specialist care facility for babies (Westren, 2015). In a recent Maternity Quality and Safety Programme (MQSP) report, that number had decreased to 8.2 percent of live births in Northland being admitted to SCBU (Northland DHB, 2017). Figure 3 shows the location of the SCBU in Tai Tokerau, and the distance whānau are required to travel if they live in the far north region of Te Tai Tokerau. This distance is 2 hours 24 minutes, and it is even further to the Neonatal Intensive Care Unit (NICU) if the baby requires tertiary, intensive medical care.

2.3.2 Te Moana-a Toi (Bay of Plenty)

![Figure 4. Map of Te Moana-a Toi (Bay of Plenty) region. Source: Adapted from Google images, 2018.](image)

Bay of Plenty is situated on the eastern coast of the North Island of Aotearoa New Zealand and is another region with a high Māori population. It has over ten iwi located in the rohe (area). I whakapapa to many areas within Te Moana-a Toi and many of my whānau reside there. I remember the countless trips travelling from Kaitaia to Whakatāne throughout my upbringing, and to this day, I still feel an overwhelming sense of belonging and pride when I see my maunga, Pūtauaki, before arriving into Whakatāne.
From the 2013 Census data, the estimated population was 267,741, with 68,943 identifying as Māori. During 2009 to 2013, 1,360 Māori babies were born per year on average, accounting for 46 percent of all live births within Bay of Plenty DHB (BOPDHB). Among the Māori births in BOPDHB, 93 babies per year on average had a low birth-weight. Of that, seven percent of Māori, and six percent of non-Māori, babies had low birth weight (Te Rōpū Rangahau Hauora a Eru Pōmare, 2015). Likewise with Figure 3 above, Figure 4 also shows the different level of care hospitals available in this region. It also shows the distance whānau are required to travel by road if their baby is to be admitted to either a SCBU or NICU.

This background knowledge of these regions allows us to understand the geographical and societal context of what this research is situated within.

### 2.4 Significance of Research

There is a considerable need “to investigate specific issues affecting Māori outcomes and the effectiveness of maternity care, viewed through a Māori centered and equity lens” (Moewaka Barnes et al., 2013, p. 47). In Aotearoa New Zealand, little is known about the quality of health care behind the well documented poor perinatal outcomes for Māori. This is so, even though the Māori solution to these disparities is through working with whānau (Cram & Pitama, 1998). Given that, this research needed to be carried out in a culturally responsive manner that seeks to expand understandings of the grief and loss that whānau may be experiencing. Only then will whānau be able to provide insight into their experiences, and speak about how the health system is, or is not, being responsive to their wellbeing needs.

Learning from the lived realities of whānau is important because “understanding how whānau function as a unit...is essential if Māori wellbeing is to be supported and if Māori aspirations are to be facilitated, both at a local level and within a policy environment” (Cram & Kennedy, 2010, p. 10). This research involved interviewing whānau and asking them to share their experiences of a very traumatic time. While this may have been difficult for the whānau, it offered them a space to share their stories, their burden, and their experiences with the maternal-infant health care system. This research project explicitly sought what worked well for whānau so as to enable the uptake of good, culturally responsive practices within maternity health care services. The implementation of such good practice may help improve whānau health and wellbeing; as well as ameliorate the hardships Māori currently face through

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6 Low birth-weight is less than 2500g (Birth registrations, Ministry of Health).
having to bear an unequal burden of poor health outcomes by encouraging the health care system to be more responsive to Māori needs.

This research also built an extensive platform of mātauranga Māori (Māori bodies of knowledge) surrounding childbirth, whakapapa, and wellbeing through underpinning and framing the research within Kaupapa Māori research. Up until recently the focus has been on the interface of mātauranga Māori and science, whereby the relationship between mātauranga Māori and Western science knowledge systems is becoming more frequently explored (Crawford, 2009). It is more than timely for the depth of Māori understandings and knowledge about health and wellbeing to inform a positive health care journey and outcomes for whānau who experienced an adverse event that led to the loss or harm of their baby. I find this aspect of the project to be highly relevant because the majority of traditional Māori maternities and understandings have been lost. Reclaiming this knowledge by drawing attention to mātauranga Māori may empower Māori maternities yet again. As Ani Mikaere (2003) explains, “in consciously re-examining from a Māori perspective material…we may begin to rescue mātauranga Māori from the state of limbo to which it has been relegated by colonisation” (p. 10). This further validates the importance of exploring the burden of a perinatal event that resulted in the harm or loss of babies through the voice of whānau.

2.5 Research aims

The two aims of this research were to:

1. Examine the experiences of whānau following a disruption to their whakawhānau journey that resulted in the harm or loss of their baby, and;
2. Explore mātauranga Māori by examining Māori concepts of whakawhānau (childbirth), whakapapa, health and wellbeing.

I was particularly interested in what roles the maternal-infant health care system had to fulfill to allow it to be culturally responsive to whānau as they journey through the system as Māori. Being a culturally responsive partner with whānau would mean the system would engage with whānau in a way that upheld their mana (prestige; spiritual authority) and wairua (spirit). The overarching goal of this project is to ensure that the maternal-infant health care system is delivering health care services that meet the cultural needs of whānau whereby it is an active partner with whānau that engages in, learns from, validates and supports whānau culture(s). This goal is supported by the PMMRC (2017, p. 19) that states, “a culturally responsive system supported by a
cultiually responsive workforce will improve access to high quality health care, and subsequently health outcomes for pregnant Māori women.” These aims and ultimate goal drove what questions the research project sought answers to.

2.6 Research questions

The questions posed in this research are:

1. Is the maternal-infant health care system delivering culturally responsive care for whānau following the harm or loss of their baby?
2. Can the lived realities of whānau and mātauranga Māori inform positive change within the maternal-infant health care system?

Harm was defined as the baby suffering poor health at birth, which resulted in the admission to a NICU or SCBU, and/or the baby dying. This definition of harm was used as the inclusion criteria of wāhine and their whānau for this project. To understand the lived realities of whānau who suffer an adverse perinatal event, culturally responsive research needed to be undertaken that was fully cognisant of the grief and loss that whānau may be experiencing, and how the maternal-infant health care system is, or is not, being responsive to their needs. Kaupapa Māori guided the research to be culturally responsive, such that it was aligned with a strengths-based tikanga lens that positioned Māori people, knowledge and practices as positive rather than a deficiency. Framing the research project within Kaupapa Māori was deemed important because “western methodologies and approaches to Māori matters undertaken from within a western values system would only ever be able to provide an outsider’s interpretation of particular observable features of Māori society and culture” (Mutu, 2004, p. 26).

2.7 Chapter Summary

This chapter has described the research kaupapa and has outlined the context it sits within. The research aims and questions have been defined, and the Kaupapa Māori paradigm that frames the research has been introduced. These first two chapters are important foundations for understanding my whakapapa and values, as these inform my research positionality. Understanding who you are as a person and researcher, and where you are from are necessary before engaging in Kaupapa Māori research. The following chapter explores Te Whare Tangata, which includes mātauranga Māori and literature around pregnancy, whakawhānau, and wellbeing.
Chapter 3: Te Whare Tangata me Whakawhānau

This chapter has been named Te Whare Tangata me Whakawhānau to align with mātauranga Māori surrounding pregnancy, birth and childcare. The primary focus of this chapter is to review sources of literature that speak to the meaning of pregnancy and childbirth within Te Ao Māori. As Māori is a largely oral culture, ‘literature’ is represented via numerous mediums, including text, kōrero (verbal communication), waiata (song), mōteatea (chant), oriori (lullaby), mahi toi (art), whakairo (carvings) and more (Jenkins & Harte, 2011). These mediums were explored to inform understandings of te whare tangata and whakawhānau (birthing). The chapter begins by outlining the underpinning philosophies of te whare tangata: the female atua and Māori worldviews derived from cosmogony, before exploring concepts immersed within te whare tangata and whakawhānau.

First, to understand the traditional birthing and infant care practices Māori employed prior to European arrival, it is essential to gain an insight into the creation narratives that inform the Māori worldview. Understanding these narratives and the worldview they encapsulate allows us to comprehend the importance of te whare tangata and why particular practices were employed during whakawhānau.

3.1 Māori Cosmogony and Te Whare Tangata

Māori cosmogony establishes the worldviews that are unique to Māori. Worldviews are what the values, beliefs, customs and practices of Māori are based upon (Marsden, 2003). It is also important to note that there is no ‘one’ Māori worldview. Each iwi and hapū hold their own specific worldview, based upon their specific account of the creation narratives within the worldview. Creation narratives are important because they assist us in understanding who we are and how we live our lives. They are particularly important to Māori because they “form an important part of their worldview, conveying myth-messages that people practice as ideals and norms in their own lives” (Reilly, 2004, p. 1). The creation narratives I share, and adhere to, are derived from my iwi background of Ngāti Awa, Ngāti Kuri, and Ngā Puhi. The narratives shared are of the Māori cosmogony birthed from the movement out of darkness to the world of light. Following this, a narrative of Papatūānuku and Ranginui as the primordial parents is shared, followed by narratives of atua wāhine (female deities) who are pertinent to te whare tangata and whakawhānau. Each narrative will be explained below, illustrating the link each has with whakawhānau, women and children.
3.1.1 Movement out of darkness to the world of light

Māori culture and worldviews originate from these unique creation narratives and have never accepted the mechanistic view that the universe is a closed system (Marsden, 2003). Rather Māori consider it a holistic system that includes all tangible and intangible, natural and spiritual (Marsden, 1992). Some iwi Māori conceive the universe existing as at least three worlds where there is a movement from a world of darkness to a world of light. In these accounts, Māori cosmogony starts with the world of Te Korekore, the world of the void or nothing (Mikaere, 2017). Te Pō, the world of the endless night and realm of becoming, was born out of Te Korekore. The final world is Te Ao Marama, and that is the world of light and being (Marsden, 2003; Mikaere, 2017). The world in which we live in is Te Ao Mārama (Pihama, Smith & Cram, 2002). The movement through these worlds is likened to the movement from conception (Te Kore) to pregnancy (Te Pō) to birth (Te Ao Marama) (Mikaere, 2003).

Te Korekore is a particularly significant realm because it is where the seeds of the universe are gestated, from which all things proceed - comparable to the woman’s womb. Māori view the process of creation as being continuous and dynamic. The process begins in Te Korekore, where we then pass through Te Pō, the world of becoming, and then into Te Ao Marama. These three realms are linked, which causes constant two-way traffic consisting of “the spirits of the departed descending to Hawaiki [the ancient homeland of all Māori], and that which is in the process of becoming ascending into the world of being” (Marsden, 1992, p. 135). For those spirits ascending into Te Ao Marama, the process is as followed: te apunga, aponga, kune roa, popoko nui, popoko nao, hine awaawa, tamaku, rangi nui tamaku. To translate the process is conception, the first signs of swelling, the distended womb, the distended vagina, contraction, membrane ruptured, first stage of delivery, and final stage of delivery (Marsden, 1992). This narrative not only highlights the complex and dynamic Māori worldview, but also the significance of creation and birth within te whare tangata (the house of humanity), or the womb of the woman.

3.1.2 Ngā Mātua Tuatahi: Ranginui and Papatūānuku

Many iwi hold the account that the two first parents were Ranginui (sky father) and Papatūānuku (Earth mother). These two gave birth to their children, Tāne-mahuta, Tangaroa, Tāwhirimatea, Tūmatauenga, Rongomātāne and Haumiatikitiki, Whiro, and many more, who all eventually became atua in their specific realms (Marsden, 2003). The children lived in a world of darkness because their parents locked themselves in a loving embrace. This world of darkness, Te Pō, which was forced by the intense
embrace between Ranginui and Papatūanuku, is also likened to the womb where life is created and trapped within darkness (Mikaere, 2003). Longing to escape from the darkness they were locked within, the children, led by Tāne, developed a plan to separate their parents so they could live in the light, Te Ao Marama. One brother, Tāwhirimatea (god of the wind), disagreed with Tāne and did not want the separation to go forth. Ignoring this, Tāne stood on his head supported by his arms, and thrust his legs against Ranginui, which resulted in the separation of his parents. Tāwhirimatea lashed out and created a raging storm on his siblings and remained in the realm of his father. Rongomātāne (god of kumara and cooked food) remained with his mother and comforted her. As did the youngest child, Rūaumoko, who is the atua of volcanoes and earthquakes. In some versions, it is told that Rūaumoko was still in his mother’s womb when Papatūanuku and Ranginui were separated. Therefore, the movement he makes in the womb of Papatūanuku is what causes the earthquakes and volcanoes. The discomfort experienced by Papatūanuku during the separation is also said to resemble the discomfort felt during labour (Gabel, 2013), and there are areas in the Kāi Tahu region of Karitane, where there are red rocks and earth. This is told to be the blood of Papatūanuku at the result of the separation (personal communication, Brendan Flack, 2013).

While this account is widely known and accepted, all iwi have different versions of the creation narrative. An example to highlight this is the version understood by Kāi Tahu. Their story explains that Papatūanuku was first married to Takaroa, and their story is as follows. The union of Rakinui and Papatūanuku was significant because at the time Papatūanuku was in a union with Takaroa. While Takaroa had gone to carry away the whenua (placenta, afterbirth) of their child, Papatūanuku coupled with Rakinui (Tiramōrehu, 1987). When Takaroa finally returned, Rakinui and Papatūanuku had already given birth to Rehua, Tāne and the other children (Reilly, 2004). Takaroa was outraged at this, which resulted in a fierce battle between him and Rakinui on the beach. Takaroa succeeded in wounding Rakinui by piercing him with his spear; however, Rakinui did not die (Tiramōrehu, 1987). Rakinui continued to live, yet from this time on his offspring with Papatūanuku were made weak, and “there were born the sickly and prostrate family” (Tiramōrehu, 1987, p. 25). Following the vicious battle, the victorious but deeply saddened Takaroa retreated to the seas; while on land, the

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7 To respect the Ngāi/Kāi Tahu iwi, this next section will be explained using their te reo Māori dialect where they replace the ng with a k.

8 Brendan Flack is a key member of Kāti Huirapa ki Puketeraki. He is a key leader of the hapū and is also a member of Kāti Huirapa Rūnaka ki Puketeraki. I was fortunate to participate in a noho marae at Kāti Huirapa ki Puketeraki in 2012 where I first met Brendan. It was here where I learnt from Brendan as he shared the creation narratives and history of Ngāi Tahu that were specific to Kāti Huirapa ki Puketeraki.
weakened Rakinui fell atop of Papatūānuku, causing the world to be locked in eternal darkness (personal communication with Brendan Flack, 2012).

After continuing to cling to Papatūānuku, “Rakinui told Tāne and his teina (younger brothers) to kill him so that people might live” (Reilly, 2004, p. 6). Rakinui continued to inform Tāne that he and Papatūānuku must be separated to let light develop into the world. Although he was hesitant at first, Tāne understood his father’s plan and gave instructions to his brothers to stamp down on Papatūānuku, and prop Rakinui up (Reilly, 2004). Tāne received assistance from his older brother Rehua, and their other brothers, to lift up their father while Paia prayed to give them the strength that they required to carry out the task (Tiramōrehu, 1987). As Rakinui and Papatūānuku began to become separated, they said their final farewells while Paia continued with his karakia. At last the brothers succeeded and Rakinui and Papatūānuku were separated (Reilly, 2004).

While these differing accounts are interesting, they both reflect the centrality of women and te whare tangata. The narratives also share the commonality of escaping the world of darkness to live in the world of light through the separation of Ranginui and Papatūānuku. The centrality of wāhine, mothers and te whare tangata (womb) in the Māori cosmogony illustrates their importance in te ao Māori (Mikaere, 2017). It was also the fundamental belief that children are gifts from the atua and represent the future continuation of the whānau, hapū and iwi. For these reasons, children were/are tapu and any disrespect to them is a violation of tapu and an offence to the atua (Jenkins & Harte, 2011). These understandings create the blueprint of whakawhānau values and practices.

3.1.3 Atua Wāhine

Before we can begin exploring te whare tangata and whakawhānau, it is important to understand what underpins their related philosophies, concepts, values and practices. These understandings can be found from the cosmogony around atua wāhine. Atua beliefs shaped Māori behaviour and value systems. These beliefs are still relevant today; however, they require unpacking because the stories that are relevant to wāhine and children have been filtered through a coloniser lens and have misplaced atua wāhine stories behind stories of heroic males (Jenkins & Harte, 2011; Mikaere, 2017).

Christianity was another arm and driver of colonisation. Christianity portrays male entities (Jesus/God) as the superior beings (Mikaere, 2017). The early missionaries are said to have been a significant driving force of the colonial agenda
because it was their primary goal to replace Māori spiritual beliefs, values and customs with their own (Walker, 1990). Māori were, according to Henry Williams, “governed by the Prince of Darkness”. Robert Maunsell thought Māori songs were “filthy and debasing”. Even the Catholic Bishop Pompallier thought of the Māori as “infidel New Zealanders” (cited in Walker, 1994, p. 102). In terms of wāhine, Ngāhuia Murphy (2012) shares how Māori women were classed as unclean and sexually inappropriate. These messages were perpetrated through the church as it was a place that held similar views of Māori being heathen and uncivilized people who needed saving (Walker, 1990).

Poor anthropological research practices in the past were also an active agent in advancing colonisation because Pākehā researchers poorly and incorrectly documented Māori values, beliefs and practices. Through these processes, Māori culture was invaded and Māori women (including atua), in particular, were wrongfully represented and/or silenced (Jenkins & Pihama, 2001; Mikaere, 2003). Naomi Simmonds’ (2014) articulates how Christianity and research practices have distorted Māori mythology and cultural practices and values, “…early ethnographic accounts presented atua wāhine, in cosmological narratives and mythology, as passive, distant, irrational, and polluting in opposition to male characters that were considered active, present, rational and powerful” (Simmonds, 2014, p. 29). The work of Naomi Simmonds and Ani Mikaere has had a profound effect on me, as they made me realise the gap of my knowledge of atua wāhine. I had grown up being taught the male atua, such as Tangaroa, Tāne, Tūmatauenga, Rūau moko, Tāwhirimatea and more. Yet, these atua were always taught over the likes of Hine, Hineahuone, Hinenuitepō, and Hineteiwaiwa. I grew up with the knowledge that Papatūānuku was our Earth Mother so it has been instilled within me to treat our mother respectfully, but this same respect was absent for other atua wāhine because their presence and importance were silenced. The objective of this section is to give voice to the silenced atua and wāhine. The section also aims to dispel the commonly held notion among non-Māori (and ill-informed Māori) that Māori women are of a lower status than Māori men. As has been stipulated, prior to when the concepts steeped within Christianity and English beliefs were superimposed onto Māori, wāhine held just as much mana and rank as men (Mauri Ora Associates for the Medical Council of New Zealand, 2008).

Te ao Māori continually sought after, and often functioned in, a state of balance. Therefore, male and female elements had their roles to ensure balance was achieved (Mikaere, 2003). There are complementary male and female roles throughout te ao Māori, and realms within that world are guarded by male and female atua, where they work together in harmony to maintain a balanced world. As mentioned earlier,
Tangaroa is the atua of the sea and he works alongside Hinemoana, the personification of the sea. It is the role of Hinemoana to create all species of the sea, while Tangaroa takes care of those species. This example highlights the importance Māori place on male and female providing guardianship and care for children together (Gabel, 2013). Understanding the role of atuatanga is important because it is the birth of these atua “that represent the template for the origin of the human form and consequent success or failure in various environments” (Heke, no date, p. 3). This means that narratives of atua can reflect the blueprint of our values, beliefs and behaviours. Narratives of Papatūānuku, Hineahuone, Hine-tītama and Hinenuitepō particularly reflect the importance and power of wāhine (women), and how revered they are within te ao Māori because of their ability to continue whakapapa by being te whare tangata (the house of humanity). This section explores these named māreikura (female deities; noble females) for their significance in te whare tangata and whakawhānau.

### 3.1.3.1 Papatūānuku

The primary atua wahine in te ao Māori is Papatūānuku as she is the Earth Mother and a personification of the land. It is said that all human beings are created from the womb of Papatūānuku, and all return to her after death. This is a contributing reason why land is held with utmost respect in te ao Māori as we are all born and nurtured by the land (Papatūānuku).

### 3.1.3.2 Hineahuone

With the successful separation of the first primitive parents Ranginui (Sky Father) and Papatūānuku (Earth Mother), the next challenge faced by their atua children was to create humans. In an attempt to achieve this, atua tāne (male deity) would procreate with an atua wahine, however this was unsuccessful as there was an absence of the human element (Mikaere, 2017). Following numerous failures at creating human life, Tāne sought the advice of his mother. She told him to go to her pubic region, Kurawaka, to create humanity. Kurawaka was the most fertile region of Papatūānuku and would hold the female essence required to complement Tāne to create human life (Mikaere, 2017). Tāne went to Kurawaka and shaped Hineahuone from the red clay before sneezing life into her: Tihei Mauri Ora! Although Hineahuone had life, Tāne did not know how to reproduce with her, “it is said that he entered the various orifices in her body, producing tears, wax, mucous, saliva, sweat, and excreta.” (Mikaere, 2017, p. 28). Tāne eventually successfully entered her vagina where he
succumbed to her great sexual force, and together they formed humanity. It was from Hineahuone where wahine is derived from, the word for woman (Mikaere, 2017).

### 3.1.3.3 Hinenuitepō

The first child of Tāne and Hineahuone was named Hine-tītama. When she grew into an adult, Tāne took her as his wife and reproduced with her to create Hinerauwharangi (Mikaere, 2017). Hine-tītama was unaware of who her father was, and one day she decided to ask Tāne. In response, he told her the answer to her question lay in the posts of the house. It was then that she realised her father was her husband and father to her children. Distraught at this finding, Hine-tītama sought advice from her kuia Papatūānuku. The following dawn, Hine-tītama recited a karakia that asked for the protection of her earthly children and for Tāne to not follow her. She then departed for Rarohenga where she rendered herself as being the mother or kuia for those in death. Since then, she has been known as Hinenuitepō. Therefore, upon death, we are greeted and nurtured by a mother again, Hinenuitepō.

The cosmogony featuring the trilogy of māreikura show the importance of wāhine and sexual power of the female in te ao Māori. Papatūānuku is our Earth Mother and provides the advice Tāne required to shape human life. Through the immense sexual power and ability of Hineahuone, Hine-tītama was derived. Hine-tītama exercised rangatiratanga when she shaped her own destiny to become Hinenuitepō. This contrasts to the commonly shared stories that Hine-tītama fled for the Underworld in shame. It was through an act of rangatiratanga that she went to the depths of Rarohenga where Tāne could not reach her, and where she chose to become our eternal mother and caregiver in the world of death.

### 3.1.3.4 Hineteiwaiwa

Hineteiwaiwa is the atua wahine of childbirth and te whare pora (weaving and female arts) (Higgins & Meredith, 2017). She was originally known as Hinaura; however, she changed her name to Hineteiwaiwa following her decision to leave her abusive husband Tinirau (Jenkins & Harte, 2011). This is another act of rangatiratanga exercised by an atua wahine. Karakia were/are often recited to Hineteiwaiwa during birth to safeguard the process for both mother and baby (Jenkins & Harte, 2011; Gabel, 2013; Mikaere, 2017). These karakia are often based on the same karakia that were recited during the difficult birthing experience Hineteiwaiwa had with her son, Tū-huruhuru (Jenkins & Harte, 2011).
3.2 Te Whare Tangata me Whakawhānau

The value of Māori women as child bearers is inherent throughout the numerous creation narratives as whānau (pregnancy), whakawhānau (giving birth) and children feature prominently. The name te whare tangata is also a key indicator as that indicates that wāhine permit the continuation of tangata and whakapapa. To be able to grow and nurture life is recounted as being of paramount importance within Te Ao Māori. The survival of ongoing generations is dependent on women as whare tangata (Mikaere, 2003). The proverb ‘Mate i te tamaiti he aurukōwhao; mate i te wahine he takerehāia’ (the death of a child may be overcome, but the death of a woman is a calamity) illustrates the value Māori placed on te whare tangata and producing children (Higgins & Meredith, 2017). If the woman was to lose a baby during pregnancy or be infertile, it was known as whare ngaro, which meant the lost house. This was considered an utmost tragedy within the whānau, hapū and iwi. Kristen Gabel (2013) explains that Māori creation stories “engage with the processes of pregnancy and birth...which reflects the prominent and valued role of the maternal body” (p. 59).

The vast importance of wāhine, whakawhānau and te whare tangata is also demonstrated through key concepts of Te Ao Māori being connected with pregnancy and birth (Mikaere, 2003). For example, the multiple meanings of the words whānau, hapū and whenua themselves articulate the significance of childbirth and children in the Māori worldview. Whānau can mean both family and to give birth; hapū can mean both sub-tribe and to be pregnant; and whenua can mean both the land and the placenta (Simmonds, 2011). Atua is another term with a significant double meaning, where it means both god or deity and the menstrual blood of a woman (Mikaere, 2003). The double meanings within these words highlight the strong interconnectedness between wairua and the reproductive role of wāhine with the significant features of te ao Māori. This is supported by Kristen Gabel’s (2013) work once again, stating

From the emergence of our physical world, the creation of our humankind and the many interactions between the atua and their descendants it is apparent that the spiritual realm plays a significant role in the development and maintenance of tikanga pertaining to mothers and the mothering of children (p. 67).

The distinctive Māori worldviews and creation narratives particularly shape the tikanga Māori adhered to by whānau, hapū and iwi. Traditional whakawhānau tikanga and practices were often recorded in waiata, mōteatea and whakataukī (proverbs), as these were the standard forms of recording customs, whakapapa and important events (Gabel, 2013). The practices employed were part of “a robust system that ensured the
wellbeing of both mother and child and ultimately the wider whānau and community” (Gabel, 2013, p. 86). Many of these traditional tikanga were relegated at the result of colonisation, however some remain in practice. Such practices include “using protective karakia (prayers), ritual disposal of the placenta, and bestowing of a Māori name as means of strength” (Abel, Park et al., 2001, p. 1142). These tikanga will be further explained as the chapter proceeds.

3.2.1 Tikanga and whakawhānau

Women are believed to be linked to Papatūānuku because “from Papatūānuku came life and the first human being, Hineahuone. This association with Papatūānuku has resulted in tikanga being put in place to protect the life-giving properties of women” (August, 2005, p. 120). Being connected with Papatūānuku through whakapapa provides women with inherent tapu (sacredness) (Mikaere, 2003). The maternal body is regarded highly in te ao Māori because bringing new life to the world ensures the continuation of the whānau, hapū and iwi whakapapa. The name given to the maternal body is Te Whare Tangata, which literally means the house of humanity. As such, tikanga were imposed during the time of pregnancy and birth (i.e. whakawhānau), including using karakia, placing tapu on the maternal body which released the woman from her duties that involved her working around food and the iwi grounds, and providing a special house for the woman to give birth in and to care for their newborn baby, te whare kōhanga (Best, 1906; Gabel, 2013; Mikaere, 2003). These practices were significant in ensuring the safety of both mother and child during whakawhānau, particularly the imposition of tapu on te whare tangata.

Whakawhānau was seen as a highly tapu act, especially if the wahine was giving birth to her first child (Gabel, 2013). Tapu involves an individual, place or thing being dedicated to the gods in return for protection from malevolent forces. As a result, the person or object is removed from the sphere of the profane and moved into the sphere of the sacred where it may not be touched or put to common use (Marsden, 2003). This was seen with whakawhānau because a pregnant woman would be released from performing common tasks, especially when working around food, and was prevented from giving birth inside the parameters of the village (Best, 1906). For tapu to hold power, the complementary institution of noa must also be present as it is noa that lifts or reduces the tapu of things (Mikaere, 2003). Women have the unique ability of whakanoa, which is to remove tapu. This “establishes their ability to traverse the spiritual boundaries of tapu and noa, therefore nurturing and protecting their
community” (Mikaere, 2003, p. 29). Food is often used to make things noa again, and this is why tapu pregnant women were often restricted from working around food.

Abiding by the enhanced level of tapu a pregnant wahine had, a small, temporary building was often erected for the wahine to give birth in that was outside of the village. This building was called the whare kahu (foetus house), and only the tohunga, kaiwhakahaere (birth assistants) and particular whānau members (partner, her parents, and relatives) were permitted to approach it and support the wahine during the birth (Jenkins & Harte, 2011). Kaiwhakahaere facilitated the birthing process and the creation and development of whānau (Kenney, 2011). Karakia to Hineteiwaiwa (goddess of childbirth) were recited to ease the birth process (Mikaere, 2003), particularly to both “facilitate the movement of the child and to assist the mother in her spiritual and physical journey” (Gabel, 2013, p. 80). The standard birthing technique employed by Māori was either squatting or standing and was always away from the village (Harte, 2001; Best, 1906). In the squat position, the women were usually supported by their whānau and kaiwhakahaere (Mikaere, 2003). After the birth of the baby, there were usually four special ceremonies carried out to confirm the special nature of the baby. Firstly, the cord was usually cut with a shell and the pito (belly button) was tied with flax, and finally the whenua was delivered (Mikaere, 2003). This ceremony was called the tua rite and karakia was done here to outline the baby’s potential and special abilities (Best, 1906; Jenkins & Harte, 2011). Following this, the tapu was lifted off the woman and ceremonies were held to welcome back the woman and her newborn baby (Best, 1906; Gabel, 2013). Once this ceremony was completed, the woman and baby were moved from the whare kahu to the whare kōhunga (nesting house) where whānau and friends could visit and meet the new baby (Best, 1906). Thirdly, a ceremony named the tohi rite was carried out in dedication to the atua. The atua that was best suited as a guardian, advisor, and kaitiaki for the child was selected and karakia were recited. This tohi rite imbued the child with mana (Jenkins & Harte, 2011). Fourthly, pure rite was carried out to confirm the mana of the child and to make it permanent. The four birth rites “bound the child to the whānau, and the whānau to the child” (Jenkins & Harte, 2011, p. 12).

3.2.2 Wairua and whakawhānau

Wairua, generally translated as the spirit, provides individuals not only religious beliefs but also a link to the environment (Cram, Smith & Johnstone, 2003). Breaking the word ‘wairua’ down into the two components it is derived from- wai and rua- helps me gain another level of understanding of the term. Wai can mean water, and rua can
mean two (personal communication, Rangitunoa Mollie Stevenson, 2015). Accordingly, wairua can also mean the joining of two waters, the parents, to create the spirit within you.

A particularly important whakawhānau practice that has a direct connection with wairua is the ritual disposal of the placenta. The whenua (placenta) of the newborn baby is taken and buried in the whenua (earth) (Moewaka Barnes et al., 2013; Abel, Park et al., 2001; Gabel, 2013). The burial usually occurs at the baby's tūrangawaewae or somewhere equally significant. This practice is important “to ground the baby's wairua and to recognise symbolically that the placenta and the land to which it was returned were sources of nurturing for the baby” (Abel, Park et al., 2001, p. 1142). Returning the whenua to the land also reflects the return to Papatūānuku and represents the ongoing growth and development of the child (Mikaere, 2003). There has been a positive change in many hospitals today where they offer the option for women and their whānau to collect their placenta after birth so that they may carry out this practice. A study by Helen Moewaka Barnes and colleagues (2013) showed that positive indicators of satisfaction with maternity care include where “hospitals increasing acknowledgement of the importance of returning the whenua was noted” (p. 53). Returning the whenua (placenta) to the whenua (earth) is directly linked with whakapapa, because it “signifies the cyclical view of the world that involves an ongoing link between the past and the present” (Moewaka Barnes et al., 2013, p. 22).

3.2.3 Whakapapa and whakawhānau

Mātauranga Māori regarding maternities and births are closely connected with the concepts of whakapapa and whenua (Simmonds, 2014). With respect to the latter, this chapter has explored the dual meaning of whenua as placenta and land, thus signaling this intimate connection. With respect to the former, in traditional Māori society, children were highly cherished because they “were seen to be a living embodiment of those that had gone before, and an essential element to the future survival of the people” (Gabel, 2013, p. 83). The birth of a child represented the continuation of whakapapa (Mitalicfe, 1974; Kahukiwa & Potiki, 1999). Whakapapa involves the inter-relationships between generations (Moewaka Barnes et al., 2013). To be born with whakapapa is to “share a heritage with the fullness of time, to feel connected...It is how Māori people connect with Māori people, how Māori people connect with the land, the waters and the sky” (Biasiny-Tule, 2006, p. 171). In this sense, whakapapa is the common thread that binds whānau, hapū and iwi together.
while additionally connecting Māori with the natural world. Whakapapa connects us to everything, including people, all living things, and the environment (Jackson, 2011).

Another important aspect of whakapapa is that it binds us to those in the spiritual realm, for example to tūpuna, Ranginui and Papatūānuku, from which all things are created; thereby making us all embodiments of intrinsic tapu (Mikaere, 2003). The maternal figures played a pivotal role in sustaining whakapapa and were “often credited as repositories of knowledge, the holders of mātauranga of the iwi, and hold the responsibility for ensuring that mātauranga was passed down on to the next generation” (Gabel, 2013, p. 86). This intergenerational transmission of knowledge was profoundly important within Māori society because it ensured the survival of whakapapa.

Traditional Māori culture used a lot of oral means to share knowledge and cultural practices. Therefore, “waiata, haka and whakataukī were the primary means of transmitting knowledge, the vehicles through which ancient concepts and beliefs have been passed down to us today” (Mikaere, 1994, p. 128). A form of waiata that was a significant method of transferring such knowledge was the oriori. Oriori were composed and sung to babies to teach them their whakapapa, histories and legends of their whānau, hapū and iwi, while also reinforcing the tapu and value of the child (Gabel, 2013; Penehira & Doherty, 2009; Jenkins & Harte, 2011). To the uninformed, oriori may be just a simple lullaby. For the informed, however, they contain a mass of information, including “ancient history, whakapapa, wars, births and deaths, love affairs, vital alliances and unions, and important events” (Mikaere, 2003, p. 57). Oriori linked the child with their atua and were usually composed by whānau members. The oriori signified how tapu the child was because of the common mention of atua, whakapapa and references to tūrangawaewae (significant place) (Jenkins & Harte, 2011). Upon the untimely, and often unusual, event that resulted in the death of the child, oriori and waiata were also used as expressions of this loss and grief (Clarke & McCreanor, 2006).

An example of an oriori that expresses the importance of childbirth, written by Kahukiwa and Potiki (1999), is translated to read

...call them all in, from the four winds let them assemble. See how perfect you are, the balance of all things. I hold you high amid whānau...our old ones gather closer, mingle their wairua with that of a newly opened heart...There are so many of us so very close, the hapū who love you now and the older ones, the bones of the house...Your whakapapa grows with you (p. 70).

This oriori illustrates the love the whānau, hapū and elders of the iwi have for the infant, while also highlighting that the child will carry on the whakapapa and fulfill the demands of the past. Oriori are an important means of knowledge transfer and should be revived
and used by whānau today because they contribute “to maintaining a healthy lifestyle and functional Māori worldview” (Penehira & Doherty, 2009, p. 370).

Understanding whakapapa in relation to Māori maternities allows us to grasp a sense of the complexities that exist within relationships in te ao Māori, whereby many layers are inter-connected. The collective whānau structure within te ao Māori demonstrate these working relationships.

3.2.4 Whānau and whakawhānau

The Māori world is a whakapapa-based society that is grounded upon structures of whānau, hapū and iwi (Pihama, 2011). Whānau are the family complexes that interacted together as a collective unit within a hapū (sub-tribe), and more widely as an iwi (tribe) (Cram & Pitama, 2008). Māori children belong to this wide network of relationships; therefore, the responsibility of raising children extends outside of the household or nuclear family (Cram & Kennedy, 2010; Gabel, 2013; Kenney, 2011). As my upbringing highlighted, it was common for a Māori child to have many homes because “infants from their first moments are embraced by multiple relationships with parents, grandparents, siblings, aunties, uncles and cousins” (Penehira & Doherty, 2013, p. 371). The collective responsibility of raising children in the whānau is modelled from the cosmogony where all beings are cared for by each other in balance (Jenkins & Harte, 2011).

The oriori of Kahukiwa and Potiki (1999) (see above) highlights the traditional view of whānau because it refers to the whānau, hapū and elders of the iwi. The dynamic and reciprocal relationships between parents, children and whānau “shaped the parents’ ability to support the child emotionally and reflected the collective intergenerational nature of Māori social structures” (Moewaka Barnes et al., 2013, p. 58).

Whānau plays a significant role within Māori maternities, as whānau members are often the main source of support and guidance for those who are embarking on the whakawhānau journey (Gabel, 2013; Kenney, 2011). Cram, Smith and Johnstone (2003, p. 4) reiterate this, stating “the whānau was seen…as a basic support structure for Māori and therefore an integral part of Māori health and wellbeing.” Having this strong support network is highly beneficial for mothers, especially those who have just given birth to their first child. The support and guidance received is a contributing factor to whānau wellbeing.

Creation narratives including “the myths and legends form the central system in which their [Māori] holistic view of the universe is based” (Marsden, 2003, p. 56).
Whānau wellbeing is also influenced by “access to both internal assets embodied in individuals and external assets that are derived from collective, societal and structural conditions” (Moewaka Barnes et al., 2013, p. 33). Examples of internal assets may include resilience and personal resources, and external assets may include hospital policies and support systems. Improving access to external assets for whānau may enhance overall whānau wellbeing.

Unfortunately, whānau wellbeing and Māori maternities are often negatively impacted in today’s society because “practices and cultural concepts that are imperative to Māori health and wellbeing have...often been undermined by dominant Pākehā views on health (Cram, Smith & Johnstone, 2003, p. 1). Compromising whānau wellbeing and Māori maternities has had a negative causal relationship with problems and disparities for whānau and Māori infants.

3.3 Chapter Summary

This chapter has outlined some of the mātauranga Māori regarding Māori wāhine and their role as te whare tangata. It provides detail of the Māori cosmogony that informs the whakawhānau practices that were commonly adhered to by wāhine. Most of these whakawhānau practices have been relegated to the more dominant Pākehā practices, however some tikanga remain active today. For example, it is common for wāhine and their whānau to engage in karakia while birthing, and adhere with the whenua ki te whenua (placenta to land) tikanga. The following chapter shares the Pākehā ontology that has become the dominant worldview and knowledge system regarding health and wellbeing in Aotearoa New Zealand.
Chapter 4: Whakatuanui ā-mātauranga

The chapter has been named Whakatuanui ā-mātauranga (promoted knowledge) to share the hegemonic discourse and relations that marginalise mātauranga Māori and all that is encompassed within that. This hegemonic discourse is steeped in and derived from Pākehā (non-Māori) ontology (nature of reality). This means that the way Pākehā view and understand the Māori world influences how Māori are considered because Pākehā are perceived as the dominant group. This chapter outlines ontology by sharing ways the Pākehā views; practices and beliefs have been superimposed on to Māori people and mātauranga Māori. In doing so, the chapter reflects on the processes of colonisation that changed Aotearoa to New Zealand, and how the trauma of colonisation continues to be borne by Māori today. Following this, the chapter will share a Kaupapa Māori ontology to show the different way Māori view and understand their world in contrast the Pākehā, particularly around te whare tangata and whakawhānau.

4.1 Pākehā Ontology of Te Whare Tangata

It is impossible to explore Māori issues without regarding the colonisation of Aotearoa New Zealand as this has brought about the domination of Pākehā ontology. This view of the world and the accompanying bodies of knowledge has become normalised and entrenched within Aotearoa New Zealand. This has resulted in Pākehā ontology marginalising mātauranga Māori and/or corrupting it to redefine the underlying ways Māori understand and behave within Aotearoa (Mikaere, 2012). As a result, systems within Aotearoa New Zealand, including the health care system, became oriented around Pākehā ideologies and practices (The Māori Perspective Advisory Committee, 1988). This challenged, and continues to do so today, Māori being Māori within the system. It is in this way that Māori have felt the devastating effects, and continue to do so to this present day, of colonisation. Marsden (2003) explains that the “social disorders from which tangata whenua presently suffer are but symptoms of the mental, spiritual, organic disease, created by the colonisation process” (p. 25). This is comparable to other indigenous cultures worldwide. For indigenous people, the trauma from colonisation is cumulative, with simultaneous or continuous damages to their wellbeing (Smith, C., 2017). The current over-representation of Māori in the ill health statistics clearly reflects this. Māori are “disproportionately represented in the lower socio-economic groups and health outcomes for Māori infants continue to be significantly poorer than those for Pākehā infants” (Abel, Park et al., 2001, p. 1136). Māori children are dying earlier than they
should and for potentially avoidable reasons. Arguably, the disparities and poor health outcomes Māori experience are the ongoing result of colonial trauma. Fenabed (2009) claims colonial trauma is represented in four levels. These are listed below within the context of Aotearoa New Zealand (Smith, 2017):

1. The physical trauma at the result of mass murder and infectious diseases.
2. The economic trauma from the forced removal of land from the indigenous.
3. The cultural trauma from the imposition of Christianity and prohibition of local belief systems.
4. The social trauma whereby the displacement of iwi (tribes) during colonial expansion damaged family structures, altered gender roles and expectations, and diminished cultural values.

Māori have experienced trauma at all four of these levels. Outlining the Pākehā ontology that has become the dominant way of viewing the world because of colonisation shows how Māori continue to be affected by colonial trauma today (Harris, Stanley & Cormack, 2018). Pākehā ontology has often viewed Māori in a deficit manner and has placed blame on them for the poor health experienced rather than examining wider systemic factors (Cram, Ormond & Carter, 2006).

For example, where there is literature available on Māori mothers, it is often based on a deficit model that constructs being indigenous as a problem and suggests the need for state facilitated solutions to solving the individual lifestyle problems Māori mothers face (Smith, L.T, 1999; Gabel, 2013). In the literature, we are told that Māori infants often suffer adverse perinatal events because “their mothers are more likely to be of a low socio-economic status, to be young, to have had little or late antenatal care and to have a young school leaving age” (Tipene-Leach et al., 2000, p. 2). However, it must be noted that these perceived problems are not due to the women being Māori. They are the result of colonial forces leading to the development and maintenance of structures that continually marginalise Māori and make them susceptible to the problems that are related with poor health. The problems associated with the ongoing colonial trauma include poverty and its related effects: racism, and having poor access to services (Tipene-Leach et al., 2000; Penehira & Doherty, 2009; Moewaka et al., 2013; Harris, Stanley & Cormack, 2018). This section outlines some of the structural determinants of health that are the driving forces behind the health disparities within the context of this project.

The first structural determinant of health to be discussed is racism. It is stipulated that racial inequities lead to greater severity and progression of disease (Williams, 2012). Figure 5 below illustrates this continuum of disease in relation to the
context of this project. This figure has been adapted both from the work of Williams (1997) and a presentation presented by Dr. Matire Harwood at the PMMRC conference (2017). The blue arrow below shows how health status is the result of a flow on effect that begins with a basic cause. The basic cause is the point where the following processes originate from, and can be seen to be at the crux of one’s health status. If we use this same process but remove Māori as the problem and instead place the system as the problem, we can see that health disparities can be the end result. This is illustrated in the red arrow.

**Figure 5.** Continuum of Disease for Māori. Source: Adapted from Williams (1997) and Harwood (2017).

What these processes illustrate is that the disparities that exist between Māori and non-Māori can be diagnosed in the same way as a symptomatic health condition. As a result of a poor basic cause, namely being marginalised from society and decision-making abilities from colonisation (red arrow), Māori have less social status and this is seen on the surface through symptoms such as poor access to culturally responsive care. As a result, disease progresses and the health status of Māori becomes (and remains) worse than Pākehā (PMMRC, 2017).

Some of the ‘basic causes’ that lead to the health status we see of Māori today are shared below, and all reflect the ongoing colonial trauma on te whare tangata. All basic causes are systemic level determinants of health, which suggests that change at the systemic level is required. Racism is such a determinant that is linked with causing colonial trauma from a systemic, structural level and contributing to the disparities Māori bore (Harris, Stanley & Cormack, 2018). Hardeman and colleagues
(2016) state, “perhaps if we shift our clinical and research focus from race to racism, we can spur collective action rather than emphasizing only individual responsibility” (p. 2). This sums up how the focus should be on addressing systemic and structural issues that contribute towards the health disparities to strive for collective wellbeing.

4.1.1 Racism

Racism is a social determinant of health and is one of the largest contributors to health disparities (Betancourt et al., 2003; Williams, 2012). It can be defined as the “institutional and individual practices that create and reinforce oppressive systems of race relations whereby people and institutions engaging in discrimination adversely restrict, by judgement and action, the lives of those against whom they discriminate” (Krieger, 2003, p. 195). Māori are more likely than non-Māori people to encounter racism because of their ethnicity (Cormack, Robson, Purdie, Ratima, & Brown, 2005; Westren, 2015). Racism is multidimensional, whereby it has an institutional, interpersonal and internalised presence. This section breaks down each layer of racism to outline how they impact on health of Māori, within the context of this project.

4.1.1.1 Institutional Racism

Institutional racism can affect the health of non-dominant groups in multiple ways. For example, institutional racism can lead to the marginalisation of the non-dominant group(s), which causes greater barriers to accessing health care, education, and employment (Williams, 2012). Māori have been marginalised from society in Aotearoa New Zealand, and as a result, Māori are more likely to be of a lower socioeconomic status than non-Māori, thus face greater difficulties accessing education and employment (Cormack et al., 2005). This level of racism causes health inequities because, “if socioeconomic position is related to health within groups, it seems probable that inequalities in socioeconomic position might be related to ethnic inequalities in health” (Nazroo, 2013, p. 2). This is reflected in Māori carrying the burden of disproportionately poorer wellbeing and health outcomes. Discrimination against Māori, such as bias and stereotyping, can also arise from current policies and practices within the health sector; contributing further to disparities in health outcomes (Cormack et al., 2005). In a report that was written in 1988, named Puao te Atatu, by the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare in Aotearoa New Zealand, it was stipulated that the national structures in Aotearoa New Zealand are developed from values, systems and views of the majority culture only and actively ignores other cultures who differ from the majority (The Māori
Perspective Advisory Committee, 1988). In this sense, national structures (including the health care system), policies and practices without discriminatory intent has and continues to have a discriminatory effect on Māori.

Institutional racism also plays a significant role in undermining Māori maternities. This is because Māori practices and cultures have been classed as inferior in comparison to the dominant, biomedical culture that is derivative of non-Māori worldviews and practices (Wilson & Barton, 2012). Thus, racism is integral to the process of replacing Māori worldviews and ways of birthing and child-rearing with superior Western worldviews and practices (Glover & Cunningham, 2011; Mikaere, 2013).

### 4.1.1.2 Interpersonal Racism

Whether it is deliberate or not, racism by the hands of practitioners contributes to disparities in health outcomes (Cormack et al., 2005; Hardeman, Medina & Kozhimannil, 2016). Racism, arising from cultural and status differences, has a causal relationship with Māori having poor access to adequate and culturally appropriate healthcare. Interpersonal racism results in a lack of cultural competency and poor communication between practitioners and racial and ethnic minority patients (Betancourt, Corbett & Bondaryk, 2014; Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). As reiterated by Jansen and Jansen (2013), problems in communication are derived from cultural misunderstandings, and unconscious bias and beliefs held by practitioners about Māori. Poor communication between whānau and health care practitioners can cause access barriers to health care because it often leads to the whānau feeling isolated and confused (Thompson, 2009; Wilson & Barton, 2012).

A study by Northland DHB showed that respondents who reported discrimination were up to three times more likely to report adverse health outcomes than those who do not report any discrimination (Northland Health Services Plan, 2012-2017). A further study carried out in Northland DHB reported that Māori are almost ten times more likely to experience three or more types of discrimination compared to their non-Māori counterparts (Westren, 2015). The report found that these women more commonly reported being treated in an unfair manner from their health care practitioners.

Cultural differences, in this case between Māori and non-Māori health care practitioners, about infant care practices and the different meanings attached to those practices may cause differential treatment of Māori patients by health care
practitioners. For example, it may be common practice of health care practitioners to communicate with an individual of the whānau rather than recognising the whānau as an entire entity that deserves communication and consultation. Accordingly, “culturally insensitive behaviour and/or conflicting advice can cause women to distrust the health professionals, effectively cutting them off from professional support” (Glover & Cunningham, 2011, p. 257).

Issues of interpersonal racism were reported as being significant problems that led to negative birthing experiences for young Māori pregnant women (Stevenson, Filoche, Cram & Lawton, 2016). Particularly regarding maternal and infant wellbeing, racism has a negative impact because “pregnant women who experience racism are more susceptible to antenatal stress, potentially explaining some disparities in birth outcomes” (Moewaka Barnes et al., 2013, p. 28). The issues raised here reveal that the legacy of racism remains; we are not yet in a post-colonial society (Cram & Pitama, 2008).

4.1.1.3 Internalised Racism

This level of racism relates to the internalised views that has been derived from racist judgements and attitudes towards their own ethnic group. One example of internalised racism that is relevant to this project is young women being pregnant and internalising the negative stigma attached to that.

Māori have a high rate of teenage pregnancy and, in general, tend to have babies at a younger age than non-Māori (Tipene-Leach et al., 2000; Mantell et al, 2004; Makowharemahihi, Lawton, Cram, Ngata, Brown & Robson, 2014). Being young and giving birth is often posed as a high risk for both mother and child in the literature (Moewaka Barnes et al., 2013; Makowharemahihi et al., 2014; Tipene-Leach et al., 2000; Ware, 2014). This is because, “teenage pregnancies [are] associated with increased mortality of babies before and after birth, and...in Aotearoa New Zealand, teenage mothers are at a higher risk of stillbirth and neonatal death compared to older mothers” (Makowharemahihi et al., 2014, p. 53). Often young Māori women internalise the negative stigma with being pregnant at a young age and feel that they have put themselves and their baby at risk. Adding to that, these young Māori women report feeling judged by health care practitioners when they access health care because of their age (Stevenson et al., 2016). It may be assumed that “the current model of maternity care disempowers young women by failing to provide an appropriate level of access to maternity care, and then blames them for not accessing care” (Makowharemahihi et al., 2014, p. 59). In this way, the current system restricts the
right of these young women to exercise tino rangatiratanga over their own and their baby’s health. Society and the health care system needs to recognise and support these young women and their rights to health care and wellbeing to alleviate disparities and to uphold the Crown’s obligation, under Article 3 of the Treaty of Waitangi, of providing equal rights to all citizens (Makowharemahihi et al., 2014; Stevenson et al., 2016). Perhaps doing so will contribute towards addressing not only the health disparities young pregnant Māori women face, but also alleviate the negative stigma that is attached to and internalised by young Māori pregnant women.

4.1.2 Poverty

Poverty is acknowledged as the key driver of disparities in health and wellbeing, and this is across all ages (Children’s Commissioner, 2017). Poverty is often defined in monetary terms, whereby a person(s) has a lack of monetary income to meet the accepted way of life (Cram, 2011). However, poverty “is not just about income, it is also about the unequal distribution of resources and the valuing of some interests over others” (Moewaka Barnes et al., 2013, p. 26). During one of my consultation hui, a Māori midwife expressed how there are different ways of defining poverty. She stated that “Pākehā define it as a lack of materialistic needs; what I think poverty is the lack of cultural identity and tikanga and mātauranga” (personal communication, Joyce Croft, 2015). This comment resonates closely to Sen’s capability approach. Sen argues that “if equality in social arrangements is to be demanded in any space…it is to be demanded in the space of capabilities (Alkire, 2005, p. 4). Sen’s capability approach has four key concepts and the one that resonates with this comment made by Joyce regarding poverty is the concept of functionality. This concept argues that wellbeing is present when we are capable of accessing and enjoying what is valued (Alkire, 2005). When poverty is present, the capability to enjoy what we value may be hindered. As such, cultural and monetary incapability can be intertwined in the presence of poverty. For example, urban Māori who have a lack of cultural connection that may want to access their whenua and whānau to reconnect and fulfill their cultural desires may lack the monetary resources to do so; thus creating inequality in that space.

The differing opinions on poverty raises the question of who has the power to define what poverty is? In Aotearoa New Zealand, it has become almost a normalised notion that Māori are, and will remain, living in poverty. In combination with this notion

9 Further details of which are provided in the methods chapter.
is the ignorance of mainstream, non-Māori structures and systems marginalising Māori (Cram, 2011).

Drawing on data from the most recent Census (2013), a gap between major ethnic groups median personal income remains, with Europeans having the highest median income. The gap between national median personal income and the median personal income of Māori increased in 2013 compared to the 2006 Census ($6,000 less than national median income in 2013 versus $3,500 less in 2006) (Statistics New Zealand, 2014). This gap indicates that income disparity has increased between ethnic groups. Having a poor income adds to the stress of parenting as it can lead to the lack of money to access childcare, health, transport and support services (Penehira & Doherty, 2009). Because of these material hardships, children are susceptible to missed doctors’ appointments (Simpson, Adams, Oben, Wicken & Duncanson, 2015). If the parents are isolated from the support of their wider whānau, the problems related to having a poor income can be intensified. Poor income also often led to overcrowded households, and this is a commonly portrayed contributing factor for Sudden Unexplained Death in Infancy (SUDI) (Tipene-Leach et al., 2000; Edwards et al., 2005). SUDI is an example of how Māori who live in poverty have been blamed for the poor infant wellbeing and whānau wellbeing, while turning a blind eye to the role the current healthcare system has in addressing this issue. While the rates of SUDI have decreased (PMMRC, 2017), the rate for Māori remains higher than the rate for other ethnic groups.

The office of the Children’s Commissioner recently reported that there has been a halt to the growth of child poverty in Aotearoa, however the rate of child poverty remains significantly higher than what it was in the 1980s (Children’s Commission, 2017). Linked with child poverty is the environment the child lives in. Many Māori whānau live in areas of socioeconomic deprivation (Ministry of Health, 2017). The 2013 Census showed that around 34% of Māori lived in poor households as defined by Census, in comparison to 16% of Pākehā, and this difference likely reflects the higher proportion of Māori children living in sole parent beneficiary households (Simpson et al., 2015). These whānau are subjected to substandard housing conditions, poor health literacy, high costs of and lack of access to transport- all factors that impact their access to timely health care (Northland Health Services Plan, 2012-2017).

Further issues that arise from living in poor neighbourhoods include “overcrowded living space, limited community resources, and [these] can lead to a sense of isolation” (Penehira & Doherty, 2009, p. 373). Ironically, though, living in these ‘deprived’ areas have also seen the development of strong links between whānau in those spaces (Cram & Pitama, 2008). In this way, the deprived neighbourhood can
become a cultural hub and place of support. This is a positive contradiction to common literature that portrays deprived neighbourhoods as being a negative indicator of health. I can relate to this because the neighbourhoods I grew up in were/are classified as deprived. But I never thought that my whānau was impoverished because we were always together, sleeping together, sharing kai together, and supporting one another. Upon reflection, living in these ‘deprived’ neighbourhoods meant I had access to a hub of collective support. The custom of blaming Māori for being impoverished needs to be shifted and instead examine the system and structural issues driving the health issues linked with poverty.

4.1.3 Access to services

As mentioned in the beginning of the thesis (section 2.1.1), maternity care in Aotearoa New Zealand is free to all eligible women, as funded by the Ministry of Health (Moewaka Barnes et al., 2013; Makowharemahihi, 2014). Every eligible women is entitled to access primary maternity care that is delivered either by “a community-based LMC, a non-LMC health practitioner (doctor or midwife), or a DHB-funded primary care provider” (Makowharemahihi et al., 2014, p. 52). The expectation of having these services for free is that every pregnant woman receives a level of care, albeit a level of care that is state-sanctioned and derived from a biomedical perspective, to provide healthy outcomes for her and her baby. However, this universal and biomedical provision of maternity care that is available has not decreased the infant health disparities between Māori and non-Māori (Makowharemahihi et al., 2014). A contributing factor for this is because Māori frequently encounter barriers that restrict their access to services (Cram, 2014; Moewaka Barnes et al., 2013; Jansen & Jansen, 2013; Penehira & Doherty, 2009; and Tipene-Leach et al., 2000; Makowharemahihi et al., 2014). For example, whānau living in communities in Te Moana-a Toi and Te Tai Tokerau are often required to travel extensive distances to access specialist level hospitals. This raises the question of the impact of rurality as a social determinant of health for whānau, particularly regarding their access to specialist care. This will be explored further throughout the thesis.

Barriers to accessing health care becomes a risk factor for pregnant Māori women and mothers as it inhibits a seamless pregnancy pathway that ensures her wellbeing throughout. Māori women are less likely to attend antenatal classes that are

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10 It is the role of the LMC to assess the mother’s needs, plan her care and her baby’s care with her, and ensure the provision of maternity services including antenatal, labour, delivery and postnatal care (Moewaka Barnes et al., 2013).
delivered from a biomedical model than non-Māori (Moewaka Barnes et al., 2013), and not attending, or inadequate, antenatal care is linked with poor outcomes for mother and child (Makowharemahihi et al., 2014). The blame for not attending these antenatal classes is often placed on Māori, as they are portrayed as being unmotivated and unwilling to receive the appropriate care for their baby. However, as a recent development proves, Māori women are willing to attend antenatal classes that are appropriate and fitting for them. Hapū Māmā antenatal classes run by Te Ha Oranga in Te Moana-a-Toi has been a great success as the classes are well attended by pregnant Māori wāhine and their whānau. These antenatal classes are based on Kaupapa Māori understandings of hapūtanga, childbirth, and tikanga Māori regarding whakawhānau. This suggests that Māori antenatal attendance is dependent on the deliverance of good culturally responsive care, rather than Māori being poor attendees with no motivation to receive care as what is commonly stipulated in the deficit models.

Māori women also face more barriers than others when accessing LMC care (Ratima & Crengle, 2013). During 2008-2012, 14.7% of Māori babies were born to mothers who were not registered with an LMC (Simpson et al., 2015). This statistic suggests that the same access to health care barriers mentioned above (lack of access information, transport issues) may be evident here for Māori pregnant wāhine trying to access LMC care in their hapūtanga (pregnancy). It may also suggest that Māori pregnant wāhine choose not to access LMC care for reasons including, but not limited to, negative past experiences with LMCs, and perceiving the care to be culturally unresponsive. With these barriers in place, it is challenging for Māori to gain adequate antenatal care. Young Māori women are often framed as commonly failing to attend early antenatal care because there is a perception that they choose to book late for antenatal and LMC care (Makowharemahihi et al., 2014; Ratima & Crengle, 2013). However, Charissa Makowharemahihi et al. (2014) found that young Māori women seek maternity care early, contrary to the perception that these young Māori pregnant women present late and fail to attend early antenatal care. Additionally, the “relatively youthful profile for Māori mothers mean that the types of support services and advice needed is markedly different than for older, non-Māori mothers” (Glover & Cunningham, 2011, p. 255). This is a significant factor because it highlights the disconnection present in the maternal-infant health care system as the support services these young mothers require are different to those required by other women. If access to the support services is inadequate, these young mothers may lack the support and guidance they need, especially if they are alienated from their whānau.

Barriers faced by Māori restrict their access to maternity care services and inhibit a seamless maternity care pathway (Ratima & Crengle, 2013). Many of these
barriers are systemic failures because the current system does not take into account the structures that have, and continue to, marginalise Māori and their infants. The maternal-infant health care system is also often unresponsive to the needs of Māori even though it has been shown that Māori women show positive health seeking behaviour to access maternity health care (Makowharemahihi et al., 2014).

Plunket services are an example where access to postnatal care is sometimes difficult for Māori, yet there has been a positive change to this since the beginning of this project. Since then, Plunket has now launched a new Māori-led strategy to improve the delivery of Plunket services. The pilot of this study was launched in Waikato in February 2017 (Plunket Annual Report, 2017). This is a positive change considering it was not until the late 1960s when Plunket first delivered their services to urban living Māori (Bryder, 2001; Gabel, 2013). Efforts should be continued throughout all maternity services to address access issues that frequently and disproportionately restrict the access of Māori.

4.2 Marginalising Māori Maternities

With the introduction of Christianity and English beliefs through colonisation, Māori birthing practices became marginalised (Mikaere, 2017). The role of “women as whare tangata was highly valued…as evidenced by the centrality of the female reproductive functions to Māori cosmogony and the powers attributed to the female organs in mediating the boundaries between tapu and noa” (Mikaere, 2003, p. 90). Colonisation devalued this with the introduction of Pākehā ideologies and practices, in particular Christian ideals that portrayed men as being superior. This viewpoint infiltrated the Māori cosmogony and changed creation narratives to portray Io (the ultimate creator) as a male, therefore mimicking the Christian belief that men are superior to the women (Mikaere, 2003). Female sexuality and maternities were cast as being shameful, which was a direct contrast to how they were viewed in te ao Māori (Murphy, 2012).

Whakawhānau practices that were common in te ao Māori were also devalued following colonisation. Prior to 1907 in Aotearoa New Zealand, highly skilled tohunga (chosen experts) facilitated whakawhānau with traditional Māori childbirth practices (Kenney, 2011). Tohunga were chosen as special individuals who had the ability to act on behalf of the gods. Their function was to mediate between the gods and the iwi to ensure the wellbeing of the people (Marsden, 1992). When it came to whakawhānau, it was common for the tohunga to be related to the prospective parents. During kōrero (conversation) with my Nana (grandmother), she shared how her father (my koroua)
was a tohunga who assisted women giving birth in their village. He had facilitated the birth of my nana, along with her siblings and cousins. All were birthed under their pear tree in the family orchard. Similar stories were shared during a key informants’ hui I held with kuia and midwives. They also shared stories of how their fathers were the tohunga who facilitated birth in their respective home areas.

With the arrival of Europeans and colonisation came laws and processes to eliminate mātauranga Māori, including knowledge processes and practices. One example of this is the Tohunga Suppression Act 1907. The New Zealand Parliament passed the Act to control tohunga and replace their ways with Western medical technologies. It was also an attempt to control charismatic and spiritual Māori leaders (for example Rua Kenana and Te Kooti) holding power and influence (Stephens, 2000). Naomi Simmonds (2014) argues that the Act was one of the most aggressive attacks on wairua knowledge inflicted by the colonisers. Although the Tohunga Suppression Act was repealed in 1962, it was successful in its objective of curtailing mātauranga Māori because it disrupted the open use of and access to tikanga and mātauranga Māori. This was because mātauranga Māori and tohunga who were experts in that knowledge were deemed superstitious and wrong (Simmonds, 2014). Consequently, tohunga were made to operate ‘underground’, where access to them was possible but more difficult. In regards to whakawhānau, the Tohunga Suppression Act 1907 contributed toward the loss of mātauranga Māori that is still evident today, as sources of Māori maternities and traditional knowledge continue to be “comprehensively displaced, invisibilised, marginalised and ultimately replaced by the mass of Western maternal knowledge that pervades our contemporary society” (Gabel, 2013, p. 4). This is noticeable in the absence of male birth attendants in contemporary society as it is more common for women to be the midwives and birth facilitators now. As of 31 March 2014, there were only six men in the midwifery workforce (Ministry of Health, 2016).

Another significant legislative move that marginalised Māori maternities was the hospitalisation of childbirths. In the 1920s, maternal and infant health in Aotearoa New Zealand was in a particularly poor state (Dow, 1999). Hospitals were brought in as part of the colonial agenda as they were established upon European models as a means to civilise Māori (Dow, 1999). In an attempt to reduce mortality rates and to attain control over births, there was a move enforced by the state to hospitalise childbirths. The important point to note from this change in practice is that although small changes had taken place following initial colonial contact (for example using scissors to cut the cord instead of shell), whānau still held control over their birthing practices. A major change occurred when legislation was brought in to medicalise
childbirth that required women to give birth in hospitals. Accordingly, whānau lost their control over their birthing mātauranga and practices (Mikaere, 2003).

The transition to birthing in hospitals involved completely different birthing techniques for Māori, where at the hospitals “they [doctors/midwives] lift your feet up in the air…you lay on your back and your legs were 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 it is because it’s so painful” (Mountain Harte, 2001, p. 95). These are the words of kuia who were interviewed in Mountain Harte’s (2001) study. They are reinforced by the work of Ani Mikaere (2003), where it is described how alienating the experience of giving birth in hospitals was for these Māori women. The women had to navigate a foreign space where control is placed directly with medical professionals and hospital staff; they were isolated from whānau and instead surrounded by strangers; they were expected to give birth lying down and accept internal examinations without question; had no karakia during their delivery; and there was no consideration for whenua ki te whenua tikanga, where instead of being collected to be buried appropriately, they were burnt without permission in the hospital incinerator (Mikaere, 2003). This move away from traditional Māori maternities often caused problems and discomfort for Māori women. Undermining the traditional Māori maternities also trampled on the tapu of te whare tangata and debilitated the worldviews underlying and informing those practices (Mikaere, 2003). In turn, this has a negative impact on wellbeing because the wairua encompassing the values and beliefs that underpin the practices becomes classed as subordinate and insignificant.

4.2.1 Redefining whānau structures

An ongoing ramification of colonisation is the reduced translation of whānau to mean the nuclear family (Cram & Pitama, 2008). In pre-colonial times, whānau were collective and complex structures that operated in balance as a collective entity to sustain wellbeing for all (Mikaere, 1994). Additional meanings of whānau include childbirth, but this definition is often overlooked and unused in contemporary society. Ani Mikaere (2003) provides an analysis of the impact of colonisation on whānau wellbeing, stating
The forces of colonisation threw Māori into a state of perilous imbalance: land loss through confiscations and the workings of the Native Land Court wreaked havoc on the relationship between people and their natural environment; forcible individualisation of land title through the Native Land Court also upset the balance between members of whānau, hapū and iwi; introduced diseases and the introduction of Christianity damaged irrevocably the connection between people and their atua; and the patriarchal assumptions underlying the common law and Christian teachings destroyed the equilibrium between male and female (p. 126).

The structure of whānau was changed from collective to nuclear because the collective philosophy of Māori culture clashed with the individualism ethic of the non-Māori coloniser (Mikaere, 1994). Redefining whānau structures to align with Pākehā structures was one of the first goals of the colonial agenda. In conjunction with this cultural clash, colonisation left Māori with insufficient land to support themselves. Land was the key economic resource of Māori, therefore when that resource was taken from them through unfair purchases, confiscations, and warfare, and Māori were left without adequate economic resources to sustain themselves (Cram, 2011). Land loss saw many consequences for Māori, including a change from being business and trade owners to being employees, which often meant having to leave their whānau, hapū and iwi lands to move to urban centers in search of work opportunities (Mikaere, 1994; Cram, 2011). Māori were left with no space and limited financial resources to live collectively on their lands, and it was these factors that exacerbated the breakdown of the collective whānau unit to smaller, nuclear units and the movement of Māori to urban centers. Urbanisation was largely driven by the range of labouring and manufacturing jobs that became available for Māori around the time of WWII. The move to the cities required Māori to adapt to a new way of life, as the communities they moved to had been formatted for Pākehā culture and tikanga (Cram & Pitama, 2008). Structural forces saw Māori being purposefully allocated to specific places to live during their shift to urban centers by making particular areas more affordable than others. Policies such as ‘pepper potting’ were developed to scatter Māori whānau amongst Pākehā neighbours (Meredith, 2017). The Government considered this a preferable option to housing Māori together in one area. However, as the population increased, state-built houses were created in estates such as Te Atatū and Ōtara in Auckland, and Porirua and Wainuiomata in Wellington; these suburbs quickly became highly populated Māori communities (Meredith, 2017). The ramifications of this purposeful allocation of Māori within urban centers is evident today as particular areas have higher concentrations of
Māori, and have greater deprivation. This is a demonstration of structural racism that is still operational today (Meredith, 2017).

Urbanisation, land confiscations, and the normalisation of the nuclear family structure have had devastating effects on Māori whānau because “as the whānau unit became progressively smaller, the responsibilities of individual women grew” (Simmonds, 2011, p. 16). The dissolution of whānau and hapū structures also placed women in a position of dependence on her husband to be the breadwinner because they were expected to follow the English model of being the primary caregiver of the home and children (Gabel, 2013). However, if there are financial pressures, women are expected to enter the workforce, as well as maintaining their duties of being the primary caregiver at home (Mikaere, 1994).

The English model of caregiving can also be debilitating for whānau wellbeing because regulations and policies prevent whānau being the main support structure for individuals. Being isolated and treated as one person rather than an integral part of the whole whānau also causes implications for health policies (Gabel, 2013). The current “minimized presence of whānau and the Euro-centric perspective on maternity care...have facilitated a practice that focuses on the individual woman to the detriment of existing and prospective whānau” (Kenney, 2011, p. 126). The policies have been derived from Western principles because Western medicine was seen to be another way of civilising Māori (Dow, 1999). Government sponsored health care for Māori began in the 1840s, but Māori were often shut out of hospitals. This was even after Māori had gifted the land to the colonisers in return for a hospital that was promised to them. Often these promises were not fulfilled and Māori were left without access to hospital care (Dow, 1999). Today, health care policies remain biomedical. As a result, the health care system embodies an environment that often opposes with Māori values and practices. For example, it is a common policy in hospitals to disallow whānau staying overnight with the patient. In this way, the policies (and those enacting them) become gatekeepers of whānau support because whānau are not allowed to stay and support the mother even if she has experienced a traumatic birth event that has affected mother and/or child. This has a direct impact on the mother and whānau wellbeing, as they are an intertwined structure. It can be argued that isolating the mothers and not allowing whānau to stay endorses culturally inappropriate care for Māori. As Kenney (2011) explains, “culturally inappropriate care and token compliance with health legislation will adversely impact the health and wellbeing of whānau (p. 127). The challenge is to bring about change in policies and practices that ensures culturally and contextually appropriate maternity care is available for Māori and non-Māori alike.
4.2.2 Introduced policies that impacted on Māori maternities

In response to high maternal and infant mortality and illness, in 1907 the Society for Promoting the Health of Women and Children, later to be known as the Royal New Zealand Plunket Society (Plunket), was established (Bryder, 2001; Glover & Cunningham, 2011). Local voluntary committees were implemented throughout New Zealand to employ Plunket nurses who provided advice for pregnant women and new mothers. However, for Māori Plunket “was born at a time of mounting public concern about ‘national efficiency’ and the future of the Anglo-Saxon race…it would be easy to assume that as a consequence it showed no interest in Māori” (Bryder, 2001, p. 69). As a result, Māori were often excluded from Plunket services and it was not until the late 1960s that Māori women living in urban areas were able to utilise Plunket (Bryder, 2001; Glover & Cunningham, 2011; Gabel, 2013). Therefore, while Plunket was credited in the early twentieth century as being the reason for great infant welfare in New Zealand, the reality was that a dual system existed in infant care, where non-Māori mothers had access to Plunket nurses and Māori mothers were provided district nurses from the Department of Health. The reasons for excluding Māori from infant welfare services were largely due to “administrative territorial disputes to local racial prejudices and culturally insensitive services or nurses” (Bryder, 2001, p. 85). This rendered Māori without access to Plunket nurses. Plunket can also be recognised as being a tool used to further government control. As Gabel (2013) explains,

Parents who receive government benefits are specifically targeted to subscribe to Plunket and Well-Child development initiatives…while these policies are promoted in the guise of the government addressing child welfare, in reality they reinforce the intergenerational ideology that the state has overall authority and control of Māori maternities. (p. 144)

This insight explains how the introduction of these non-Māori ideologies has dismissed Māori maternities and encouraged state control of services by being developed and delivered from a biomedical perspective that disregards mātauranga Māori. Explaining the problems that Māori face through a Kaupapa Māori theory may be more effective because Kaupapa Māori is a holistic, strengths-based approach that takes into account all dimensions of the Māori worldview. Therefore, providing the capability and structure to explain the problems Māori suffer from a wider, Māori-oriented lens that does not immediately place the blame on Māori (Lawton et al., 2013).

4.3 Adjusting the lens: Kaupapa Māori theory of the problem

To understand Kaupapa Māori theory, it is necessary to understand what kaupapa Māori means. Kaupapa Māori is a “term used to describe traditional Māori
ways of doing, being and thinking, encapsulated in a Māori worldview” (Henry & Pene, 2001, p. 235). I link kaupapa with Papatūānuku because she features in the word. All plans and practices are therefore expected to be respectful and tika to the values instilled in us by our Earth Mother.

Kaupapa Māori flourished during pre-European contact. At the beginning of European contact, many iwi continued to progressively flourish because of the greater opportunities they had for trade with the newcomers (Walker, 1990). However, the arrival of an overwhelming numbers of settlers and the colonial agenda brought about colonisation processes that actively discouraged and disrupted kaupapa Māori (Glover, 1997; Marsden, 2003). The Māori population decreased dramatically at the result of land wars, raupatu (land confiscations), introduced diseases, and Māori being removed from their whenua (Walker, 1992). Following over 150 years of being subjected to this colonial agenda, the 1970s and 1980s saw Māori increasingly protesting for equality and tino rangatiratanga. These protests were supported by political and organisational developments, such as the passing of the Treaty of Waitangi Act 1975; the growth of immersion language education movements such as Kōhanga Reo and Kura Kaupapa Māori; and the emergence of specific Māori health models, such as Te Whare Tapa Whā (Durie, 1994). Māori efforts to reinstate their tino rangatiratanga were further encouraged by worldwide Indigenous sovereignty (Maaka & Fleras, 2005). It was within this context that Kaupapa Māori theory developed.

Academic research by Māori was also becoming more prevalent during this time (Orange, 2004). In particular, Māori academics, such as Graham and Linda Smith, began to question why non-Māori knowledge was deemed legitimate, whereas Māori knowledge was seen to lack validity and legitimacy (Smith, G.H., 2002; Smith, L.T, 2006). Therefore, Kaupapa Māori was a deliberate movement that resisted the “colonial heritage and hegemony of New Zealand’s colonial past [who] are at the forefront of developing the Kaupapa Māori paradigm” (Henry & Pene, 2001, p. 234). When Kaupapa Māori theory emerged in the late 1980s it was (and is) a theory and praxis of resistance and transformational change (Smith & Reid, 2000). It also offered Māori academics encouragement and a space within academia because it was a

11 The passing of the Treaty of Waitangi Act 1975 was significant because it facilitated the development of a process that would allow the settlement of Māori grievances for Crown Treaty of Waitangi injustices (Orange, 2004). This saw the emergence of the Waitangi Tribunal, and “if the Tribunal considered that Māori interests were, or could be, prejudicially affected, it could make recommendations on the appropriate course of Crown action” (Orange, 2004, p. 144). The Act was amended numerous times; perhaps the most significant amendment was the 1985 Amendment Act which extended the jurisdiction of the tribunal back to the 6th February 1840 to include all issues arising from that date (Stokes, 1992).
“Māori-authored body of work that asserted the requirements for Māori to be participants in, rather than merely the objects of, research” (Mikaere, 2011, p. 30).

Definitions of Kaupapa Māori theory include “research [which] embraces traditional beliefs and ethics, while incorporating contemporary resistance strategies that embody the drive for tino rangatiratanga for Māori people” (Henry & Pene, 2001, p. 236); and culturally safe research that involves the researcher receiving guidance by kaumātua (Irwin, 1994). The common ground in descriptions of Kaupapa Māori theory is the Māori-orientation to serve the needs of Māori, with the hope of producing service and research outcomes that are beneficial to Māori.

In more recent times, Kaupapa Māori has developed as a theory of transformation in a variety of fields to assist in Māori development (Smith, G.H., 2002). This is made possible through the principles of Kaupapa Māori theory being applicable across multiple contexts. Graham Smith (2002) and Pihama, Cram & Walker (2002) explain that there are six key principles of Kaupapa Māori theory:

1. Tino Rangatiratanga (the ‘self-determination’ principle);
2. Taonga Tuku Iho (the ‘cultural aspirations’ principle);
3. Ako Māori (the ‘culturally preferred pedagogy’ principle);
4. Kia Piki Ake i Ngā Raruraru o te Kāinga (the ‘socio-economic’ mediation principle);
5. Whānau (the ‘extended family structure’ principle) and;

The six principles effectively “encapsulate Māori values and knowledge but also provide bridges through which other...strategies can be put into practice” (Mead, 1996, p. 209). It is important to note that two further principles have been added to the theory by influential Māori researchers: Tiriti, added by Leonie Pihama, as she argues Te Tiriti o Waitangi is a crucial document in the articulation of Kaupapa Māori theory (Pihama, 2001); and Ata, added by Taina Pohatu, which focuses on growing meaningful relationships (Pohatu, 2005). These additions highlight the fluidity of Kaupapa Māori theory. While it is important to mention these two additional principles, I will build upon only the original six principles. This is because they resonate with my Kaupapa Māori theoretical understandings that allow me to explore the problems and disparities whānau face when they suffer an adverse perinatal event that results in the harm or loss of their baby.
4.3.1 Tino Rangatiratanga

In contemporary society, although Māori make up 15 percent of Aotearoa New Zealand’s population now (Statistics New Zealand, 2017), Māori hold just enough influence to effect decisions made at a structural policy level concerning their wellbeing (Maaka & Fleras, 2005). The initial loss of Māori tino rangatiratanga (sovereignty, control) was the result of colonisation and breaches of the Treaty of Waitangi, including raupatu, assimilation tactics and the loss of authority over their resources and people (Maaka & Fleras, 2005). Colonisation is considered to be a deliberate process because colonisers “have a central belief in their own superiority and that they therefore have superior rights to the territory and resources of indigenous peoples” (Reid & Robson, 2006, p. 27).

The tino rangatiratanga principle (the principle of self-determination) lies at the heart of Kaupapa Māori (Smith & Reid, 2000). Tino rangatiratanga stems from the Treaty of Waitangi and relates to sovereignty, autonomy, self-determination, and control (Mutu, 2010; Orange, 2004). When signing the Treaty of Waitangi, “Māori signatories understood the Treaty as guaranteeing their rights to tino rangatiratanga (chiefly autonomy); sovereignty over their individual lands, property, treasures and resources; and ōritetanga (equity): comparative status with British citizens” (Kenney, 2011, p. 124). Ōritetanga, as guaranteed by Article 3, promised Māori to have the same rights and responsibilities of non-Māori (Orange, 2004; Wyeth et al., 2010). The implication of Article 3 is that health care structures have the obligation to support Māori patients on an equal level to non-Māori. This is based on the treaty principle of partnership that is, in turn, based on the assumption that “Māori ceded sovereignty or kāwanatanga to the Crown in Article 1 of the Treaty, in exchange for the Crown’s protection of Māori tino rangatiratanga” (Waitangi Tribunal, 2004, p. 130). The principle of partnership indicates that the Crown and its structures have the obligation to protect Māori as well as allowing Māori their rights to tino rangatiratanga (Kenney, 2011).

There needs to be efforts made to fulfill the partnership principle and allow for the integration of tikanga and mātauranga Māori, particularly within the health care system. A common misunderstanding of tino rangatiratanga is that it promotes a lack of unity between Māori and non-Māori (Bishop, 2008). Exercising tino rangatiratanga does not suggest Māori exist in isolation from non-Māori. Rather, exerting tino rangatiratanga allows the ability to open communication pathways between Māori and non-Māori (Bishop, 2008; Pihama, Cram & Walker, 2002). This would mean that, in practice, tino rangatiratanga would allow for Māori to have the freedom to shape their goals, behaviours and actions in relation to their cultural outlook (Bishop, 2008).
will empower Māori during decision making, especially within policy development. Giving whānau a voice to share their experiences empowers and enables them to exert tino rangatiratanga because they have the position of knowledge-holders that I wanted to learn from. Their knowledge and experiences will also be central to the development of informed policies and maternal-infant health care systemic changes.

4.3.2 Taonga Tuku Iho

Taonga tuku iho “means that Māori language, knowledge, culture and values are normal, valid and legitimate” (Bishop, 2008, p. 442). In effect, this develops environments that allow Māori cultural identities and practices to be portrayed as normal, thereby asserting the position that to be Māori is normal. Knowledge may be acknowledged as a taonga. This treasure is “handed down as taonga tuku iho, that is, treasure from ancestors, and as such is tapu” (Bishop & Glynn, 1999, p. 172). The place “of Māori children as taonga within whānau and the lifeblood of generations is particularly important” (Moewaka Barnes et al., 2013, p. 22).

The cosmological narratives of Māori all stress the importance of Māori women and their role in sustaining whakapapa (Simmonds, 2011; Mikaere, 2013). The child’s mother or whānau (Gabel, 2013; Penehira & Doherty, 2013) often passed these narratives down through oral means. The “orally acquired and orally transmitted knowledge, so frequently devalued and belittled by non-Māori...is highly valued by Māori” (Bishop & Glynn, 1999, p. 172). Taonga tuku iho was, and still is, an important means of maintaining mātauranga Māori throughout generations of whānau. Unfortunately, many whānau are denied this intergenerational transmission of knowledge because they are disconnected from their whānau, hapū and/or iwi. Consequently, they are alienated from the sources of mātauranga Māori. In relation to this theory, taonga tuku iho may be linked with intergenerational transmission of knowledge. The lack of oriori used today also highlights not only the loss of mātauranga Māori surrounding maternities, but also the loss of oral transmission of whakapapa and knowledge passed on to babies. Extensive efforts have been made to revive te reo Māori, through Kōhanga Reo, Kura Kaupapa and Wānanga (Smith, G.H., 2002). There needs to be a similar push to revive Māori maternities and practices within the health care system.

4.3.3 Ako Māori

Closely linked to Taonga Tuku Iho is Ako Māori as it promotes “teaching and learning practices that are unique to tikanga Māori” (Pihama, Cram & Walker, 2002, p.
10). Māori have raised the concern that maternity services, such as antenatal classes, are culturally inappropriate and that being unable to access culturally appropriate care is one cause of high dissatisfaction with maternity care in New Zealand (Ratima & Crengle, 2013). It was suggested that antenatal classes should incorporate culturally appropriate venues, have a higher focus on spiritual needs, and be inclusive of whānau (Ratima & Crengle, 2013).

Ako Māori can also relate to the provision of co-constructed health care. This would mean that patients and health care practitioners both have something to learn and something to teach throughout the journey within the health care system. The co-construction of care can enable better, more open communication pathways between whānau and health care practitioners as both parties develop an understanding of diagnosis and treatment.

The Ako Māori principle therefore highlights the need for better education in the health service to teach health practitioners tikanga and mātauranga Māori, and ask them to “understand, rather than blame, the victims of historical and social processes for their current situation” (Kruske, Kildea & Barclay, 2006, p. 74). Culturally responsive care should be endorsed and practiced because it not only ensures patients feeling physically, spiritually, socially and emotionally safe; it also acts as a strategy to contribute towards delivering equitable outcomes for Māori and non-Māori (as promised in Article 3 of the Treaty of Waitangi).

4.3.4 Kia Piki Ake i Ngā Raruraru o te Kāinga

This principle is translated to mean the socioeconomic status principle, and refers to the social and economic disadvantages many Māori face. The goal of the principle is to address “these issues and the potential to overcome them through processes of decolonisation that can become part of education and health practices” (Penehira & Doherty, 2009, p. 376). This principle relates closely to poverty and the struggles Māori face from being disproportionately represented in the lower socio-economic realm (Abel et al., 2001). There is considerable evidence “that societal benefits accrue to the more advantaged members of society and that poor health is distributed as a gradient of socioeconomic position” (Moewaka Barnes et al., 2013, p. 7). As a result of having a low socio-economic status, Māori often face challenges that impact on their wellbeing. Such challenges have been previously mentioned under the poverty section.

Kia Piki Ake i Ngā Raruraru o te Kāinga assumes that although there is hardship, Kaupapa Māori principles and practices can still intervene and contribute
towards alleviating the negative pressures that bear on whānau and their children (Pihama, Cram & Walker, 2002). For example, whānau facing similar hardships are seen to band together to develop hubs of support for each other. These hubs can overcome some of the barriers to health care access that are caused by material hardship.

**4.3.5 Whānau**

Whānau, or the ‘extended family structure’ principle also lies at the heart of Kaupapa Māori. Whānau are perceived to be the cornerstones of Māori society; “it is about collectivism and about communal notions of family and family responsibilities…in today’s society…this is often sadly missing for many parents who find themselves isolated and struggling to raise their children with little support” (Penehira & Doherty, 2009, p. 377). One reason for the loss of whānau support is because colonisation changed the structure and operation of whānau (Simmonds, 2011). As reinforced by Penehira & Doherty (2009), “processes of colonisation in New Zealand have led to the breakdown of social and traditional whānau based structures evidenced by the loss of land, language, beliefs and identity” (p.371). The effects of the breakdown of this extended family structure have been explored earlier in the chapter.

The whānau unit can be a powerful source of health, support, and wellbeing, particularly during the times of adversity (Elder, 2017). Efforts need to be made to harness this ability of whānau by facilitating whānau support in the health care system, and also encouraging the development of kaupapa-related whānau so hubs of support for those facing similar situations have access to a whānau support that can restore health and wellbeing.

**4.3.6 Kaupapa**

This principle encompasses the ideas of a collective vision and commitment (Pihama, Cram & Walker, 2002). The literal translation of kaupapa is a task or a plan (Smith, L.T., 1999). This research project has the kaupapa of addressing the evident disparities between Māori and non-Māori infants and allowing for enhanced whānau wellbeing. As Helen Moewaka Barnes and colleagues (2013) explains, “Māori women have a higher prevalence of maternal risk factors compared to other women, and therefore have greater maternity needs” (p. 8). While this is true, Māori women continually face barriers that prohibits their access to maternity health care. These disparities “are unjust, unethical, costly and unacceptable- and integrating strategies
to achieve equity as part of the transformation of our healthcare system will give us an incredible opportunity to comprehensively address them” (Betancourt et al., 2014, p. 144).

4.4 Chapter Summary

This draws the chapter to an end, and also Wāhanga Tuatahi. The personal journey I have shared has outlined my whakapapa and passion that drives this PhD research project. Te Whare Tangata me Whakawhānau chapter has outlined the literature and mātauranga that surrounds Māori maternities and whakawhānau. Of particular importance is the role of atua wāhine and Māori cosmogony because those shape the tikanga and practices adhered to in Māori maternities. These various knowledge streams have been silenced through colonisation, so it was the aim of this chapter to bring voice back to mātauranga Māori maternities and whakawhānau.

Wāhanga Tuarua follows and within that sits Chapter 5, Tukunga Rangahau. The purpose of this chapter is to explain the methodology and methods that were employed in the research project.
This whakataukī speaks of the ability to use the skills and abilities one has to bring about success. As I have progressed through my PhD journey, I have been taught valuable skills and abilities by whānau, kuia, koroua, kaumātua, health care practitioners, and other researchers. These skills and abilities have been applied in this research project and will be shared in this wāhanga.

This wāhanga covers the methodology and theoretical understandings that frame this research. It also outlines the research method of kanohi-ki-te-kanohi kōrero that was employed.

Chapter 5 – Te Tukunga Rangahau
Chapter 5: Te Tukunga Rangahau

The aim of this research is to understand the lived realities of whānau following the harm or loss of their baby. Exploring whānau experiences will help to identify (and enhance) the facilitators of access to the maternal-infant healthcare system for Māori whānau, and expand mātauranga Māori surrounding the concepts of childbirth, whakapapa, whānau healing processes, health and wellbeing. This research was conducted within a Kaupapa Māori Research paradigm. The foundations of Kaupapa Māori research lie in the political struggles that leading Māori academics engaged in to develop and enable a culturally informed space to investigate Māori issues using a Māori lens, and grounded in a Māori worldview (Mead, 1996; Smith, G.H, 2002; Smith, L.T, 2006; Pihama, 2001; Smith & Reid, 2000; Henry & Pene; 2001; Glover, 1997; Cram et al., 2015). Kaupapa Māori acknowledges that Māori research has a different ontological (what is viewed as reality) and epistemological (theory of knowledge) foundation than non-Māori research paradigms. This decolonising space has provided the opportunity for Māori research undertaken by, with and for Māori. It has also placed a responsibility on contemporary Māori researchers to carry forward the work done by foundational researchers and continue the development of Kaupapa Māori theory and research practice. As such, Kaupapa Māori does not necessarily instruct researchers about what methodology and methods should be employed in an inquiry. Rather it encourages researchers to engage with Kaupapa Māori and develop specific methodology and methods that are applicable to the given research kaupapa (Cram, Kennedy, Paipa & Wehipeihana, 2015). This may be seen by some as a limitation of Kaupapa Māori; however, I view it as an embodied strength as it recognises the diversity of Māori kaupapa and Māori people.

The decision for this project to be framed within a Kaupapa Māori research paradigm was a natural step for me, as it ensured the project promoted the aspirations of whānau who have experienced the harm or loss of their baby by placing their needs and voice at the center, while also allowing for a collaborative and reciprocal approach to research. Methods that were tika (true) to the research kaupapa and paradigm were employed in the research project to address the research aims and question. These methods were chosen following a consultation journey undertaken at the commencement of the study that sought advice and guidance from kuia, kaumātua, Māori midwives, and Māori health research experts.

Kaupapa Māori research will be outlined in this chapter, tracing its evolution and explaining the axiological, ontological, epistemological, and methodological assumptions that underpin it. Sitting within Kaupapa Māori research are a set of
community-up research practices to help guide and inform researchers. These will also be outlined and it will be explained how the methodology and methods employed in this project extended from these. Following that, the chosen method for data collection will be described. Detail will also be provided regarding the data analysis, whereby Interpretational Phenomenological Analysis (IPA) was utilised alongside Kaupapa Māori.

5.1 Kaupapa Māori Research

Prior to the 1970s-1980s, the political context of Aotearoa New Zealand was hostile for Māori. The Māori voice and requests were repeatedly ignored and pushed aside, causing the Māori population to suffer the consequences of marginalisation (Mutu, 2010). This was also the time where almost all research on Māori was conducted by non-Māori researchers. Unfortunately, this further marginalised Māori because the research was commonly undertaken on Māori communities rather than for or with them. As Fiona Cram et al (2015) explains,

Research practices with Māori have not always been adept at representing their lived realities...instead representations have often been, for example, based on the stereotyped understandings of the evaluators, and the deficit-based views held of the indigenous peoples by the dominant culture (p. 4).

The results of such research were “used to define and further malign Māori politically, spiritually, culturally, economically and socially” (Edwards, McManus & McCreanor, 2005, p. 89). Similar impacts are reverberated throughout other indigenous cultures (Cidro, Maar, Peressini, Schroth, Broughtonm Jamieson & Lawrence, 2017; Lawrence, Cidro, Issac-Mann, Peressini, Maar, Schroth & Jamieson, 2016).

Accordingly, we can argue that research played a role in facilitating colonisation through two means. Firstly, non-Māori interpreted Māori realities within their own worldview, which resulted in deficit-based research that labeled Māori as being a problematic population that needed corrective solutions imposed upon them (Ormond, Cram & Carter, 2012; Foley, 2003). These interpretations were often left unquestioned because “European researchers determined whose knowledge is and what was [considered] legitimate...the result was that indigenous knowledge was seen as inferior” (Foley, 2003, p. 44). In this way, colonial researchers were considered experts even though they had misrepresented, displaced, and misconstrued Māori cultural practices, their lived experiences, and the meanings behind those experiences (Bishop, 1999; Mikaere, 2017).
Secondly, research was used to justify the theft of Māori land, the suppression of Māori culture and language, and the marginalisation of Māori (Cram & Phillips, 2012). These poor research practices inevitably caused Māori to hold a negative stance towards research and researchers. Consequently, Māori communities were discouraged from being involved in research, thereby further disadvantaging themselves because they were unable to express their views and opinions throughout the development of policies and services. Without input into policies and services, especially regarding healthcare, the wellbeing of Māori is compromised because policies and services that shape the health care system become culturally inappropriate and inaccessible (Port et al., 2008).

Indigenous populations across the globe can relate to these poor research experiences. For example, the Inuit have felt a lack of engagement, involvement and data sharing when researchers have come into their community to research them (Okalik, 2013). The impact of poor research practices is linked with poor health outcomes for indigenous peoples. As explained, “colonialism had a detrimental impact on the health of Aboriginal peoples by producing a range of social, political and economic inequalities” (Lawrence et al., 2016, p. 180). During my research journey, the Director of Center of Aboriginal Health Research, Dr. Josée Lavoie, invited me to visit and work alongside some of the aboriginal communities residing in Manitoba, Canada. This was an eye-opening opportunity and I was able to witness first-hand the similar challenges faced by First Nations and Métis populations as by Māori. ‘Solutions’ to an indigenous community’s poor health care continues to be provided through government-led initiatives that often lack input from the communities themselves, rendering the ‘solutions’ to be largely inappropriate and inaccessible.

Today, there is an increasing number of Māori whānau and communities becoming aware of the benefits of culturally responsive research and are determined to increase their tino rangatiratanga in key decisions regarding their health and wellbeing by engaging with appropriate researchers (Edwards et al., 2005; Cram et al., 2015; Elder, 2017). The same can be said with the Canadian indigenous populations (Lavoie, Forget, Prakash, Dahl, Martens & O’Neil, 2010; Okalik, 2013; Cidro et al, 2017). The drive by indigenous communities to participate in and deliver culturally responsive research is beneficial because they are better equipped to impose their tino rangatiratanga (self-determination) with regards to key decisions concerning their health and wellbeing (Edwards et al., 2005). In many instances, indigenous methodologies have been recognised and utilised as the most appropriate research tools (Cidro et al., 2017, p. 2). In Aotearoa New Zealand, the drive for tino rangatiratanga in research has led to the development of research frameworks and
practices that guide researchers to work with and for Māori communities (Cram, 2001; Lawton et al., 2013; Simmonds, 2014; Thompson, 2009; Pihama, 2012; Lee, 2009). Kaupapa Māori research is an example of how tino rangatiratanga is being expressed in the research context because it is “based upon and informed by mātauranga Māori that provides a cultural template, a philosophy that asserts that the theoretical framework being employed is culturally defined and determined” (Pihama, 2010, p. 6). Other indigenous research frameworks have also been developed worldwide, such as a southern African ethical framework named Ubuntu, and the Medicine Wheel framework as derived by a Cherokee woman (Chilisa, 2012). These developments signal that indigenous communities are increasingly being invited to participate in culturally responsive research. It also signals that the research capacity of indigenous people’s is being built so that communities can engage in research with their own people being the researchers. These frameworks may be viewed as an expression of indigenous tino rangatiratanga (self-determination/authority) through the communities actively re-claiming research contexts and decision making processes concerning their health and wellbeing (Edwards, McManus, & McCreanor, 2005).

Kaupapa Māori research is a Māori response to deficit-based knowledge seeking practices that continue to dominate research. A Kaupapa Māori research paradigm prioritises Māori ways of knowing and doing as valid and legitimate, dismisses victim blaming, and seeks to intervene at structural levels to improve the health and wellbeing of Māori whānau (Pihama, Cram, & Walker, 2002). The foundations of Kaupapa Māori research are inherently political because the paradigm has been derived from the struggle for tino rangatiratanga and mana motuhake (Pihama, 2012). The overall aim of Kaupapa Māori is to conduct research that upholds the mana of Māori during the research process, in the reporting of findings, and in the advocacy for Māori that follows on from the research. Kaupapa Māori research “embraces traditional [Māori] beliefs and ethics, while incorporating contemporary resistance strategies that embody the drive for tino rangatiratanga for Māori people” (Henry & Pene, 2001, p. 237). Kaupapa Māori research therefore acts as a resistance to Western research and critiques the dominant hegemony of it. As Leonie Pihama (2012) outlines, given the diverse cultures and worldviews there needs to be a range of theories developed from these diverse knowledges and ways of understanding in order to explain the world and experiences from various vantage points. Kaupapa Māori encompasses the idea of Māori for Māori by Māori and challenges the structures and philosophies of mainstream organisations because Māori are no longer classed as the ‘other’ (Smith, 2006; Pihama, Cram & Walker, 2002). By no longer classing Māori as the ‘other’, Kaupapa Māori research also has a decolonising aspect whereby
“it is about re-occupying previously colonised space so that Māori can be heard, can be seen, can act and can be valued” (Cram & Phillips, 2012, p. 37). Therefore, Kaupapa Māori aims to retrieve space for the Māori voice and perspectives to be heard and to legitimise Māori theories, realities and knowledge (Cram, 2006; Henry & Pene, 2001). It also drives the argument that Māori have the right to theorise because research and theories do not belong entirely to the colonisers (Pihama, 2012).

Kaupapa Māori research has also become more influential on the basis that it is increasingly used as a framework for Māori scholars carrying out research. Linda Smith (1999) describes Kaupapa Māori research as setting out to make a positive difference for Māori, as well as being active in building the research capacity of Māori. Kaupapa Māori research “acknowledge[s] and accommodate[s] Māori ways of being within an approach that remains academically rigorous” (Mahuika, 2008, p. 4). With respect to the latter point above, Kaupapa Māori is about more than providing a legitimate academic space, “its impetus is to create the moral and ethical conditions and outcomes which allow Māori to assert greater cultural, political, social, emotional and spiritual control over their own lives” (Smith, G.H., 2002, p. 456). Therefore, not only is Kaupapa Māori an academic framework, it is also a way of living for Māori. Kaupapa Māori research attempts to give support to how Māori live their everyday lives. This is because Māori individuals with a strong and ingrained cultural identity act out their cultural values and practices throughout their daily activities without too much conscious thought; yet, these Māori practices and ways of doing are challenged regularly within the dominant non-Māori societal context in which they operate (Smith, G.H., 2002). Kaupapa Māori research aims to support Māori practices and knowledge in an attempt to gain wider societal support and acceptance.

This research project was undertaken within a Kaupapa Māori research paradigm and prioritised Māori ways of knowing and doing as valid and legitimate. Kaupapa Māori Research was specifically chosen as the research paradigm for this project “in order to avoid the binary trap of Western epistemologies that either challenged the knowledge of parents or whānau or approached this knowledge from a compliance driven medical model framework” (Jones, Ingham, Davies & Cram, 2010, p. 3). I wanted to provide a space for whānau to have a voice and share their experiences. To enable this space, Kaupapa Māori holds unique theoretical foundations because it is grounded in Māori worldview(s). Māori worldviews shape Māori understandings, values, practices and is continually informing the culture (Marsden, 2003).

Another aspect of Kaupapa Māori research is that the paradigm is not set; it is a fluid and flexible framework that allows for continual evolvement (Pihama, 2012).
While there is extensive documentation regarding the theoretical underpinnings of Kaupapa Māori, this does not necessarily instruct researchers what methodology and methods should be employed to do an investigation. It is encouraged that researchers engage with Kaupapa Māori and develop specific methodology and methods that are applicable to the given research kaupapa (Cram, Kennedy, Paipa & Wehipeihana, 2015). During the stage of the project where I was determining the methodological path I would take for inquiry, I was required to engage in purposeful reflection. It was within that period of reflection that I found it was necessary to embark on a journey of consultation, facilitated by the Māori ontological principles of whanaungatanga (relating to one another) and whakapapa (genealogy). It was determined that the purpose of the consultation journey was to gain the advice and guidance I needed to develop the appropriate methodology and methods to undertake Kaupapa Māori research on the lived realities of whānau following their experiences of the harm or loss of their baby. This was necessary because determining the methodology and method through exploring literature alone was deemed inadequate. This next section explores the process undertaken to develop this methodology.

5.2 Developing the Kaupapa Māori methodology

Methodology refers to the process of enquiry in knowledge production, describing how the research will or should proceed (Milne, 2005; Porsanger, 2004). Kaupapa Māori methodological choices are influenced by the epistemological, axiological and ontological assumptions underpinning the framework. Māori practices are epistemologically validated within the Māori cultural context and so too are Kaupapa Māori research practices. In this sense, Kaupapa Māori “represents a way of doing based on a way of knowing” (Macfarlane, 2013, p. 135). This is because Kaupapa Māori research has rules, processes and frameworks that have been established as taonga tuku iho, protected and maintained (Bishop, 1999).

There are fundamental differences between Māori and non-Māori methodologies, where non-Māori “approaches to enquiry and knowledge production involve inductive methodologies…conversely, Māori approaches to enquiry and knowledge production usually involve looking outwards, developing relationships and connections” (Milne, 2005, p. 8). A Western research approach “is more of a fact-finding approach, whereas to Indigenous researchers, it is key to preserve and include cultural and traditional knowledge” (Okalik, 2013, p. 246). The emergence of Kaupapa Māori research has encouraged new ways of thinking about research practices.
In developing the appropriate methodology for this project, I needed to understand how to engage with whānau participants in a culturally responsive way that would ensure the safety of all involved in the research project. As methodology is one component of a Kaupapa Māori inquiry paradigm (Cram, Kennedy, Paipa, Pipi & Wehipeihana, 2015), I first explore the other components of this paradigm and their implications for my consultation journey to develop a methodology. These components are: axiology (the nature of ethics), ontology (the nature of reality), and epistemology (the nature of knowing).

5.3 Axiological assumptions of a Kaupapa Māori inquiry paradigm

Cram and Mertens (2016) explain, “axiology concerns the ethics we bring to our evaluation practice...the range of possible assumptions underlying ontology, epistemology and methodology is constrained by the paradigm’s axiological assumptions” (p. 10). Axiological assumptions ground the paradigm and inform critical decisions regarding why, how, when and where the research is undertaken.

Kaupapa Māori axiological assumptions tend to be founded on whanaungatanga, particularly between tangata, the spiritual world, and the environment (Henry & Pene, 2001). This research adds empowering mātauranga Māori and placing whānau at the center of the project to these axiological assumptions.

Linda Smith (1999) and Fiona Cram (2001) have developed a set of seven community-up research practices that assist and guide researchers engagement Māori communities: Aroha ki te tangata: a respect for people; He kanohi kitea: the importance of the seen face; Titiro, whakarongo...kōrero: looking and listening before speaking; Manaaki ki te tangata: sharing, hosting and being generous; Kia tūpato: being careful; Kaua e takahia te mana o te tangata: being aware to not trample on the mana of others; Kia māhaki: being humble (Cram, 2001; Lawton et al., 2013; L. Smith, 1999; L. T. Smith, 2006). This ethical guideline is well regarded within Kaupapa Māori as it ensures the mana of all research stakeholders are upheld. Essentially, the values “set an engagement context in which researchers are called upon to respect one another, share and listen, be cautious and humble, acknowledge ontological and epistemological differences, and build commitment to the development of mutual understandings” (Cram & Phillips, 2012, p. 36). The following section illustrates how the practices had a role in guiding my ethical considerations.
### 5.3.1 Aroha ki te tangata

This cultural value is about having respect for people, and part of that respect is about allowing people to meet in their own space and on their own terms (Cram, 2001; Cram & Phillips, 2012). This practice means that we as Māori researchers “are mindful and respectful of the individual or group we are engaged with at all times…it means that we bring a deliberate compassion to the situation and view others as complete persons, with the accompanying recognition of their wairua” (Kennedy, Cram, Paipa, Pipi & Baker, 2015, p. 92). Language is also key as often experiences can only be shared in te reo Māori (Māori language) and not translatable to English. Aroha ki te tangata was practiced throughout this project through the following means:

- Being guided by kuia and kaumātua throughout the entire project.
- Involving kuia and kaumātua and key experts from the areas of research.
- Following tikanga Māori at meetings and interviews. Tikanga that was followed in these hui and interviews included opening and closing with karakia, having a mihimihi (informal welcoming with introduction of who and where I am from), whakawhanaunga (relationship building) with each hui and/or interview, and welcoming all participation in the kōrero.
- Visiting whānau and key informants in their chosen space.
- Giving whānau the option of having their interview in te reo Māori.

### 5.3.2 He kanohi kitea

He kanohi kitea is about the importance of the seen face; therefore it promotes face-to-face communication and researchers being known to the community. This was beneficial for this project because it allowed for whanaungatanga and positive relationship building. Kana & Tanatea (2006) explain the importance of He kanohi kitea by stipulating that “the continued returning to the region, the shared stories, the sustained relationships, the continued revisiting and retelling of the stories occur because of the presence of particular faces” (p. 15). He kanohi kitea was practiced throughout this project as follows:

- Interviewing whānau, stakeholders, and kuia in their own place.
- Acknowledging the importance of building and sustaining relationships with the wāhine and key informants.
- Being committed to sustaining the relationships I had developed beyond the duration of the project.
5.3.3 Titiro, whakarongo...kōrero

This practice involves the researcher looking and listening intently before speaking (if there is a need to). This is an important process because it allows the researcher to understand the situation and find a place where they can speak from that is both meaningful and appropriate (Cram, 2001). It was applied throughout the project as follows:

- A hui with key informants was held where I listened to their advice and guidance. Following that I carried out their suggestions and recommendations by developing the research methodology and methods most appropriate for this project.
- Continuously seeking input from key informants, whānau, and experts within the field to learn how to deal with sensitive research, how to work with whānau, and how to carry out research processes in a culturally safe and appropriate manner.

5.3.4 Manaaki ki te tangata

This practice is about the care and support for group members. Manaaki ki te tangata also includes creating a safe environment when there are diverse knowledge systems and ways of doing within the group (Cram & Phillips, 2012). I carried out this practice throughout the project as expressed below:

- Inviting key informants to visit Wellington for hui and related project events.
- Providing flights, accommodation and kai for those who travelled to be involved with any hui I held.
- Opening and closing hui with karakia to allow for a safe space and allowing everyone to have a voice in the hui.

5.3.5 Kia tūpato

Kia tūpato translates to mean be careful. This practice encompasses this meaning and is about ensuring cultural safety by being careful. Being careful means being politically astute, culturally safe and reflective about our status as an insider/outsider during the research journey (Cram & Phillips, 2012). These three characteristics of being careful allow researchers to be considerate in thoughts, word and action (Cram & Phillips, 2012). It was an important practice to work through tensions or confusion in a manner that kept everyone involved safe and comfortable. This was how I ensured I was cautious throughout the entirety of the project:
• Gaining appropriate permissions for the research, particularly Māori consultation and ethical approval.
• Establishing a research advisory group that included kuia, koroua, Māori research academics, and health experts.
• Managing project expectations under the guidance of supervisors and advisory group.
• Being guided by kaumātua (elders) to ensure the project was tika. This was ensured by always checking with the kaumātua that I was carrying out research processes that were culturally appropriate and safe for all involved.

5.3.6 Kaua e takahia te mana o te tangata

This practice means to not trample on the mana or dignity of a person (Cram, 2001). I paid heightened attention to this practice as it is deeply disrespectful within te ao Māori to belittle an individual’s, or whānau, mana. Processes I undertook to ensure this practice were as follows:
• Liaising with other Māori researchers who are experts in dealing with Māori sensitive research. I was able to do this by attending numerous conferences and following opportunities that allowed me to meet these Māori researchers and have kōrero with them.
• Following the advice of kuia and kaumātua to ensure tikanga Māori was followed in meetings and interviews.

5.3.7 Kia māhaki

This practice means to be humble. It is important to remain humble so that one may acknowledge the limitations of their understandings, while also being open to share what knowledge they do have with others (Cram & Phillips, 2012). I remained humble throughout the project by the following means:
• Requesting advice and guidance from supervisors and key informants.
• Accepting invitations to talk to stakeholder groups about the project.
• Being committed to ongoing engagement with key informants and Māori health stakeholders.

These community-up principles provided me the ethical guidance I required and informed my own research methodology throughout this PhD journey.
5.4 Ontological assumptions of a Kaupapa Māori inquiry paradigm

Ontology is the philosophical study of the nature of reality (Cram & Mertens, 2016). The axiological assumptions inform what is considered real in te ao Māori because the ethical assumptions we hold prescribes how we interact with one another and our surroundings (Mertens, 2012). Therefore they reflect how people understand or view their reality. The nature of reality for Māori is relationships and whakapapa, and Māori engaging in respectful ways that builds and sustains relationships reflects this. This is known because of the creation narratives that are portrayed within the Māori worldview. Based upon creation narratives, the Māori worldview is “the corporate view that Māori hold about ultimate reality and meaning” (Marsden, 2003, p. 3). Māori worldviews are unique to Māori and is what the values, beliefs, customs and practices of Māori are based upon. There are many creation narratives that contribute towards our understandings of Māori maternities, some of which have been shared in the previous chapter. This diversity within te ao Māori creates the necessity of Kaupapa Māori to be diverse like the people within te ao Māori so it is accessible and available to all (Pihama, Cram & Walker, 2002). Consistent within each worldview though is that Te Ao Māori, the Māori world, is based on whakapapa (Jones, Ingham, Cram, Dean & Davies, 2013).

The ontological assumption of Kaupapa Māori research aligns with the Māori worldview whereby it acknowledges the world is “kinship relationships - whanaungatanga- that include genealogical or whakapapa connections with the natural environment and the spirit world” (Cram & Mertens, 2016, p. 15). The whakapapa connections are made explicit with pepeha.

Pepeha are “identity axioms linking land and people into a whole in such a way that make them inseparable” (Murton, 2012, p. 87). At the beginning of the thesis, I provided my pepeha to show my connection with my ancestral places. Kirimatao Paipa (2010) also described pepeha as being a tool used as part of a Māori global positioning system because it anchors Māori to significant sites they occupy or are connected to. Pepeha are also particularly important for identifying relationships with Papatūānuku (Kana & Tamatea, 2006), as they are an explicit expression of whakapapa.

These ontological assumptions of Kaupapa Māori illustrate the complexity of the Māori interpretations of reality because Māori ontology portrays the notion that what is real is not necessarily visible (Cram & Mertens, 2016). This is a direct contrast to non-Māori ontologies that often portray reality being linked only to tangible things.
5.5 Epistemological Assumptions of Kaupapa Māori Research

Kaupapa Māori research is “highly complex, reflecting the nature of Māori thought and being” (Edwards, 2009, p14). It covers distinctive thoughts over a vast range of social, spiritual, physical and interpersonal spectrums. Epistemologies refer to “those things that are considered the essential principles of knowing and being for those within a culture, and that provide the bedrock of theory and practice” (Edwards, 2009, p15). Māori epistemologies are applied by many Māori in their everyday lives and provide guidance on how to understand reality in their world (Edwards, 2009). Interestingly, within the Māori culture, the epistemological and ontological assumptions are similar. By this it is meant that how Māori understand their ways of knowing and ways of being are alike. Marsden (2003) explains that the reason for this similarity is because epistemology and ontology are connected by whakapapa within a distinct Māori worldview.

Whakapapa is the continuous process of placing layers upon one another. The layers are built upon Papatūānuku, the past, and build towards the now and future. Within these layers are taonga tuku iho expressed by tikanga, kawa, mātauranga that all connect with each other, including the land and tūpuna (Swann, Swann & Crockett, 2017). This shows how all living beings in te ao Māori are considered to trace back to our Earth Mother, Papatūānuku, and this is reflected in the name whakapapa (Marsden, 2003).

Whakapapa is the common thread that binds whānau, hapū and iwi together, and “whakapapa knowledge is the unbound collection of theory, observation and experience as seen through Māori eyes” (Edwards, 2009, p. 1). Kaupapa Māori epistemologies (i.e., theories of knowledge) view the world “as one of connectedness and relationships between Māori, the natural world, and the universe” (Cram & Mertens, 2016, p. 17). Whakapapa links these three realms as it connects us to everything, including people, all living things, and also the environment (Jackson, 2011; Marsden, 2003). Understanding the role of whakapapa and how it operates in its many levels, contributes towards knowing how to work with whānau and how to act as researchers (Jahnke & Gillies, 2012).

Nepe (1991) elaborates and claims that Kaupapa Māori is “a body of knowledge that has distinct epistemological and metaphysical foundations, which date back to the beginning of time and the creation of the universe” (as cited in Mahuika, 2008, p. 2). The epistemology of Māori knowledge is founded on Māori creation narratives that have been passed on for generations by our tūpuna and “are an integral part of the corpus of fundamental knowledge...of the Māori” (Marsden, 2003, p. 55). It
is for this reason that Māori knowledge should not be confused for being Pākehā knowledge that has been translated to Māori. Mātauranga Māori “validates the Māori worldview and is owned and controlled by Māori through te reo Māori” (Pihama, Cram & Walker, 2002, p. 36). Mātauranga Māori provides a distinct Māori epistemology and way of knowing and draws upon a range of both verbal and non-verbal forms for its expression” (Pihama, 2012, p. 7).

As a result of being grounded upon distinct Māori cultural foundations, the Kaupapa Māori inquiry paradigm shapes the questions we ask and the ways we seek to answer those questions (Smith, L.T., 1999). It has opened a space where Māori resist the colonial dominance of Western academy and instead “re-asserts their own range of literacies in the modern world as the basis for fulfilling Māori aspirations…and to reclaim the legitimacy of their own traditional spaces” (Barrett, 2013, p. 224).

5.6 Consultation to inform Research Methodology

Consultation with key informants was the path chosen to develop the research methodology because speaking with elders and experts is how I seek knowledge and guidance in my everyday life. Therefore, sourcing advice and guidance about developing a sensitive Kaupapa Māori research methodology from repositories of knowledge was a natural choice. Guided by the principles of whakapapa and whakawhanaunga, the journey of consultation began. Having whakapapa links with many of the key informants of this study assisted with entry processes and initiated the consultation journey. Where I did not have a whakapapa connection, I held a kaupapa connection with the key informants whereby we held the same vision and goal of wanting to explore whānau journeys, utilising Kaupapa Māori and mātauranga Māori, so we can contribute towards creating better experiences and health outcomes for whānau. We bonded through this collective aspiration, triggering whanaungatanga further. Whakapapa therefore facilitated entry into pre-existing relationships, as well as allowing the opportunity to meet others who have similar research goals and aspirations. These whakapapa and kaupapa connections also held me accountable to ensuring the key informants and wāhine and their whānau were kept safe and central to the research project. Adding to that, the use of ‘I’ in this thesis carries these whakapapa and kaupapa connections I held with the key informants. I use ‘I’ in this thesis because I must take accountability for the research and writing up of the work, yet I carry and use it from a position that has been nurtured and informed from the consultation journey and the aspirations shared by the key informants, wāhine and whānau.
On my journey whakawhanaunga was established prior to any consultation with key informants. Whakawhanaunga is the act of building relationships with others. It is commonly portrayed as being whakawhanaungatanga, but I have been taught that this is an incorrect term. If we break the word down, we can see how it is incorrect to add the -tanga suffix. The prefix whaka- is used to mean causation, and whanaunga is a core Māori construct and “…can be seen as the process of engagement through which relationships, connections, obligations and responsibilities are strengthened” (Macfarlane, 2013, p. 143). Whakawhanaunga is therefore the act of building and engaging in meaningful relationships. The practice “of actively building and maintaining relationships emanates from and embraces whakapapa” (Jahnke & Gillies, 2012, p. 502) because it allows for the continuation of the foundation that our relationships derive and are built upon. Once the relationship is created, it is known as whanaungatanga. This is an unquantifiable measure as whanaungatanga is the flourishing of energies and comes about when we are comfortable with each other and within the space together. Therefore, to say whakawhanaungatanga is incorrect because the word pre-determines the outcome of the interactions between people and space. In other words, it eliminates the process of relationship building to find the shift in energy that allows us to be comfortable with one another (personal communication, Tukaha Milne, 2018). Whakawhanaunga was essential during the consultation journey because once relationships had been established; it opened a space for mātauranga, including their experiences, knowledge and advice, to be freely shared. Whakawhanaunga guided the process of establishing ground rules of talking and working alongside the key informants, as it would later do with whānau. The consultation journey began with the goal of learning how to approach and invite whānau who had a harmed baby to be part of the research (Stevenson, 2017).

The first consultation hui (meeting) was a small, focused hui with already established contacts, in July 2015. Present at this hui was a kuia (Māori elder woman), along with one Māori midwife and two Māori health research experts and practitioners. Discussions were based upon their mātauranga about maternal and child health, and their knowledge of the health care system. At this hui, the key informants were asked to consider the interface between their own knowledge and mainstream health care. These discussions enabled key informants to share with and learn from one another, and to build mutual understandings of how Māori knowledge systems might assist mainstream health care services to improve access and equitable outcomes for Māori women and their whānau.

Following this hui, I was granted permission by the key informants to contact further individuals who had expertise in this area. Having this permission enabled a
process of whanaungatanga to begin through mutual contacts, creating an opening for me to shoulder-tap key individuals. This process escalated progressively and rapidly as key individuals were continually recommended to me at each interview. As a result, I was able to connect with several Māori midwives, Māori health practitioners and Māori health researchers in the Wellington, Te Tai Tokerau, Te Moana-a-Toi and Southern regions. Following whanaungatanga when I met these key individuals kanohi-ki-te-kanohi (face-to-face) at hui or one-on-one, kōrero were held where they shared their experiences, advice and guidance. Consultation occurred with my whānau, four Māori midwives, three Māori health provider organisations, three kuia, one koroua (male elder), four Māori health researchers, and two Māori neonatal clinicians.

Another level of consultation I engaged in was a journey to find out more of my whānau, hapū and iwi mātauranga. This journey was recommended to me by one of the kuia for two main reasons. The first purpose was to learn the stories and knowledge held within my whānau, hapū and iwi. As a Māori midwife shared in one of the key informants' hui, “if you’re actually connected with your own whānau, hapū and iwi, that mātauranga is within them. There is no need to go outside of that because it is actually in there” (Personal communication, Joyce Croft, 2015). The second purpose was to keep my whānau informed of what I was doing in my work and to ensure I had their support during every step of this research process.

Embarking on this journey allowed me to gain a deeper understanding of the mātauranga Māori that is present in my whānau. My whānau journey also solidified my passion of wanting to carry out research in my home areas. I was supported by my supervisory team to follow this passion and explore whānau experiences from those whānau that whakapapa to Te Tai Tokerau and Te Moana-a-Toi because I whakapapa to these areas and consider them my tūrangawaewae (significant place of belonging through whakapapa and kinship). The literature also supports researching in areas where the researcher has whakapapa. Having such whakapapa ties allows “researchers to gain access to the shared vision and to initiate their individual research projects” (Kana & Tanatea, 2006, p. 13). The relationships I built and maintained with the key informants and participants helped initiate this project because I was provided with rich advice and guidance. Returning home to carry out the project and working alongside whānau allowed me the opportunity to fulfill my aspiration of contributing to ahi ka (keeping the home fires burning). This metaphor speaks of the importance of returning home to contribute towards strengthening the shared vision of improving whānau wellbeing.

Consultation with the key informants and my whānau was particularly important prior to interviewing whānau because these whānau interviews dealt with highly
sensitive information. If I had been ill equipped to encounter the raw emotions of whānau, I may inadvertently re-victimised and re-traumatised those I was interviewing (Connelly, 2003), and I may have been traumatised. Connelly (2003) explains that researchers should make every effort to engage in meaningful consultation throughout the research process. Although this is a time and resource dependent process, it is one I found highly necessary. This is also supported by Thompson (2009), who explains that “consultation is vitally important to any research involving the community and even more so with a Māori community” (p. 36). She goes on to say, “the purpose of consultation is to inform and consult with relevant communities, gain feedback on the proposed research, and to elicit support in undertaking this research in an ethically and culturally safe way” (Thompson, 2009, p. 36). Surrounding myself with kuia, kaumātua and experts within the field allowed me to safeguard myself while also gaining the advice I needed to deal with sensitive research, to approach whānau in these situations, to ask appropriate questions, and to mitigate situations where the whānau no longer felt comfortable and safe in an interview. The knowledge I gained from the all the consultations was recorded, collated, and reflected upon. As a result of synthesising all discussions held throughout the consultation process, the methodology, Te Pūkenga Mātauranga, for this project was developed.

5.7 Te Pūkenga Mātauranga: Research Methodology

The process of consultation with key informants and my whānau allowed for the development of a Kaupapa Māori research methodology that I named Te Pūkenga Mātauranga. Professor Meihana Durie suggested this name as it encompasses how the methodology has been developed from the expertise and skill of those I consulted with. Te Pūkenga Mātauranga was employed while engaging with whānau Māori following the harm or loss of their baby. There are five components to Te Pūkenga Mātauranga: whānau, wāhi haumaru, whakaaro, kaitiaki and hononga (see below for translations). Each component is described below – how it was developed and how it guided the research with whānau.
5.7.1 Whānau

The first methodology component is whānau. As a researcher, you must
Take your whānau with you; you can’t go out into the world and leave your
family behind… until you hold that whanau hui there is a shift in understanding
your place in that family, and them knowing where you are and what they have
actually put you out there to do. That’s really important, and it tells you that they
really care about what you are doing. Then you have the karakia with them and
away you go. (Personal communication, Whaea Moe Milne, 2015)

This component was prioritised because it was repeatedly articulated that
researchers must know who they are and where they come from before they can begin
even contemplating working with whānau. Self-knowledge provides a strong
foundation of wholeness and support that is essential when researchers are faced with
dealing with sensitive and often difficult subject matter. This component demonstrates
whakapapa being an ontological foundation of Kaupapa Māori research.

For my research project this component was realised by holding a small
whānau hui so I could share with friends and relatives what the research project
involved. This was an important step as it allowed me to keep my whānau informed of
my mahi (work) and in return I gained their support and advice. Whānau, especially
with grandparents, are a rich source of mātauranga Māori. Speaking with kaumātua
such as grandparents is enriching because they are often the repositories of
knowledge and are often recognised as being the mentors and guides who hold the
responsibility of intergenerational transfer of knowledge (Jahnke & Gillies, 2012). This
is particularly true for me as I am blessed to have had a nana who was an expert of
our whānau whakapapa (although she claims not to be), and who is open to sharing
that knowledge with me. I was also blessed with a karakia (prayer) from my nana to
protect me throughout this sensitive research journey.

5.7.2 Wāhi Haumaru

The second methodology component is wāhi haumaru, which can be translated
to mean a safe place. It entails being,

Upfront from the start. Even if it is your own whānau you are interviewing, you
still have to create a space, it’s all about being Māori. In a pōwhiri [welcoming
ceremony], what the pōwhiri is all about is that I see you, you see me, I see you
being safe to come into my presence and vice versa; so that’s the first part of
the pōwhiri. The second part of the pōwhiri process is here is the space that
you can put your kōrero [conversation] in to, and it’s a safe space. I’ll put in my
experiences and you put in your expectations and experiences and so on into that safe space. (Personal communication, Whaea Moe Milne, 2015)

This instruction shows how mātauranga Māori is harmonious in the way Māori think and act. The kuia shares how the cultural practice of pōwhiri provides a safe space for conversations to be freely shared, and how this should be followed as a research practice when interviewing with whānau.

To apply this component in my research project, I worked alongside the lead maternity carers (LMCs) that I had established relationships with to ensure wāhi haumaru for the whānau. I asked the LMCs to inform me when they had cared for a whānau who had experienced the harm or loss of their baby. The LMC would then approach the whānau, provide them with information of the project, and gauge their interest in participating. In this way, someone they already knew and trusted approached them first, thereby ensuring a safe space where the whānau could consider participating in the project without any outside pressures.

If the whānau were interested and happy to be involved with the research, the LMC would then pass on their contact details to me to make contact. From there we would arrange a meeting time that suited them and I would go visit and speak with them. The whānau were kept central throughout the whole process, and it was constantly reiterated that they had control over how and where the kōrero would take place. As such, there was no formal interview structure, rather the whānau was asked to share their kōrero the way they wanted to; the space was entirely theirs to share their story how they chose and saw fit.

5.7.3 Whakaaro

The third methodology component is whakaaro. This component is inclusive of the holistic worldview of Māori, expressing that “you need to look at the hinengaro [mental], tinana [physical], and wairua [spiritual]. It’s the three focus points and outlining that is like the whariki [mat/foundation]” (Personal communication, Wārihi Campbell, 2015). There are many spheres within the Māori worldview, and this is highlighted in the comment made by the koroua, where he acknowledges that the researcher should not focus solely on one aspect of health, but all dimensions of health and wellbeing concurrently.

Being steeped in Kaupapa Māori allowed the application of the whakaaro component, because the research project is grounded in te ao Māori and encapsulates the holistic Māori worldview. Often during kōrero, whānau would share how their experience impacted on their wairua and hinengaro. Having a methodology that
validates and normalises these dimensions was essential to ensuring that whānau were not silenced and enabled to speak about all aspects of their wellbeing.

5.7.4 Kaitiaki

The fourth methodology component kaitiaki speaks of the importance of being empathetic. It was advised,

You’ve got to have empathy because if you don’t have empathy you won’t hear the story, what you’ll hear is the sad tale and it’s quite soul destroying…so you have to learn to listen to the story with empathy so you end up doing the work listening with passion but you are not taking it away with you, because when people are telling you their story, it’s their chance to try to get over their grief themselves. (Personal communication, Whaea Moe Milne, 2015)

This component offers advice about how to protect everyone throughout the entire research project and ensuring researcher empathy. Being empathetic involves the ability to share the feelings of those sharing their kōrero and experiences. As this kuia articulates, the skill of empathy is complex because it involves the researcher listening carefully in order to understand the feelings expressed and experienced by the participants, while at the same time, protecting oneself from the transition of grief and trauma. Mastering this skill may be assisted through building trusting relationships with the research participants prior to listening to their kōrero as this may help the researcher know how to show empathy to those particular participant(s).

I was always cognisant of being empathetic when having kōrero with the whānau involved in my research project. This was done by letting them share their story without interrupting, and ensuring I was listening skillfully to the story being shared. Each whānau was different so showing empathy and support was offered in a way that was perceived as being appropriate for them. For example, some whānau wanted hugs, some felt most support when sharing kai, and others found support through me keeping my distance and just being there to listen. I also safeguarded myself throughout my entire project by seeking the support of my whānau and swimming in the ocean to let Tangaroa and Hinemoana take away my mamae (hurt) that I often felt after listening to the wāhine and whānau experiences and replenish my mauri (life force, energy).

5.7.5 Hononga

The fifth methodology component, hononga, is about the connections and relationships with people. As explained, “the other thing you will learn as a Māori
researcher, once you have the relationship with people, it doesn’t stop” (Personal communication, Areta Koopu, 2015). Similarly, “one of the words that I think is important is continuity” (Personal communication, Joyce Croft, 2015). Developing and maintaining relationships with research participants ensures that the work is collective, with the aim of producing reciprocal benefits for all parties involved, including researchers, participants, and their communities. Disrespecting these relationships by not providing research progress updates and feeding back information to the participants or checking in on them after the project is completed will repeat poor historical research practices.

For my research project, the relationships developed prior to and throughout the consultation process have been maintained by keeping in touch with the key informants and reporting back to them on the progress of the research project. The relationships gained with the wāhine and whānau involved in the research are also upheld by touching base with them regularly to keep them central to the research. I would regularly send a text message to the wāhine to provide updates of the research and to check on their and their baby’s health progress. I also visited the wāhine on occasions that I was home. Although I was not able to meet them all for follow up visits every time I was in my home areas, I was able to re-engage with the wāhine numerous times throughout the research project. It is a responsibility to maintain all relationships until the completion of and after the research project. Maintaining these relationships assists with ensuring the research carried out has reciprocal benefits for all involved because it holds the researcher accountable.

**5.7.6 Synthesis of Components**

Taking these five components, I developed a methodology of how research into this area might be carried out culturally responsively, with and for Māori (see Table 1).
Table 1.  
*Summary of methodological guidelines for undertaking culturally responsive Kaupapa Māori research*

<table>
<thead>
<tr>
<th>Methodology component</th>
<th>Description</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whānau</td>
<td>Have an awareness of your own whānau, whakapapa and heritage. Also, keep whānau informed of the research and mahi you are undertaking.</td>
<td>Hold whānau hui to share your work with them so you gain their advice, guidance and karakia.</td>
</tr>
<tr>
<td>Wāhi Haumaru</td>
<td>Create a safe space throughout the entire research, but particularly so in interviews.</td>
<td>Be honest and open to the research participants. Keep participants and their needs central to the project and interview so they may remain safe throughout the entire process. For this project utilising LMCs, who had already pre-established trusting relationships with the whānau, to recruit whānau to the project, created a safe space for whānau and myself.</td>
</tr>
<tr>
<td>Whakaaro</td>
<td>Be aware of all aspects of Māori health and wellbeing - it’s more than just having good physical health, it is about having balanced and good emotional, spiritual and mental health as well.</td>
<td>Before undertaking Māori health research, understand the Māori worldview and Māori views of health and wellbeing. This would be strengthened by employing a Māori-oriented research framework such as Kaupapa Māori.</td>
</tr>
<tr>
<td>Kaitiaki</td>
<td>Be empathetic in order to listen to the research participants fully and with respect. Listen with empathy to also provide protection from the transference of grief.</td>
<td>Listen with empathy, especially when the participant experienced great grief. Empathy will allow the participant to share their story and feel completely listened to, while also providing protection to all involved.</td>
</tr>
<tr>
<td>Hononga</td>
<td>Build, sustain and maintain all relationships throughout the research process.</td>
<td>Whakapapa and whanaungatanga will facilitate hononga.</td>
</tr>
</tbody>
</table>
My consultation journey resulted in a series of shared discussions that have informed the development of a methodological guide, embedded in mātauranga Māori that informs Kaupapa Māori research in this given context. This methodology has the potential to safeguard both researchers and participants while promoting research that potentially generates positive outcomes for Māori. Aspects of the methodology employed could be considered research methods as well. This is reflective once again of how everything in te ao Māori is interconnected. Similarly to how the Kaupapa Māori ontological, epistemological and axiological foundations are alike, the research methodology and methods in this project proved to be as well. For example, aspects of whakawhanaunga in the methodology also played a role in the research method of kanohi-ki-te-kanohi kōrero. The research method will be explored in the following section; first an explanation of how Interpretative Phenomenological Analysis also provided methodological guidance in this research project is outlined.

5.8 Research Method

A Kaupapa Māori research approach was adopted because Māori whānau are the core focus of this project; thereby it is a project that is “by Māori for Māori” (Pihama, Cram & Walker, 2002, p. 14). It was profoundly important to select research methods that are compatible with Kaupapa Māori so that the research kaupapa and mātauranga Māori were not comprised. The Kaupapa Māori methodology, Te Pūkenga Mātauranga, and IPA informed each method employed. As such, the research methods involved a subjective, qualitative approach to data collection and analysis. Marsden (1992) explains that

The route to Māoritanga through abstract interpretation is a dead end. The way can only lie through a passionate, subjective approach…the so-call objectivity some insist on is simply a form of arid abstraction, a model or a map. It is not the same thing as the taste of reality (p. 117)

It was this justification in conjunction with the advice and guidance I had received that assisted with selecting the following data collection method of kanohi-ki-te-kanohi kōrero. First, I explain the process undertaken to gain ethical consent.

5.8.1 Ethical consent process

Ethical approval for this research was obtained from the Northern B Health and Disability Ethics Committee (16/NTB/29). Northland DHB and Bay of Plenty DHB also approved locality in 2016. The process to gain ethical approval was taken seriously as I wanted this research to be carried out in a manner that empowered whānau and kept all stakeholders safe. The consultation journey informed how I applied for ethics as
they informed how to best carry out the research. Unlike most projects, I applied for locality ethics before national ethics. I found this was the most respectful way for the areas involved in my study. I first visited the Chief Medical Officer of Northland DHB and their kaumātua. In this hui, we discussed my proposed research project, covering what it involved and what it would mean for our people. I was granted locality approval following this hui. I also met with the Operational Manager of Kaitaia Hospital to advise her of my research intentions. She was very supportive of the research project and provided me access to hospital resources during my research. A few weeks later I visited Bay of Plenty DHB. Present at this hui was myself, my three supervisors, my kuia advisor, Māori health workers in Bay of Plenty DHB, and Bay of Plenty DHB Māori health leaders and managers. This was a special hui as I was able to reconnect with whānau through whakawhanaunga following the mihi whakatau. I presented my proposed research project again at this hui and gained valuable feedback and input. I was later granted locality approval following this hui. Once both localities were approved, I applied for national ethics through HDEC. National ethics was approved and my data collection of whānau kōrero could commence.

5.8.2. Recruitment of Wāhine and whānau

The guidance I received on my journey of consultation was synthesised to develop the research methodology, Te Pūkenga Mātauranga. This methodology informed how the whānau participants were recruited to the research journey. All key informants stressed the importance of approaching whānau in a safe, non-intrusive way. The lead maternity carers (LMCs) I had established relationships with informed me when they cared for a whānau who had experienced an adverse perinatal event. If the whānau were interested in being involved with the project, the LMC would pass their contact details on to me. From there I would contact the whānau, arrange a meeting time that suited, and then visit and speak with them.

5.8.3 Wāhine and whānau as ‘participants’

In total, ten wāhine and their whānau shared their journey with me. I have purposefully chosen not to name the wāhine and their whānau as research participants because we developed a strong relationship throughout this research journey and calling them participants sounded too detached. I firmly believe that they are experts in their own rights and do not need a research label to confirm their expertise.

Six wāhine were from Te Tai Tokerau, and 4 were from Te Moana-a Toi. There were various reasons why ten wāhine and whānau were recruited. Firstly, there was
the logistical aspect, whereby it took me a year and a half to recruit ten. If I had recruited more, there would have been limited time to analyse and report on the data. Secondly, the project dealt with sensitive information and I valued ensuring that I developed a trusting and meaningful relationship with all wāhine and whānau so that all were kept safe (including myself). Thirdly, IPA does not require data saturation to develop meanings as it concerns an in depth analysis of particular experiences (Brocki & Wearden, 2006).

Each wāhine and their whānau shared their kōrero with me over one interview styled kōrero that was recorded for analysis. I travelled to Te Tai Tokerau and Te Moana-a Toi to meet wāhine and their whānau for kōrero, and this process spanned 14 months. I have also followed up with all whānau participants throughout the research journey. The follow up kōrero were informal and not recorded. I found following up with the wāhine and whānau important as it gave me the opportunity to check that the transcripts of their kōrero were correct, check with them that the findings were verified, to always keep them updated with the research progress, and to check how they were. Table 2 below provides an overview of information that was relevant to the whakawhānau journey of each wahine. This table can be used as an aid to grasp important aspects of each whānau journey. Pseudonyms have been used to protect the anonymity of the wahine.
Table 2.
Overview of the whakawhānau journey and delivery outcome of each wahine

<table>
<thead>
<tr>
<th>Name</th>
<th>LMC</th>
<th>First pregnancy</th>
<th>Transferred from home</th>
<th>Distance away from home (by road)</th>
<th>Length of time away from home</th>
<th>Maternal outcome</th>
<th>Gestational age at delivery</th>
<th>Neonatal outcome</th>
<th>Admit to special care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kristen</td>
<td>Māori community midwife</td>
<td>No</td>
<td>Yes</td>
<td>4 hours</td>
<td>5 weeks</td>
<td>Polyhydramnios</td>
<td>30 weeks</td>
<td>Congenital anomalies</td>
<td>Yes, NICU</td>
</tr>
<tr>
<td>Justine</td>
<td>Community midwife</td>
<td>No</td>
<td>Yes</td>
<td>4 hours</td>
<td>2 days</td>
<td>Loss of blood</td>
<td>18 weeks</td>
<td>Neonatal death</td>
<td>-</td>
</tr>
<tr>
<td>Becky</td>
<td>Community midwife</td>
<td>Yes</td>
<td>Yes</td>
<td>2.5 hours</td>
<td>2 weeks</td>
<td>Post-term labour</td>
<td>41+5 weeks</td>
<td>Intrauterine hypoxia</td>
<td>Yes, SCBU, NICU, Yes, SCBU</td>
</tr>
<tr>
<td>Nadia</td>
<td>Community midwife</td>
<td>Yes</td>
<td>Yes</td>
<td>1 hour</td>
<td>4 weeks</td>
<td>Mastitis</td>
<td>38 weeks</td>
<td>SGA</td>
<td>Yes, NICU</td>
</tr>
<tr>
<td>Tahlia</td>
<td>Community midwife</td>
<td>No</td>
<td>Yes</td>
<td>2 hours</td>
<td>4 weeks</td>
<td>-</td>
<td>39 weeks</td>
<td>Seizures following delivery</td>
<td>Yes, SCBU, NICU, Yes, SCBU</td>
</tr>
<tr>
<td>Aroha</td>
<td>Māori community midwife</td>
<td>No</td>
<td>No</td>
<td>2 hours</td>
<td>1 day</td>
<td>Episiotomy</td>
<td>40 weeks</td>
<td>Intrauterine hypoxia</td>
<td>Yes, SCBU</td>
</tr>
<tr>
<td>Teina</td>
<td>Māori community midwife (2nd)</td>
<td>Yes</td>
<td>Yes</td>
<td>3 hours</td>
<td>4 weeks</td>
<td>EMCS</td>
<td>36 weeks</td>
<td>Preterm twins: SGA and respiratory difficulties</td>
<td>Yes, 2x SCBU</td>
</tr>
<tr>
<td>Ashton</td>
<td>Community midwife</td>
<td>Yes</td>
<td>Yes</td>
<td>2 hours</td>
<td>3 weeks</td>
<td>-</td>
<td>33 weeks</td>
<td>Preterm birth</td>
<td>Yes, SCBU</td>
</tr>
<tr>
<td>Ngahuia</td>
<td>Did not specify</td>
<td>No</td>
<td>Yes</td>
<td>5 hours (NICU 1), 2 hours (NICU 2)</td>
<td>6 weeks</td>
<td>-</td>
<td>34 weeks</td>
<td>Preterm birth</td>
<td>Yes, 2x NICU, Yes, NICU, SCBU</td>
</tr>
<tr>
<td>Waiata</td>
<td>DHB midwife</td>
<td>Yes</td>
<td>Yes</td>
<td>2 hours</td>
<td>3 weeks</td>
<td>-</td>
<td>33 weeks</td>
<td>Preterm birth</td>
<td>Yes, SCBU</td>
</tr>
</tbody>
</table>

12 SGA: Small for Gestational Age.
13 EMCS: Emergency Caesarean Section.
5.8.4 Kanohi-ki-te-kanohi kōrero method

The aim of the project was to explore the experiences of wāhine and their whānau who had a disrupted whakawhānau journey that resulted in the harm and/or loss of their baby. The research method employed to achieve this aim was a Kaupapa Māori-oriented style of interviewing called kanohi-ki-te-kanohi (face-to-face) kōrero.

The use of kanohi-ki-te-kanohi kōrero acknowledges Māori traditions and ways of being while also providing an avenue for the Māori voice to be heard (Cram, 2006). Kanohi-ki-te-kanohi kōrero is likened to interviewing as it allows the researcher access to the participants’ subjective understandings through questioning. This in turn facilitates the researcher to gain an understanding of the meanings and purposes behind the participants’ actions, behaviours and practices (Seidman, 1998). This style of interviewing also complies with the community-up research practice, He kanohi kitea (Cram, 2001). Kanohi-ki-te-kanohi is critical in research within Māori communities when one has to address an important issue because face-to-face contact allows for the participants to fully assess and evaluate whether or not they should become involved in the project (Cram & Pipi, 2000). Another key strength of this style of interviewing was that “we can come to understand the details of people’s experiences from their point of view” ...thereby helping lead to a “deeper understanding of the issues, structures, processes and policies that imbue participant’s stories” (Seidman, 1998, p. 112). In addition, Māori tend to exchange views and information through meeting face-to-face (Taurima & Cash, 2000). Meeting face-to-face with the wāhine participants and their whānau allowed for greater opportunities to build and maintain relationships and provide reassurance to them that I value their experiences and kōrero. Reinforcing this notion, “when we pay attention to language and to meanings, we invite whānau into making knowledge about their own lives” (Swann, Swann & Crocket, 2017, p. 42). Therefore, ensuring that the whānau voice is valued and heard.

Whakawhanaunga was utilised to build relationships with the wāhine and their whānau prior to meeting for kōrero. Whakawhanaunga is a core Māori construct and “…can be seen as the process of engagement through which relationships, connections, obligations and responsibilities are strengthened” (Macfarlane, 2013, p. 143). Bishop (1999) holds a similar stance, where he describes whakawhanaunga as being one of the most fundamental ideas within Māori culture, both as a value and social process. Therefore, whakawhanaunga refers to the importance of developing respectful and trusting relationships with the participants so that it engenders collective commitment between all involved with the research to sharing information and knowledge freely for the benefit of Māori wellbeing (Porsanger, 2004; Bishop, 1999;
Building relationships with the community involved in the given research project has also been found to be vitally important in other indigenous research too. As explained by Okalik (2013), an Inuit researcher, “community support is key to advancing the goals of the research because the community will knit the scope of the project to our daily lives or future aspirations…ensuring that the community is aware of the scope of the research is important for success” (p. 245). Once a comfortable and trusting relationship was developed between the wāhine, their whānau and myself, we would arrange a time to meet and engage in kanohi-ki-te-kanohi kōrero.

Within each kōrero interview, wāhine and their whānau were asked to tell their stories regarding the disruption to their whakawhānau journey that resulted in the harm or loss of their baby. The kōrero space was made free and safe to allow for the whānau to openly share their stories and experiences how they wanted to. Given that, it was constantly reiterated that they had control over how and where the kōrero would take place. It was important to allow wāhine and their whānau to have the opportunity to reflect upon and share their experiences how they saw fit because they are the experts of their lived experiences and hold significant knowledge that may be transformed into positive changes (Eruera, 2010). The use of kōrero allowed for this opportunity, while also acknowledging the “oral traditions of Māori and the significance of the rituals of the hui, the Māori communication process” (Wong, 2006, p. 47).

With consent from the wāhine and whānau, each kōrero was recorded. During the kōrero, my role as the researcher was to listen empathetically, and clarify or probe only where appropriate. As a result, a rich description of the event was built up, with wāhine and their whānau identifying significant points on their journey (e.g., a decision made, a person involved, etc.). These points were then explored in depth, through follow-up questions and inquiry, to understand their significance and the attributions whānau made about the direction (e.g., positive, negative) their journey took. Three of the ten wāhine spoke with me without the support of their whānau. The remaining seven had a range of two to five whānau members present, and they also contributed to the kōrero. Each kōrero ranged from one to three hours.

Following each kōrero interview, I followed-up with the wāhine for three main reasons. Firstly, to ensure they were in good health. Secondly, to check if the transcribed account of their kōrero was accurate. And thirdly, to keep them informed of the research progress. These follow-up meetings were informal and not recorded.

A summary of the kōrero process is provided in bullet-point format for ease of replicating in future research:
- Whakawhanaunga with those taking place in the kōrero to establish trust and comfort
- Meet with whānau in their place of choosing
- Go through information sheet and consent forms again to ensure all are willing to participate in the research. All whānau were aware of what the research consisted of because they had been introduced to it by their LMC prior to me contacting them (see section 5.8.1). Therefore going through the forms was to remind them and ensure they were willing to participate. Once the forms are signed, recording and karakia (if they wanted karakia) started.
- Open the kōrero by asking the whānau to share their whakawhānau journey however they see fit. I had no set interview questions because the research method was kanohi-ki-te-kanohi kōrero rather than a semi-structured interview. As such, some whānau began their journey from when they became pregnant, whereas others began from then their adversity began. I found this interesting as it indicated to me what they considered to be significant moments of their whakawhānau journey.
- My role in the kōrero was to primarily be the listener, and only probe when the whānau asked what else I wanted to know. When I was asked to offer such probes, the questions I asked were if they felt mātauranga Māori was present in their journey through the health care system, and what they found helpful during their journey.
- Once they had shared their journey with me, I turned off the recording and offered each whānau a koha to thank them for their time and generosity. I assured them that I would keep in contact and send back their transcripts so they could have the opportunity to change or delete anything they had shared with me.

5.9 Data Analysis

All ten interviews held with the wāhine and their whānau were transcribed verbatim following their kōrero. Once the transcripts were written, they were sent back to the wāhine to check that I had accurately recorded what they had shared. Once all transcripts were confirmed accurate by the wāhine and their whānau, data analysis began. The transcripts of each whānau journey were analysed to understand their experience of the maternal-infant health care pathway. IPA and Kaupapa Māori were employed as analytical tools. This section covers the analytical method and the process of its application in this project.
**5.9.1 Interpretive Phenomenological Analysis and Kaupapa Māori partnership**

Interpretative Phenomenological Analysis (IPA) was employed alongside Kaupapa Māori Research to uncover the meanings wāhine and whānau attributed to their experience and its subsequent impacts. IPA and Kaupapa Māori held differing, but complementary, roles which I took advantage of. IPA was used to provide an interpretative lens to describe the whānau experiences, and Kaupapa Māori was used to provide the interpretative lens that was grounded in the Māori worldview. Analysing through Kaupapa Māori also provided the critical lens that sought opportunities to reclaim tino rangatiratanga from the whānau experiences. The IPA and Kaupapa Māori analysis process allowed me, as a Māori researcher, to be immersed in the whānau experiences and data while continually working together with whānau.

As it has been described, Kaupapa Māori is open to the use of non-Māori inquiry tools, so long as they fit within the cultural understandings and ideologies of Kaupapa Māori (Jones, Ingham, et al., 2010). This is also true of IPA, whereby it is fluid in its approach to inquiry and analysis. This allows IPA to be open for adaptation and development rather than being a stagnant, fixed research methodology (Brocki & Wearden, 2006). Therefore, although IPA is not grounded within Kaupapa Māori, it was viewed as a hoa rangahau (suitable ‘friend’ of Kaupapa Māori research) because it aligned well with the cornerstones principles of Kaupapa Māori, those being tino rangatiratanga and whānau. IPA was also chosen as a hoa rangahau and additional analysis tool because, “phenomenology…has been used successfully with other indigenous peoples in the USA and Canada” (Jones, Ingham, Davies and Cram, 2010, p. 4); therefore IPA has proven success with indigenous research and may be used in this research project to complement Kaupapa Māori methodology. Lafarge, Mitchell and Fox (2013) used IPA in their research on women with pregnancy termination for foetal abnormality so it has been employed in a similar sensitive research area. Jones, Ingham, Davies and Cram (2010) used IPA to investigate whānau experiences of those who have tamariki with asthma. Pidduck (2016) applied IPA to explore tamariki understandings of hauora. The use of IPA in these Kaupapa Māori research projects indicate how IPA is a fitting and appropriate tool to inform inquiry and analysis with sensitive\(^{14}\) and Kaupapa Māori research projects.

The origin of IPA is based on the assumption that humans are not passive objects, but rather that they are active agents in interpreting and understanding their

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\(^{14}\) Research is deemed sensitive if it enquires about those who are considered marginalised and/or vulnerable. Māori are considered vulnerable on the virtue of being a minority and indigenous group (Jahnke & Gillies, 2012).
world by making sense of their experiences. This origin underlines the subjective nature of IPA. Abiding by this, IPA was developed because “meanings individuals ascribe to events are of central concern but are only accessible through an interpretative approach” (Biggerstaff & Thompson, 2005, p. 215). This project is phenomenological because it explored the experiences and lived realities of particular wāhine (and their whānau). Experience is a complex concept but, in this context, it can mean what happens when something occurs in one’s everyday life that has particular significance. IPA also “acknowledges the importance of the social and cultural context of the participants and demands that analysis pays attention to these contexts” (Jones, Ingham, et al., 2010, p. 4). The social and cultural context of this project is a Māori worldview. By acknowledging these contexts, IPA allows for the researcher to unpack the meanings behind the experiences by being aware of outside impacts that may or may not be influencing the experiences (Brocki & Wearden, 2006). This subjectivity is a strength of IPA because it allows me, as the researcher, to be engaged in the shared experiences to find meanings of those experiences. In this process I was able to bring my views and knowledge to the analysis. I found this fitting for Kaupapa Māori inquiry because it is not possible to interpret or understand what Māori knowledge systems, Māori culture and worldviews are through objective and abstract means; it is only possible through adopting a passionate and subjective approach (Marsden, 2003).

Another way IPA was found to align with Kaupapa Māori was that it has a collaborative approach to analysis because it encourages the participants’ involvement and feedback throughout the analysis process. This process is known as member-checking (Bond, Foley & Askew, 2016). This aligns with Kaupapa Māori methodology because it ensures the research is whānau centered and led because they have continual involvement and ownership of the research project. Kaupapa Māori focuses on generating solutions and aspirations from within Māori realities (Cram, 2010). IPA fits with this as it seeks to make meaning of one’s realities and experiences in their contexts. I found that being guided by Kaupapa Māori and IPA in this sense allowed a platform that centralised wāhine and their whānau (and their wellbeing).

IPA allows researchers to explore this process of meaning making by examining the accounts of people’s experiences (Brocki & Wearden, 2006). Smith, Flowers & Larkin’s (2009) explains, “when people are engaged with ‘an experience’ of something major in their lives, they begin to reflect on the significance of what is happening and IPA research aims to engage with these reflections” (p. 3). Thus, the analysis of their experiences was deeply rooted in their kōrero and the analysis of those narratives was done from a bottom-up rather than a top-down analytical approach. This bottom-up approach is suited for the exploration of complexities without
making (possibly ill-founded) assumptions before commencing the research as the latter approach can do (Brocki & Wearden, 2006). IPA has become increasingly used in health research because there has been a growing recognition of understanding patient experiences (Brocki & Wearden, 2006). IPA is also an appropriate analytical method to use when there are a small number of interviews, as it enables the researcher to access and interpret participants’ unique and shared experiences. The process of analysis is explained below.

### 5.9.2 Data analysis process

Analysis began with the reading and re-reading of transcribed kōrero interviews and describing the language used and emotions expressed during each kōrero. I logged the significant points that were shared within each journey. Such significant points included how they were treated, what support was offered, what positive moments they had, and what difficulties they faced.

Once all individual journeys were analysed, I looked for connections and/or differences between the journeys. The goal of IPA was to identify the commonalities and differences in meaning that the same and different participants (within and across participants) give to an experience (Thompson, 2009; Lafarge, Mitchell, & Fox, 2013). The process of identifying commonalities and differences allowed for repetitive themes to emerge. It is important to let the themes emerge from the data, rather than finding themes through preconceptions (Smith, 2009). I found similarities throughout the journeys regarding communication issues, receiving minimal support, and feeling valued while sharing their story with me. There were also findings within some journeys that did not share commonalities with all ten wāhine and whānau. Yet, these findings remained central to the results. This is because they were important experiences that informed themes and sub-themes. Using IPA as an analytical tool allowed for these findings to be included in the results because IPA concerns the in-depth exploration of all findings, not generalisable outcomes (Brocki & Wearden, 2006).

The themes that emerged were compared across all of the transcripts and sorted into super- and sub-ordinate themes (Biggerstaff & Thompson, 2005). NVIVO (qualitative software) was used to aid the analysis. It was used to code the transcripts for themes and subthemes to better organise the vast amounts of kōrero data. Having that organisation enabled me to visually grasp an understanding of the themes and sub-themes that were emerging amongst the vast amount of data produced from the kōrero. While I led the data analysis process, it was considered important to check my analysis with my supervisory team. This process allowed us to discuss the themes that
had emerged to reach a consensus on those themes and how they should be appropriately shared.

Following this stage in the development of themes and findings, I shared all with the wāhine and their whānau. This process is known as member-checking and is encouraged when analysing data with IPA (Bond, Foley & Askew, 2016). Member-checking was done to ensure the rigour of the analysis by confirming with the wāhine and whānau that the meanings I had derived were appropriate and accurate. This re-engagement with whānau was possible (and appropriate) because of the established relationships I had made with them. When I contacted them again, they were happy to hear of the research progress, and all verified the themes and findings that were derived.

Another level of member-checking was conducted with the key informants. This was to ensure mātauranga Māori was being utilised and acknowledged in the data analysis. The consultation journey I embarked on before the whānau kōrero interviews tailored how I approached and worked with whānau. It also provided me understandings of health and whakawhānau from a te ao Māori worldview. Therefore, this consultation journey also had an influence on my analysis by providing background knowledge and interpretations of health, whānau wellbeing, and whakawhānau through a Māori lens. I re-engaged with two key informants during the data analysis for member-checking. These two were kuia had a wealth of knowledge and experience in Māori health and Māori health research. I met up with the kuia and shared with them my findings to once again confirm the validity of themes and rigour of analysis. Likewise with the participants’ feedback, the key informants had positive feedback and supported what I had found. Alongside this positive feedback, they also helped me recognise the ‘silences’ within the themes. These silences (for example, the lack of karakia and kaumātua in the shared experiences) became key findings. This key informant review allowed me to recognise not only what was said, but what was not said in the shared kōrero. The process of member-checking with not only the wāhine, their whānau, and the key informants not only ensured the themes that emerged were accurate, it also illustrated respect for the expertise held by all.

The themes and subthemes that emerged from the analysis are explained in Te Whaiao, including the phase of the whānau journey they correspond to. The phases of the whānau journey are haputanga (pregnancy), whānautanga (labour and delivery), piripoho (post-birth), onāianei (current era). Within each theme, quotes are used to provide support the validity of the theme (Smith, 1999). The quotes are a representation of what was shared with me and where the themes originated. In this way, the quotes not only led my interpretations of the whānau experiences but they
also validated the themes to which they were linked with. Quotes were chosen based on their ability to articulate what the themes and findings were. I found this important because it was my objective throughout the analysis to privilege the voices of the wāhine and their whānau. This contrasts to a top-down approach, whereby quotes are found to support preconceived thoughts and ideas.

Analysis was deemed complete when no more themes had emerged from the data, and when all themes that were found were checked for validity through member-checking. The final Wāhanga, Te Ao Marama, unpacks the common themes further and explains how these common themes led to the development of a nuanced culturally responsive health care framework, named Te Hā o Whānau, to inform maternity care following disrupted whakwhānau journeys (see Chapter 10).

5.10 Chapter summary

The axiological, ontological and epistemological assumptions underpinning a Kaupapa Māori inquiry paradigm are linked by a common focus on the importance of whakapapa and whanaungatanga within te ao Māori. From this foundation, the methodology for this study was developed from the expertise and advice shared with me when I embarked on a consultation journey with kuia, kaumātua, health experts, and my whānau.

Whanaungatanga was utilised to build and develop respectful and trusting relationships with wāhine and their whānau, when they agreed to be part of this research following a birth event in which their baby was harmed. They were the drivers of the direction of kanohi-ki-te-kanohi kōrero about their experiences, and the narratives that they shared were analysed using IPA and Kaupapa Māori.

The findings are presented in the following chapters that have been broken down into the parts of the whānau journey from hapūtanga (pregnancy) to whānautanga (labour and delivery) to piripoho (post-birth), and finally to onāianei (current time era). The chapters have followed this continuum to share the findings from the whānau experiences.
Wāhanga Tuatoru

Te Whaiao

Tohaina ō painga ki te ao
Share your gifts with the world

This wāhanga contains the analysis of the whānau journeys through the health care system following their pregnancy and the harm or loss of their baby. Their stories are gifts of knowledge that the whānau have provided for me to share.

Te Whaiao means the glimmer of light seen just before one enters Te Ao Marama, the world of light. Te Whaiao is also the name given to describe the stage of birth where the baby is locked in position in the birth canal. The baby is in the middle of the darkness, being the womb, and the world of light. Likewise, this stage of the thesis – describing what has been found - is between the darkness (not knowing) and enlightenment (knowing). Each chapter within this wāhanga contributes to the movement towards enlightenment by sharing the themes that emerged from the kōrero with whānau.

Synopsis of Whānau Journeys

A synopsis of each whānau interview and journey is provided below to outline their whakawhānau journey. A disruption to their whakawhānau journey meant that the wāhine had to enter the maternal-infant health care system under unanticipated and unexpected circumstances. The synopses will allow readers to follow each whānau whakawhānau journey through: Hapūtanga, Whānautanga, Piripoho, and Onāianei.

Pseudonyms have been given to maintain anonymity of the wāhine participants, and whānau members where their understandings of the whakawhānau journey are included here. Table 2 in Te Tukunga Rangahau (see section 5.8.2.2) outlines relevant information of each wāhine and the delivery outcomes of all babies.

Ashton

I met Ashton at her home where she shared her kōrero on her own as her partner was at work. Ashton was a first-time mother who had what she perceived to be a healthy pregnancy. Through her descriptions, she was adamant that everything was going fine in her journey until one day she was out shopping and went into spontaneous preterm labour. She delivered her baby two hours later. Her baby was
cared for in a SCBU unit two hours away from her home, where they both remained for over four weeks as her son received respiratory and nutrition care. Ashton was pleased with the care her son received from all of his health care practitioners and was grateful that she was taught how to carry out aspects of his care in SCBU. This allowed her to bond with her son while he was in SCBU. She had positive support from her partner, and the networks she developed with families in similar situations in the SCBU. Ashton shared that they experienced some difficulty when they transitioned home from hospital, particularly around her breastfeeding and confidence as a mother. However, when I met to speak with her, she was positive about her future with her now healthy baby boy.

**Becky**

I met Becky and her husband for dinner as they shared their kōrero with me. Becky and her husband had planned this pregnancy, so they shared how pleased they were when they found out they were expecting their first baby. Becky experienced a minor difficulty in her second trimester when she became ill and reported decreased fetal movements to her LMC. Her LMC was quick to respond and a checkup found the baby’s heartbeat was healthy. Becky then went on to carry post-term and experienced a long, difficult labour at over 42 weeks gestation. As her labour did not progress and baby was becoming stressed, she was transferred to a secondary hospital over two hours away from her home to receive higher-level care. When Becky delivered her baby he had low apgars because of intrauterine hypoxia. Her baby received good immediate care, which allowed his apgars to increase by ten minutes. Although her baby received good care, Becky felt she received inadequate support and guidance about breastfeeding her baby. She did not know how to latch her son on properly, and this led to Becky developing severe mastitis. She was admitted to hospital numerous times with repetitive mastitis, and it was this experience that Becky and her husband were most disappointed about.

**Waiata**

When I met with her in her home, Waiata was on her own with her baby because her partner had work commitments. Waiata was a first-time expectant mother

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15 Secondary hospitals provide care for normal births, complicated pregnancies and births including operative births and caesarean sections plus specialist adjunct services including anaesthetics and paediatrics (Ministry of Health, 2017).
who had to have regular antenatal scans and check-up appointments because her baby was measuring small for her age. Waiata went into spontaneous preterm labour and was transferred to a secondary hospital two hours away from her home to deliver her preterm daughter. She believed her baby received top-quality care from the SCBU practitioners. Waiata was also pleased with the wrap-around services she received, such as transport and accommodation support for her and her partner. Waiata and her baby were discharged home after numerous weeks and, when I met her, her baby was continuing to make good progress.

**Justine**

I shared kai with Justine, her husband, their three kids, and Justine’s cousin when we met up in her home. Justine shared her journey that involved the loss of her baby at 19 weeks pregnant. The pregnancy was unexpected because her husband had recently had a vasectomy. Initially, Justine was apprehensive about the pregnancy because she was a busy mother of three children and a university law student. However, her husband was excited to have another child, which made her excited as well. Justine shared how she had a lot of nausea with her pregnancy that often left her bedridden. The night she experienced her miscarriage she was camping with her whānau in a rural coastal area. She reported that members of her whānau experienced unusual activities that night, and Justine believes these were somehow linked with her miscarriage. Justine reported feeling unsupported by health care practitioners, and to this day, received poor follow-up and communication following her loss. Justine expressed how she has found the experience to be traumatic because not only did she have to deal with the loss of her baby with minimal formal support and follow up, she also had to endure her body recovering from the entire pregnancy, labour and delivery. When I met Justine, she was focusing on finding alternative means of health care to support her health needs so she can continue being a strong mother for her whānau.

**Teina**

Teina was a first-time mother who delivered preterm twins. Teina shared her kōrero with the support of her partner, her cousin and her father. I met them in their home. Teina lived rurally with strong whānau support, as indicated by the number present when I met her. Teina did not have a seamless maternity journey. She faced initial struggles finding an LMC midwife who would support her and address her needs as a first-time mother. Teina felt her first LMC midwife was racist and unsupportive, resulting in Teina abandoning her and navigating the maternity health care system to
seek another LMC midwife. A friend recommended a local Māori LMC midwife to Teina who agreed to care for Teina. Teina immediately noticed the difference with this LMC and thoroughly enjoyed the supportive, caring relationship they shared.

The next struggle faced by Teina was when she was being prepared to deliver her twins. A treatment plan that was put in place by obstetricians and SCBU staff at her nearest secondary hospital was for her to deliver the twins by elective caesarean section at 36 weeks. Teina and her whānau had agreed to this plan. Unfortunately, this plan was changed on the day of the booked elective caesarean section and Teina was transferred to another hospital located a further hour away. When she was being transferred, one of the twins became stressed with decreased fetal movement. Teina was rushed for an emergency caesarean section, and her twins were delivered with low apgar scores. Both had to receive respiratory support, with one being placed on CPAP.\textsuperscript{16}

The twins were cared for in the SCBU unit at the second secondary hospital for three weeks, and during that time Teina felt she personally received poor care but that good care was provided to her babies. Teina outlined experiencing what she perceived to be racism at this hospital. Teina and her twins were then transferred to the first secondary hospital where she remained for a number of weeks. Teina enjoyed the health care practitioners at this hospital and was positive about the time spent here. When Teina became ill with pneumonia, she had to receive treatment and leave her babies to be cared for by her whānau and SCBU practitioners.

Teina and her twins were eventually discharged home. When I met her and her whānau, they were open about their disappointment in the last-minute transfer to the second secondary hospital. They felt they were inadequately communicated with and were not treated with respect. The whānau were determined to write a letter of complaint against the hospital and health care practitioners.

**Tahlia**

Tahlia shared her kōrero at her father’s house. This was Tahlia’s second baby, and she reported that she carried and delivered a healthy baby boy. Tahlia focused her kōrero on the time following the birth of her son. Tahlia was discharged from hospital with her son a few hours following his birth. Once she got home, she noticed he was doing strange movements. This distressed Tahlia and she rushed her son back to hospital. From here, he was sent on a helicopter to the nearest secondary hospital.

\textsuperscript{16} CPAP stands for continuous positive airway pressure therapy and it is a machine that is used to combat respiratory failure. The positive pressure helps keep the alveoli in the lungs open during expiration to improve oxygenation.
to receive immediate care in SCBU. Tahlia believes she was inappropriately discharged because a midwife made a comment that she thought her son was jittery. Tahlia’s son received numerous tests, however Tahlia was never told what was wrong with her baby.

**Aroha**

I met Aroha by herself, in a local café of her choice, to share her kōrero. Aroha was positive about her entire whakawhānau journey, and the only difficulty she faced was during the delivery of her son because he was born with low apgars. She shared how she was excited when she found out she was pregnant with this baby, as this was her second baby. Her pregnancy had been positive with no major issues. She felt well supported by her whānau, particularly her partner. Although her labour was difficult because her baby was breech\(^7\), she shared how she enjoyed it because she felt she was able to share the moment with her partner. Aroha was discharged with her son after he received appropriate and timely treatment and was optimistic about their future.

**Kristen**

I met Kristen at a local café where she came to meet me without her whānau. She offered the invitation to her husband to join but he chose to stay home with their children. She shared how he was dealing with their experience in his own way, which was fine. Kristen unfortunately experienced the loss of her baby at eight days old. Her pregnancy was perceived as being normal until she went for a scan at a local hospital. Following protocol, the sonographer said nothing to Kristen (which Kristen perceived as her being rude and unprofessional) but referred her for another scan. Kristen complied and had the second scan, where she also felt the sonographer was impolite. Kristen was then referred for a third scan at her nearest secondary hospital, which was a two-hour drive from her home. Following the scan at the secondary hospital, Kristen was transferred again, this time to a tertiary\(^8\) hospital a further two hours’ drive away. At this hospital, Kristen shared how different the sonographer was, as she was friendly to Kristen and her whānau. It was following this scan that Kristen was told by a team of obstetricians and pediatricians that they suspected her son had congenital

\(^{17}\) When the baby is positioned feet-first instead of headfirst before birth. Most babies are in breech position during pregnancy but turn to the preferred headfirst position near the end of the pregnancy.

\(^{18}\) A tertiary level facility is a hospital that can provide care for women with high-risk, complex pregnancies by specialised multidisciplinary teams of health practitioners (Ministry of Health, 2017).
anomalies (structural or functional disorders that occur while in utero and can be identified antenatally, at birth, or sometimes later in infancy (World of Health Organisation, 2018)). Kristen’s baby’s suspected congenital anomalies was identified late in her first trimester. This news was a shock to Kristen and her whānau because they were under the assumption that they were only getting scans because prior hospitals had inadequate equipment. Kristen spent the remaining weeks of her pregnancy in the tertiary hospital and had to receive polyhydramnios treatment, which involved her being drained of excess amniotic fluid. Kristen delivered her baby, and he was immediately taken to NICU to receive acute care. He survived eight days, and Kristen was grateful for the care he received. Following his loss, Kristen felt largely unsupported by formal wrap-around services and has yet to receive confirmation of his diagnosis other than congenital anomalies. The experience was still raw and difficult for Kristen to share; however, she was grateful for the opportunity to share her son’s journey as this was her way of ensuring his potential lives on.

_Nadia_

I met Nadia and her husband when they shared their experience with me at their home. This was Nadia’s first pregnancy, and she reported having an easy pregnancy with no difficulties during her first and second trimester. Unfortunately, difficulties arose when it was found that her baby was small and becoming distressed. This placed Nadia down a clinical pathway that involved regular monitoring, until Nadia went into labour at 38 weeks. The delivery was difficult because her baby was struggling with the contractions due to her small size. With medical interventions, her baby was born and transferred immediately to NICU. Unfortunately, this was not communicated to Nadia and her husband, as they were told their baby was just being admitted to a regular newborn unit. This miscommunication left Nadia and her husband unaware of the severity of their baby’s health needs, and they were shocked and disheartened when they found out their baby was receiving intensive care. They spent over a month in NICU with their baby and were dissatisfied with their experience there. Although they felt their baby was predominantly well cared for, they identified areas in need of improvement, including better breastfeeding support, less clinical focus on parenting, and improved communication. Once Nadia and her husband could return home with their baby, they felt more positive as they could finally be the parents they had imagined they would be.
Ngahuia

I met Ngahuia at her home with her children, and she shared her kōrero with the support of her mother. This was Ngahuia’s eighth baby, and she had vast experience of NICU as her previous six babies were also admitted to NICU. She had also experienced the loss of one of her babies, but was never told what happened to him. Ngahuia had had an unremarkable pregnancy, but went into spontaneous preterm labour. She delivered her baby at 30 weeks, and her baby was cared for in a tertiary NICU five hours away from her home. Ngahuia reported her baby received good care, however there was a disappointing moment for Ngahuia when her baby was transferred to a different NICU without her being informed. Ngahuia experienced great wrap-around care from a social worker who organized accommodation and travel support for her and her partner. Comparing this experience with her most recent, previous NICU experience, Ngahuia stated that communication and the wrap-around services delivered by clinicians and health care practitioners had improved. She also expressed how grateful she was for the follow-up care she and her baby received from the NICU practitioners, where they travel to Ngahuia in her home rather than asking Ngahuia to travel to them.

Summary of whānau experiences

The overarching sense of the whānau experiences was that each disrupted journey had glimpses of positive moments amongst predominantly difficult circumstances. Through analysing the kōrero shared by the wāhine (and their whānau in some cases), I interpreted the quality of their experiences throughout the different stages of their journeys. These moments of positives and negatives provided the arbitrary measure to produce Figure 6 below. Based on the experiences that were shared with me, this graph provides a visual depiction for the reader to see the range of experiences that were present within each whānau journey as a whole. The scale used in Figure 6 ranges from 0, unpleasant, to 10, pleasant. I ranked the quality of their experiences based on their shared kōrero. I checked with the wāhine that I had correctly perceived and ranked their quality of experiences before constructing this graph. The purpose of this figure is to provide a visual aid to show the range of experiences throughout each whānau journey.
Figure 6. Interpretation of quality of whānau experiences throughout each whānau journey for the ten participating wāhine
Many of the wāhine considered their hapūtanga (pregnancy) to be mostly positive and healthy, except for three (Justine, Kristen, and Teina) who felt their pregnancy was more difficult. As the participants' journey moves into the whānautanga (labour and delivery) phase, the quality of experiences decreased for all except Tahlia, Ngahuia and Waiata. The piripoho period (postnatal period) was also a time of many negatives for several wāhine and their whānau, with only one wāhine rating their postnatal journey to be largely positive (Aroha). I argue that this downward trend across these phases is no coincidence; experiences decrease as whānau enter the health care system in a manner that was not expected because the birth of their baby did not go according to their imagined plan. Possible reasons for this decrease include stress over the wellbeing of their baby and whānau, having to leave their home environment and enter a foreign, clinical environment, such as hospitals and special care units. Supporting this argument is the quality of their experience increasing again when whānau were able to transition home in onāianei (the current era).

There are four chapters in this wāhanga that follow the whānau journey continuum (as expressed in Figure 6) Hapūtanga, Whānautanga, Piripoho, and Onāianei. The findings pertinent to each phase of the journey are shared. The chapters in this wāhanga will explore the experiences in their journey to promote the positive glimpses of health care to increase their frequency, while outlining practices and issues that are in need of addressing to help reduce their occurrence in the health care system. Exploring these experiences is an important primary step towards determining if the maternal-infant health care system is culturally responsive to Māori. The experiences are reflected upon to influence systemic change that enables whānau to restore their wellbeing following the harm or loss of their baby.
Chapter 6: Hapūtanga

This chapter, Hapūtanga, explores the pregnancy experiences within the whānau journeys. The hapūtanga period is a significant time for wāhine and whānau as it is within hapūtanga that the foundation for the subsequent health of mother and baby is laid. Although whānau experiences of hapūtanga were diverse, the overarching notion was that the hapūtanga period was a fragile time as circumstances could change in an instant. This chapter explores the themes that emerged from the whānau experiences during their hapūtanga: beginning of the hapūtanga, maternity health care, and health carer communication. Table 3 below sets out these themes and their related subthemes.

Table 3. Hapūtanga themes and subthemes

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6.1 Beginning of the Hapūtanga

The wāhine had a range of reactions to becoming hapū. This section explores the differences in the starting points of their hapūtanga journeys, between those who had a perceived regular start to their hapūtanga and those who had a more disrupted start. Before exploring these, there were a number of wāhine who felt their hapūtanga was unexpected.

6.1.1 Unexpected conception

Four of the ten wāhine said that their pregnancy was unexpected, saying it was a “surprise” or a “shock.” Teina, for example, had an unexpected hapūtanga because she had accepted the norm that she was incapable of carrying a pregnancy to full term or beyond her first trimester. This norm was informed by her history of successive miscarriages in the first trimester of her pregnancies. To satisfy her desire to be a mother, she focused her attention on raising a pet instead. As she states,
We got told that we couldn’t have kids...cos I kept getting pregnant but it wouldn’t stick so we had accepted the fact that we would never have a baby because I kept having miscarriages...so we got a dog and treated her like a baby. (Teina)

However, in a final effort to have a baby, Teina sought assistance from fertility drugs to improve her chances of conceiving and carrying to term. The use of medical assistance suggests that this hapūtanga was planned because she was trying to get hapū even though she had accepted her assumption that she would not carry beyond her first trimester. In other words, Teina had a planned, but unexpected hapūtanga journey. When the drugs were a success and Teina became pregnant with fraternal twins (non-identical twins due to two separate eggs being fertilised by different sperm), she experienced a mix of emotions.

And then we got pregnant, and they were twins! So, we were just like ahhhhhh! (Teina) I still remember the look of excitement and apprehension when Teina shared this kōrero. Throwing her face into her hands and screaming “ahhhh” as an expression of her various emotions, including: joy that she was pregnant, nervousness that she had twins on the way, and anxiety that she would miscarry once again.

Kristen and Tahlia reported feeling “shocked” when they found out they were hapū because they had both accepted the idea that they could no longer conceive. For Tahlia, there were nine years between her first child and this, second pregnancy. As those nine years had passed she grew in her assumption that not getting pregnant meant she could not and would not get pregnant. This assumption became her accepted reality. When she found out she was pregnant and this reality was challenged, Tahlia was both surprised and excited, as was her partner. She shares,

He was a bloody surprise this one though. I’ve been with this one’s dad for just over two years and he’s got no kids and I told him I couldn’t have kids and he was really cool about it but when we found out we were having him he was stoked. (Tahlia)

Kristen’s initial shock at finding out she was hapū with her fifth child was quickly followed by unease and nervousness because she felt her age was a risk factor. She shares,

So, he’s our 4th boy, 5th child. It was quite a shock to find out we were pregnant so at the start...But nothing was unusual. (Kristen)

Personal assumptions of their infertility held by Tahlia and Kristen were the backbone to their unexpected hapūtanga. These wāhine developed their infertility assumptions based on their age and experiences, even before they had sought medical advice and/or counsel. Tahlia even established a new relationship on the foundation that there was no possibility of children for them. For these two wāhine, when these assumptions were challenged and they became hapū, they became provoked and excited to move this inbuilt mindset and prepare for what they previously had thought was improbable.
Justine also had an unexpected conception and did not have immediate initial positive feelings about becoming hapū. She became pregnant two days before her husband had a vasectomy. She shares,

I got pregnant unexpected, we didn’t know we were going to get pregnant because [husband] had a vasectomy...so I found out I was pregnant three weeks after the vasectomy and I was three weeks pregnant, so I had become pregnant two days before the vasectomy! So, I started freaking out about needing a bigger car and more room, and freaking about my studies, so it was a real whirlwind of a time...I was quite reluctant to get excited because I knew how much it would change things. (Justine)

Becoming hapū for Justine came with feelings of fear and anxiety (“freaking out”) because she was already a mother of three and was focused on completing her tertiary studies to become a lawyer. This mix of fear and anxiety made her feel initially reluctant about her hapūtanga. Her husband had a different reaction though as he was excited they were pregnant again. His excitement and support was what enabled Justine to overcome her reluctance to the hapūtanga and she eventually became excited also to become a mother again. The role of facilitating balance and support for their wahine is an important role of the tane during this time of vast change and transition. Having balance within the whānau is an integral component of whānau wellbeing.

6.1.2 An easy start

The remaining six wahine did not talk about their time of conception. I interpreted this to mean that they did not share the same ‘shock’ and surprise as Teina, Tahlia, Kristen, and Justine when they became hapū. Some wahine felt their pregnancy was as they imagined a normal pregnancy would be. Having a hapūtanga that aligned with their hapūtanga imaginary made them reflect positively on their pregnancies, which included their hapūtanga being healthy. Some of the wahine perceived the early stages (i.e from their first trimester) of their hapūtanga as regular or normal. A key aspect of this normality was that they had no issues in their early pregnancy, leading at least Kristin to forget at times that she was pregnant and Becky to describe this stage as easy. Becky adds that her midwife helped her gain reassurance that everything was normal and “easy.”

My pregnancy went well, I actually forgot I was pregnant a lot of the time {laughs}...everything was on the go and everything was sweet. (Kristin)

I had a pretty easy pregnancy, I didn’t have any issues at all and my midwife was awesome... Like any concerns that I did have she answered pretty much straight away. (Becky)

A commonality of the wahine who had pregnancies with a regular start (that being an easy first trimester) was that the hapūtanga was a positive and good
experience. Nadia and Ashton shared commonalities in their hapūtanga experiences whereby both were healthy first-time mothers, had received appropriate antenatal care, were not classified as high-risk pregnancy, and were surprised to have a disrupted whakawhānau journey. Ashton went into preterm labour at 33 weeks while she was out shopping. Leading up to this day, Ashton said she felt fine and excited about becoming a mother for the first time. She noted that her first and second trimesters were healthy and that everything was normal leading up to the day she went into labour. She shares,

I was feeling fine all week leading up to it [premature delivery]. My partner was actually away fishing at the time because I was six weeks out and feeling fine. (Ashton)

Regarding Nadia’s journey, she stated

And through my whole pregnancy there was no reason to think that anything was gonna go haywire. So I think going into it, I was pretty calm. (Nadia)

These experiences signal how the hapūtanga can be regular and easy until things suddenly changed, as was the case with Ashton and Nadia. The sudden change in their journeys here is further shared in the following whānautanga chapter.

Aroha shared another journey perspective. Up until her third trimester, Aroha felt healthy and was reassured by her LMC that her pregnancy was normal. Her ‘normal’ was unique to her because in her third trimester her baby slipped into a posterior position. This occurred also in Aroha’s first pregnancy, therefore on self-reflection, this position became her norm. She shares,

My first baby was posterior as well, so according to my midwife my boy slipped through to where my daughter was positioned. (Aroha)

Accepting her baby being in this position as her norm had two effects on Aroha. Firstly, she was able to prepare and expect this to happen in her pregnancy because it was a part of her imagined norm. This norm helped her mentally prepare for what would be required of her for her baby as her journey progressed. This raised the second point, whereby she understood that she would require an episiotomy because that is what she required with her first pregnancy. Aroha anticipated that she would go through the similar experience of her first baby, and emotions involved (fear, anxiety, pain preparation) with this baby. However, this time she was able to retain her wellbeing by being prepared to deal with these emotions and medical procedures.

6.1.3 Disrupted beginnings

Some wāhine experienced a regular first trimester, up until a disruption in their journey that caused things to suddenly change. Ashton, Ngahuia and Waiata all experienced preterm labour that resulted in the disruption to their hapūtanga journey.
This disruption is a representation of the fragility of the hapūtanga. Some wahine described how they had difficulties from the first or second trimesters of their pregnancies. Waiata was a first-time expectant mother whose early scans showed that her baby was small for her age. This led Waiata down a care pathway that included continual monitoring and scans. She shares,

We had to have lots of scans all the time so I wouldn’t say my pregnancy was easy… (Waiata)

Waiata had imagined what an easy pregnancy would involve, even though she was hapū for the first time. She had imagined an easy pregnancy that was absent of medical interventions and monitoring because she aligned those measures with illness and something being wrong. In contrast to what she imagined as being ‘normal’, she received a high level of medical monitoring,

It was full on. It made me worry [getting all the scans] that I was doing something wrong for my baby…and we had to move houses during that time too. (Waiata)

The contrast between her reality and her imagined hapūtanga caused anxiety for Waiata, and she felt that she did not receive the reassurance she needed from her health practitioners. The continual monitoring and poor reassurance was combined with the stress of relocating. These factors contributed towards Waiata consider whether she was doing something that was affecting her baby.

Teina was hapū for the first time too and also experienced a medical care pathway during her hapūtanga. Her perception of what being hapū would be like differed from Waiata though. Teina had imagined she would require medical intervention throughout her hapūtanga, and this imaginary was informed by her previous miscarriage experiences and becoming hapū via medical assistance. Even though she had this expectation, Teina faced difficulties in receiving quality antenatal care. As a result of being unsatisfied by the care provided by her first LMC, Teina replaced this LMC with another LMC midwife. Teina was recommended this second LMC through whānau and friends following their positive experiences under her care. Teina thought this second LMC provided excellent care during her hapūtanga. It was through this second LMC midwife that Teina received regular antenatal care (more of this aspect of Teina’s journey will be shared as the chapter proceeds). As her pregnancy progressed, Teina also had to be placed under specialist care because she was regularly monitored, often in the hospital setting, to check the health of her twins. She accepted this required care pathway and became familiar with the hospital context and hospital-based health practitioners.

So, they put us into hospital…to get all that monitoring stuff, and by then we made friends with all the midwives and maternity ward there. (Teina)
This statement outlines the difference in how Teina and Waiata felt during their hapūtanga. This difference could be due to the two holding differing views of hapūtanga and/or the different relationships with the practitioners during their care pathways.

Justine shared that her hapūtanga had a different āhua (feeling; form) compared to her previous pregnancies,

I was always real conscious of the pregnancy, like I almost felt like it wasn’t gonna go through. (Justine)

She continues,

I was carrying really big and because I had always carried quite small with my other kids, but this baby was really big. And the night…like there were no pains or anything leading up to it, I thought I felt baby kicking and stuff…Yeah but when I told my midwife that I was bedridden and stuff she would just say that it was unfortunate that some mothers are like that, and I agreed with her, cos you know, by the fourth kid you just kind of relax. (Justine)

Justine expressed that she intuitively felt that something was wrong with her hapūtanga. She knew what a healthy pregnancy was supposed to feel like and she felt (and thereby inherently knew) that her current pregnancy differed from that feeling. She was bed ridden, carrying big and experiencing high levels of nausea. Justine said she was not offered any nausea relief by her LMC, and that she thought her LMC assumed she was just another “unfortunate” mother who suffered sickness in hapūtanga. By Justine’s account, she did not receive appropriate care from her LMC because Justine’s physical and emotional concerns were dismissed.

Justine recalled her hapūtanga as being an emotional rollercoaster that began with feelings of apprehension, to overcoming these feelings and becoming excited about having one last baby, to the devastation of having a miscarriage at 19 weeks pregnant. She also believed she had a strong wairua connection the night she lost her baby. Justine shares,

My family is quite spiritual and when we started listening to family members and listening to what they were experiencing, we all kind of tied it in to what was happening to me. My daughter started screaming her head off… and my brother had went toilet and he looked up and said he saw a bright star shooting across the sky and it was just doing zigzags…and when we got to the coast, the sky was bright red and real blotchy, and that was the night my brother seen that star. And then when I went to the toilet that night I thought someone, like a dark shadow, was following me out of the toilet and I was thinking cut that out, and I just got the water I was washing my hands with and blessed myself. (Justine)

As Justine’s description of the night she miscarried illustrates, she believed there were strong warning signs of what was going to occur. When Justine put the
wairua experiences together with her intuition about the āhua of her hapūtanga, she knew she had been right to be concerned that things were not normal with her baby.

Kristen, who had been pregnant with her fifth child, was initially concerned because she thought she was too old and too overweight to have a healthy hapūtanga. As she stated,

It was quite a shock to find out we were pregnant so at the start I was quite worried because of my age and secondly because I was carrying a lot more weight than what I was with the other kids, so I was a bit worried how I’d carry. (Kristen)

Even with this initial apprehension, she soon became excited that she could welcome another taonga (treasure/child) into the world. Kristen said that everything was fine with her until she went for a routine scan at her local hospital. She had invited her whānau to attend the scan of their latest treasure and had been excited to share this moment with them. However, Kristen described how this excitement quickly evaporated when the sonographer did not greet or talk to Kristen and her whānau. Kristen felt this was very disrespectful.

Following this scan, the sonographer noticed something was not right and asked Kristen to come back for another scan. Kristen came back for another scan, with her husband and children present. From here, the sonographer asked Kristen if she could travel to the secondary hospital two hours away to be scanned again. The reason given was that the equipment in the local hospital was insufficient and Kirsten was reassured that there was no need to worry. Kristen agreed and travelled with her husband to the secondary hospital, where she was transferred again to the tertiary hospital another two hours away. In total, Kristen received four scans at three different hospitals, the furthest one being four hours away from her home. Throughout these scans and hospital visits, she said she was never informed that anything was out of the ordinary, so Kristen and her whānau did not suspect anything was wrong with her baby. It was following her fourth scan at the tertiary hospital that maternity and neonatal care specialists met with her and her husband and informed her that they suspected her baby had congenital anomalies. She shares,

I knew that when you had the cardiac [specialist], the paediatrician, the head of department, the obstetrician and the geneticist come in, and this was probably the worst moment, worse than his passing, was they told us what they believed what was happening. She [the specialist] said that we could possibly have a trisomy 13 or 18 chromosomal boy...I knew it wasn’t good when they moved us into our own room and I tried to just brush that feeling off but I knew that something was up and then she started talking and explaining to us what the images she had seen were; they had seen a lot of anomalies (cries). (Kirsten)

This moment was a significant point in Kristen’s journey, which is highlighted by her stating that it was worse than her son’s eventual passing. This moment was made
more poignant because Kristen and her husband did not find these health practitioners acted in an empathetic manner. According to the key informants in my consultation journey, being empathetic means to understand and share the feelings of those you are speaking with so that you may safeguard them. The number of specialists wanting to meet with Kirsten and her husband in a private room immediately put her on edge and sent a signal to her that something serious was wrong. Then when an explanation was provided, Kristen and her husband did not perceive much empathy in the highly medicalised and difficult to understand diagnostic language used by the health care practitioners. They were also unprepared for the difficult news about their baby, as prior to this meeting they had been continually reassured that there was nothing to worry about. The combination of these factors created an unsafe environment for Kristen and her husband and left them vulnerable to the shock and grief that the news brought. More of Kristen’s journey is shared as the chapter proceeds, with a particular focus on the communication (or lack thereof) she received from the health practitioners during this time.

6.2 Maternity Health Care

Lead Maternity Carers were often the primary source of formal support for the wāhine and their whānau during their hapūtanga. Along with LMC midwives, the wāhine interviewed talked about their experiences with primary health practitioners and medical specialists. This section describes these experiences.

6.2.1 Lead Maternity Carers

All the wāhine had a community-based LMC midwife, three of whom were reported by the wāhine as being Māori. Three of the wāhine (Kristen, Becky, Teina) reported having a particularly positive relationship with their LMC. Statements such as, “honestly, I couldn’t ask for a better midwife...like any concerns that I had, she answered pretty much straight away” (Becky), reflected the positive care the wāhine and whānau felt they received. Having a positive relationship with their LMC and maternity care practitioners allowed these wāhine to progress with their pregnancy feeling well cared for, especially when adversity happened.

Kristen shared how she felt supported by her LMC when she learned baby’s diagnosis.
I'm really lucky that I had my midwife that I had for the talks, but cos you know, I was her first unexpected diagnosis in pregnancy, so she cried when I cried. We're still really good mates now...She gave me a book - holding on and letting go - and it had stories of experiences from people who had unexpected diagnoses and loss in pregnancy and they had clinical reflections from clinicians as well, and they had stories from those who had let go and those who had continued with their children, so it was really great. It was honestly my saving grace because it made me confront things that I hadn't yet in my pregnancy. (Kirsten)

According to Kristen, her LMC was responsive and her care was noted as being professionally compassionate. This contrasted with Kristen’s experience of the sonographer(s) in her first trimester, and the specialists who informed her of her son’s suspected diagnosis who, in Kristen’s view, lacked this same level of compassionate support. Kristen shared how the book offered by her LMC allowed her to understand more about unexpected diagnoses and prepare for the possibility that she may lose her baby. Although Kristen said that the specialists had told them of this possibility, it was not comprehendible at the time because of the shock Kristen and her husband were experiencing. The book and her LMC’s support enabled Kristen to come to terms with what might happen to her son.

Kristen shared that this was her LMC’s first time caring for a mother who had received an unexpected diagnosis, so she too was learning how to understand that situation and accompanying emotions so she could provide the best possible care for Kristen. In this sense, Kristen and her LMC journeyed through this difficult time together, and Kristen said they developed a real bond from doing so. They cried together and shared resources to enhance their wellbeing. Teina (with her second LMC midwife) and Waiata were also able to develop a real connection with their midwives, where they both felt supported.

Teina felt that her second LMC, who was Māori, worked in partnership with her by providing the cultural reassurance and professional advice she required. Teina felt that she “just got me”, because she knew how to communicate and manage Teina’s hapūtanga appropriately. This support and understanding allowed Teina to work through her concerns and progress with her hapūtanga.

I’m 30 with my first kid, and they were twins, my parents weren’t in the country, I was scared I was going to lose them, but [my second LMC] would always do what she said she would…and the cool thing about [my second LMC], cos I’m a real drama queen, she managed to rail me in and get me into the mind-frame of believing that I could do a natural birth when the time would come. (Teina)

The contrast in care between Teina’s two LMCs was evident when Teina expressed how her first LMC was not responsive to her needs.
I didn’t like the first midwife I had because when I found out I had the bleed, she wasn’t available, she never told me she was on leave…so when I rang her it went to another lady who said, ‘oh I can’t meet you there [local hospital] because I’ve had a hard night.’ (Teina)

Teina felt unsupported by her first LMC during her initial hapūtanga period, as she found her to be dismissive and unprofessional.

When I first got pregnant, I went to her and she said that I don’t need to have a scan because she said I was pretty sure of my dates. And my friend who came with me said ‘what if she’s having twins?’ And the midwife goes ‘well that’s highly unlikely because she couldn’t even have one baby let alone two’. (Teina)

This LMC’s dismissive and unprofessional behavior had a negative impact on Teina’s wellbeing because she was made to organise her own antenatal scans.

[First LMC] made me organise all my own scans and I had no idea who I was supposed to even ring or anything to do. She was useless, I frikken hated her. (Teina)

These negative emotions were a reflection of the frustration Teina experienced during this phase of her hapūtanga. These scans were essential because Teina was pregnant with twins and had occurrences of antenatal bleeding. She found organising her own scans difficult as this was her first pregnancy and the maternal health system was foreign to her.

Becky’s experience was similar to Teina (second LMC midwife) and Kristen, as she also had a supportive LMC who she felt connected with. Becky was also a first-time mother who experienced a slight scare in her pregnancy, yet her responsive LMC was able to offer her reassurance at the time.

I couldn’t feel him move for a couple of days, day and night, so I started to freak out and it was her weekend off but [my LMC] still came and met us at the hospital, and he was fine as…so I was 25 weeks so that was cool, she put us at ease there. (Becky)

Becky acknowledged her LMC’s effort to meet her at the hospital on her weekend off as a sign of her support and respect. Her prompt responsiveness to monitor Becky and her baby to show they were both fine also provided the clinical reassurance Becky required at that time. The three wāhine who shared their positive experiences with their LMC appreciated the real connection they had with their respective LMC midwife. All three LMCs who participants reported were able to develop a real connection with their wāhine demonstrated compassion, respect, and responsiveness (clinically and culturally). These are positive qualities of LMC care that helped the wāhine retain wellbeing during their adverse events.

**6.2.2 Cultural responsiveness of practitioners**

In the late stages of her second trimester and following the diagnosis of her baby’s suspected congenital anomalies, Kristen was admitted to the tertiary hospital
for regular monitoring. Kristen had also developed polyhydraminos, the retention of too much amniotic fluid. This caused her to “carry big” and, to relieve the pressure, her maternity care practitioners decided to drain the excessive amniotic fluid. She shares,

I should have asked for my amniotic fluid that they drained away, but I was too out of it at the time. (Kristen)

Kristen said she had encountered culturally ignorant health practitioners during her journey, which caused her disappointment. There was a lack of consideration or recognition on the part of those involved in her care of the importance of the amniotic fluid as part of her whakapapa. The taking of body parts, blood or body fluids by health practitioners without karakia and/or without informing whānau where they will be expelled demonstrates ignorance of tikanga Māori and a lack of cultural responsiveness. Kristen reported that no health practitioner asked and her whānau what they wanted done with the amniotic fluid that had been drained from her. This may have a negative impact on the wellbeing of wāhine who have experiences like those of Kristen because cultural values, beliefs, and practices are inherently connected with wellbeing. Whakapapa – as in the body parts or body fluids that are taken – should be discarded with appropriate tikanga and karakia. This is to respect the tapu of that whakapapa and to not diminish the mauri (life force) of the individual.

In relation to the experiences of the wāhine, some health practitioners also demonstrated cultural ignorance of whakamā (reticence or shyness). This was done by putting some of the wāhine in positions where what they considered to be private was unceremoniously made public. Teina felt shame when this happened to her,

I fainted at one point because of my bleeds…and I came to sitting in the room naked and had about 20 people in my face….shame, I was naked! This example shows how embarrassed Teina was about being naked in front of numerous people she did not know. It is interesting that there were a number of people present in the room, yet no one considered respecting her dignity and covering her.

Waiata expressed her whakamā about health practitioners touching or looking at her genital region,

I was really nervous when I was pregnant because I didn’t want anyone putting their hands down there and looking around down there. (Waiata)

Wāhine feeling whakamā about their sexuality and their body has become an internalised notion within te ao Māori. This is an impact of colonisation superimposing Christian beliefs, which portrays that females should be covered and not exposed, over mātauranga Māori and Māori worldviews, which celebrates the female body and sexuality. That aside, Waiata felt that her midwife respected and acknowledged this whakamā by letting Waiata take the lead in this situation,
...she just let me be, she let me follow my instincts and left me alone until I thought that I was ready to be examined. I really appreciated her for that. (Waiata)

This is a positive example of respectful, culturally responsive care by health care practitioners because Waiata felt the midwife empowered her by allowing her to take control of her hapūtanga journey at that point. Cultural ignorance has a harmful impact on whānau wellbeing because Māori values and practices are often subjugated, intentional or not, for the dominant Western health care practices. Communication between health practitioners and whānau can help raise awareness of tikanga Māori and the impact cultural ignorance has on whānau wellbeing.

6.3 Health Practitioner Communication

When the wāhine and/or her whānau said they had a positive relationship with their health practitioner, they also reported that communication with those health practitioners was “good.” When communications from a health practitioner were difficult or not understandable for wāhine and/or their whānau, the relationship they had with that health practitioner was often noted as being less positive. Three levels of communication are explored here: the unspoken, the silent treatment, and medical jargon. The examples provided below highlight the significance of communication and outline the areas in need of improvement when communication is not effective for wāhine and their whānau.

6.3.1 The ‘unspoken’

Non-verbal or unspoken communication can be as important as what is spoken. Teina felt that her first, non-Māori LMC judged her because she was Māori from a small, coastal Māori community. Although Teina said there was nothing racist said by her LMC, Teina felt that the atmosphere was tense and that her partner felt it too.

It felt like I was being judged and that’s how we both felt, my partner felt the same, and we didn’t like her. So, we swapped and got [a second, Māori LMC]. (Teina)

According to Teina, her first LMC did not develop the real connection that was spoken about earlier in the positive examples of LMC care. This type of unspoken communication was also evident in Kristen’s journey. Kristen felt the sonographer who took her first scan was “stand-offish” with her and her whānau because she did not interact with them and seemed irritated that there were so many people present. Kristen said,
I’ve had so many different scans with so many different people...so I know what the high quality of interaction should be...I brought my whole entire family and anyone that was free and available to come to that scan, and [sonographer] was a bit stand-offish that there was so many people there but I was thinking to myself, 'well this is the wellbeing of me and my child so they’re allowed being here'. These people are a part of his life and I wanted to make it a great experience, so I just overlooked her cold front to me. But yeah, it took a lot of sucking in. (Kristen)

In this case, the sonographer did not take the time to introduce herself, which immediately eliminated the opportunity to whakawhanaunga with Kristen and her whānau. This was acknowledged as being rude behavior by the whānau. Despite this, Kristen was determined to allow her whānau to enjoy the moment of witnessing the scan, so she chose to ‘suck it up’ and ignore what she perceived to be the sonographer’s negative attitude. This demonstrates her effort to create a safe space, a wāhi haumaru, for her whānau in that situation.

### 6.3.2 The silent treatment

A lack of communication from health practitioners can leave wāhine and their whānau feeling unsupported and without knowledge. It is an example of how health care professionals can passively communicate poorly. Following her fourth consecutive scan, Kristen and her husband were asked to wait for the obstetric team in a waiting room on their own. Having been under the assumption prior to this request that she was receiving numerous scans because of inadequate equipment – an explanation that Kristen went on to describe as a “pretence” – being asked to wait in a separate room immediately caused distress and anxiety for the pair. Kristen shares her experience,

> We were blissfully unaware and just thinking how fantastic it was that we got more opportunities to see our baby in the scans...I knew it wasn't good when they moved us to our own room... (Kristen)

Kristen was “blissfully unaware” of her circumstances leading up to this appointment because the real reasons behind her repeated scans had been concealed from her. Arguably, the health practitioners had four opportunities before this appointment to share their concerns of what they were recognising in the scans. As they did not, Kristen and her whānau were unprepared for the news that they received about their son’s congenital anomalies.

Nadia also reported ‘silent treatment’ from her sonographer.

The sonographer was like [looked stressed] because they’re not supposed to say anything but you could just tell from her body language though that something wasn’t quite right. So, we rang our midwife afterwards and was like ‘maybe just ask for the report’, and like an hour later she said ‘I'm gonna get you to go up to the hospital and induce you’. (Nadia)
The interaction Nadia and her husband had with the sonographer elevated her stress and anxiety because the sonographer's body language made her suspect something was not right. Nadia reflected that she has an understanding that sonographers are not allowed to talk, however she recalled this phase of her hapūtanga experience being impaired due to this interaction with the sonographer. Perhaps greater awareness and control of her body language by this sonographer would have prevented Nadia from being stressed and anxious as a result of this interaction.

6.3.3 Medical jargon

Often their health practitioners used language that the wāhine and their whānau did not understand. This was particularly evident for whānau when unforeseen circumstances occurred with their baby (i.e. following a disruption to their whakawhānau journey), and health practitioners were required to explain complex health circumstances to them. At these times, whānau felt they were being talked ‘at’ rather than ‘to’, and in language that is too difficult for them to comprehend. As a result, whānau felt they were left uninformed, confused and often overwhelmed when they entered the hospital environment under unanticipated circumstances.

When the team of specialist maternity carers met with Kristen and her husband to inform her of her baby’s congenital anomalies, she said they were spoken to in highly medical language,

Me and my husband were just sitting there like we had been slapped in the face because we couldn’t understand what we were hearing…she was using all of these words, I was trying my absolute hardest to understand…I tried to absorb as much as I could and pick up keywords that I could go look up after…So when I googled [the suspected chromosomal condition], it sent all these images and information up from a real clinical point of view and it was hugely scary…we were completely gob-smacked. But we just tried pushing through and carrying on, but it was just horrendous. (Kristen)

What Kristen shares here illustrates how the use of medical jargon can be difficult for whānau to comprehend. Not being able to understand what is being spoken to them restricted their ability to engage in meaningful communication with the health practitioners. As she remained hopeful that her baby would have a fighting chance to survive his expected diagnosis, she was determined to understand as many aspects of his diagnosis and needs as possible. The contrast in communication is noticeable when Kristen shares how she was able to understand her son’s suspected condition when she had communication with her LMC. Kristen said her LMC’s layperson’s explanation of her baby’s condition finally enabled her and her husband to grasp the
severity of what was happening because she was able to have equal participation in the conversation.

My midwife was an outstanding support to me...we met her [LMC] afterwards and she explained to us in layman terms. We hadn’t realised how severe everything was until then. (Kristen)

Having her LMC midwife present when Kristen was informed of her son’s suspected diagnosis would have been beneficial, but as Kristen was under the assumption that there was no need to worry, her concern for travelling to a tertiary hospital for a scan was not shared to her LMC.

Ngahuia and Waiata both said they appreciated their doctors’ ability to communicate well with them. When they provided her a layperson’s explanation of her circumstances, Waiata said they did not use medical jargon. She stated,

The doctors are great...they explain really well and they don’t use long words, they just break it down. (Waiata)

Ngahuia said that as a mother of six she had acquired a level of familiarity with the maternity and neonatal health care system. Even so, she said she was still appreciative of her doctors breaking down medical terms to comprehensible language during her journey (see 8.3.1). These experiences reinforce the importance of appropriate communication and how communicating well can positively impact on hapūtanga journeys.

6.4 Chapter Summary

There was a widespread mix of hapūtanga experiences across the ten wāhine participants. Some wāhine were pregnant for the first time, while others had already experienced being pregnant and giving birth. Out of the wāhine who had given birth before, some had endured complex previous pregnancies and births, while others reported having ‘normal’ pregnancies and deliveries. These previous experiences inevitably impacted upon the pregnancy journey and informed how they imagined this hapūtanga. The imagined view of hapūtanga was also impacted by the expected or unexpected nature of becoming hapū. Four of the ten wāhine claimed having an unexpected conception. Although some of these four faced initial apprehension over becoming hapū, all four became excited and prepared for their hapūtanga journey.

The hapūtanga journey was perceived as being a normal and positive experience for wāhine, up until a point where things suddenly change. This sudden change represented how fragile the hapūtanga experience can be. As a result of this disruption to their hapūtanga journey, wāhine entered the hospital environment under unanticipated circumstances. When this happened, wāhine and their whānau became reliant upon health practitioners for empathetic care and explanations of what is
happening to them and their baby. The experiences of the wāhine revealed that LMCs play a key role in their hapūtanga journey. Not only are LMCs relied upon by the wāhine for professional care, but also as practitioners of emotional support.

Communication delivered by health care professionals was another running theme that impacted on the whānau journeys. It was recognised that wāhine often gauge their quality of experience on the interactions they have with their health practitioners. If health practitioners delivered messages in a respectful manner that facilitates active participation of whānau in the conversations, there was a greater perceived quality of experience made by the wāhine. Therefore, speaking with the wāhine (and their whānau) not to or at, and in appropriate language that is easy to understand was considered being good health care. The following chapter, whānautanga, will discuss the experiences of labour and delivery across the whānau journey.
Chapter 7: Whānautanga

This chapter explores the whānautanga (labour and delivery) experiences that were shared by eight of the wāhine and their whānau. Ngahuia and Tahlia did not share aspects of their whānautanga journeys, even though both endured adversities. They both instead focused their kōrero on the other phases of their whānau journey.

This chapter explores the themes that emerged from the whānau experiences during their whānautanga: Imagined births versus reality; access to whānau support; maternity health care; and the biomedical health care system environment. Table 4 below sets out these themes and their related subthemes.

Table 4. Themes and subthemes of Whānautanga

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7.1 ‘Imagined births’ versus Reality

The eight wāhine that shared their whānautanga journey had encountered a starkly different birth reality to what they had imagined would occur because their ‘imagined birth’ had not included an adverse perinatal event. As stipulated in Chapter 2 (section 2.2), I have purposefully used the term imaginary to conceptualise the perceptions held by wāhine and their whānau of the aspects of their whakawhānau journey. The term is considered to capture another dimension of the experiences expressed by the wāhine and their whānau that extends further than describing what they expected, but to also include what they identify with and what they envision as being their ideal. This section focuses on the whānautanga, that being the labour/birth, imaginaries. Common aspects of birth imaginaries that were described by the wāhine included delivering at their due date, in their local environment and with minimal medical interventions. For these eight wāhine, their imagined birth differed markedly
from their reality, resulting in unforeseen paths in their whānau journeys. Nadia depicts this in her statement,

It was quite horrific but it just wasn't what I was expecting or preparing for; I think all you can do is know that you have to just go with the flow, you just do whatever you can to get your baby out. (Nadia)

Often, “doing whatever” meant relinquishing their imagined ‘normal’ labour and delivery to receive necessary medical care. Commonly, this resulted in the wāhine being transferred to a secondary or tertiary hospital, located away from their home base, to continue with their labour and delivery. Being transferred away from home and whānau became a significant feature of their birth reality. This was because it encompassed more than just the physical transfer but also transferring away from their birth imaginary. Another two features associated with this theme of altered birth imaginaries that emerged was preterm labour and experiencing loss. These three sub-themes are explored below.

### 7.1.1 Transferred away from home and whānau

The first sub-theme involved wāhine being transferred away to a secondary or tertiary hospital located some distance from their home. The wāhine whose journeys are shared in this sub-theme (Becky, Kristen, Justine and Teina) were transferred due to complications with their pregnancy. Becky was transferred while in labour because her baby was showing signs of distress; Kristen was transferred prior to labour because of her baby’s suspected congenital anomalies; Nadia was transferred to tertiary care prior to labour because of concerns over the growth of her baby; Justine was transferred while in labour due to heavy bleeding and suspected miscarriage; and Teina was transferred in early stages of labour for an elective caesarean section, but during the transfer her babies became distressed and she was taken immediately for an emergency caesarean section. Other wāhine (Ashton, Waiata, Ngahuia) were transferred due to the onset of preterm labour, and their experiences are shared in the next sub-theme.

Transfer often represents the first step in shattering the imagined birth of a wahine, as it clearly signals complications with her hapūtanga. The wahine experiences shared here provide insight into the complexities involved in the physical transfer away from their home and whānau, and the abandonment of their imagined labour and delivery. All that were transferred were required to travel a vast distance by road travel because most lived in rural communities. The distances travelled raised the idea of rurality as a social determinant of health. This will be further discussed as the chapter proceeds and in the following wāhanga.
Becky’s birth imaginary included giving birth at her local hospital on her due date with no need for medical intervention. Her reality was carrying post-term to over 41 weeks and, when she eventually went into labour, it was long and slow to progress and lasted over 40 hours. Becky’s baby was in breech position and was showing signs of distress towards the later stages of labour. Becky’s LMC repeatedly asked if Becky would consent being transferred to the nearest secondary hospital (two hours away) so she could receive medical interventions for the sake of her baby. Becky resisted this transfer because she was adamant that everything would return to normal and she would continue to deliver locally. Her reluctance to forsake her imagined birth and accept that things were not going to plan informed her decision not to physically transfer.

I was so determined to have baby in [home hospital]...but it didn't work out that way. My midwife said it wasn't good, baby wasn't in position and he was the wrong way so...she wanted to send me to [secondary hospital] straight away but I was asking if there would be any chance not to go there because I had it in my head that it was going to be fine and he would turn at the last minute and everything will work out...I was just so determined to have baby at [home hospital]...I was like, next time just make someone make the choices for me, don't let me make them because I'm stupidly stubborn and think that I can do it. (Becky)

Becky’s journey indicates that the notion of being transferred away from home entails more than just the wāhine consenting to being physically removed from their whānau and whenua, it also requires the wāhine to relinquish their birth imaginary and accept a significant change from what they had planned or wanted. This is what Becky struggled with the most. As she expressed, she was determined that she was going to have her baby at her local hospital and that everything would be fine and ‘normal’. In the end, the decision to be transferred was made on her behalf by her LMC, to which Becky eventually agreed upon. Other wāhine were more accepting of their need to be transferred away and were more willing to make the sacrifice of being with their whānau whenua for the sake of their baby. This is evident in Kristen’s journey.

When Kristen and her husband were informed of their baby’s congenital anomalies, although they were hurt and shocked by the news, they accepted the need for Kristen to relinquish her imagined birth and be admitted to the tertiary hospital four hours away from their home. Kristen and her husband demonstrated their tino rangatiratanga here through exercising their right to make decisions regarding the health and wellbeing of Kristen and their whānau. Tino rangatiratanga is also evident in Kristen’s maternal leadership and placing the needs of her baby ahead of her own, to make a decision that she was comfortable with. Kristin outlines her decision-making process,
Me and my husband had talked extensively about what we were going to do, and we were quite okay with being split so he could look after the kids and I could go down to [tertiary hospital] to deliver… (Kristen)

Although Kristen’s example illustrates a wāhine approving the decision to be mentally and physically transferred away from home, it also highlights how it came at the cost of being isolated from her other children and husband.

The physical transfer to a secondary or tertiary hospital often involved two or more hours of travel for wāhine (and their whānau). The distance caused great discomfort, and in some cases, increased the trauma experienced by mother and/or baby.

I just remember, we drove down to [secondary hospital] and I started having real bad contractions. By the time I got to [secondary hospital] they were still the same distance apart, they had never changed throughout the whole day, just stayed between 7-10 minutes, they never got any closer to 5…but yeah that made the drive worse. (Becky)

Becky’s two-hour road journey was uncomfortable because she was experiencing labour contractions. On the journey, she became increasingly worried about her baby and her husband, which added to this discomfort because the transfer had indicated to her that health complications were evident. Stress is heightened when there are major complications at play. Justine’s journey illustrates this.

Justine was camping at a rural coast with her whānau when her complications began. From here, Justine had to travel over two hours to reach her hospital and during that time she had to endure the discomfort of labour while knowing she was miscarrying her baby. She articulates,

I had full on contractions for the whole trip and they were so close together. So that was real traumatic too, just knowing that I had to go through all of that labour as well as knowing that my baby was dying. (Justine)

There were multiple layers of pain, physically and emotionally, that Justine bore during this traumatic experience. Justine experienced great labour pain and heavy bleeding prior to her transfer to hospital. This was accompanied by the emotional trauma of the knowledge that she had to endure labour and deliver her deceased baby. She had to go through the transfer without the support of her husband, who was working in their home area. Instead, she travelled in the ambulance with her mother, and worried that her husband might not be present when it came time to deliver their baby. More of Justine’s journey is shared in the sub-theme of experiencing loss.

The important note to make here is the trauma that may be associated with the distance travelled during a transfer.

Teina was another wahine who was required to transfer to a secondary hospital to deliver her twins. However, her transfer came about under different circumstances to the transfers that have been shared so far. In her second trimester, Teina and her
obstetrician agreed to a clinical plan that involved Teina having an elective caesarean at her local secondary hospital (one hour away from her home) and once delivered, her babies would be admitted to the SCBU there also. This plan became her birth imaginary. Unfortunately, this plan was not communicated to all health practitioners involved, and on the day of her booked elective caesarean, Teina was asked to transfer to another hospital located a further hour from her home and whānau to deliver her babies. Teina and her whānau believed that Teina’s transfer happened because miscommunication had occurred at the hospital. She shares,

We were booked to deliver at [home base] hospital…but then we had to go to [second hospital] because the SCBU unit was full. But they had us there [home base hospital] all weekend and they knew the plan so that’s what pissed us off that they didn’t make the decision to transfer us to [second hospital] two hours before we were supposed to have had surgery. (Teina)

Teina’s cousin expressed her disappointment too,

We had signed the papers with the obstetrician and all weekend the nurses and the obstetrician was saying everything was good to go with the plan of delivering on Monday in [home hospital]…and between the time it took the obstetrician from coming to see us on Monday morning, the head of SCBU there had decided they had no capacity for our babies. (Teina’s cousin)

With no choice, Teina was made to transfer to the next hospital and was sent in an ambulance to the next hospital two hours before she was booked for surgery. Her cousin travelled with her in the ambulance, and it was during this one-hour road transfer that the heart rate of one of her twins decreased dramatically. There were concerns also for the second twin because she was measuring small for her age. The concerns were elevated when she arrived at the second hospital, and the obstetricians there promptly delivered Teina via an emergency caesarean section. Teina described this journey as,

We got there about 2pm and they put us on the monitor and [twin 1]’s heart rate went down so they rushed us in for an emergency caesarean section. And then I had to have a general and they just cut me open and did whatever and the babies were born, and she (pointing to cousin) was in the room waiting for them. They had to go to SCBU. [Twin 2] had to be put on CPAP, [Twin 1] was the little one and was 1500g when she was born, tiny but tough as, but her sister was sick and had to have all the breathing stuff…and then I just remember waking up and then they wheeled me in and I saw her on that fucking thing [CPAP] and she was in her own little bed… (Teina)

Teina’s birth plan was shattered by a combination of events that eventually led to her having to be delivered in a hospital that she had not being before, and with health practitioners she did not know. This caused disappointment for Teina,
It was just a combination...like we were having twins, and they were coming early, and one was bigger than the other...it seemed one thing on top of the other...and then we got told we had to go to [secondary hospital 2], it was just shit...Everything that could happen, did happen, but I didn’t realise the seriousness of it until everybody started saying it wasn’t normal... (Teina)

Through these statements, the disappointment Teina felt as a result of her imagined, and desired, birth plan being shattered and instead needing to have an emergency caesarean section under general anaesthetic and waking to the shock of seeing her babies in a poor health condition is evident. While the whānau consider the events that led to Teina’s disrupted whakawhānau journey deriving from poor communication between maternity care practitioners and neonatal care practitioners, it may have been a series of events that the hospital could not control that resulted in the SCBU having no capacity to take the babies following the weekend.

Nadia was also a first-time mother who went into labour before full term at 38 weeks gestation. In the week leading up to her labour and delivery, Nadia’s baby had not grown. This caused concerns by Nadia’s midwife and Nadia was asked to travel to the hospital for a growth scan and monitoring. This scan found that Nadia’s baby was receiving limited blood flow to her brain because the placenta was failing. Associated with this, Nadia’s baby was measuring small for her age. It was this stage where Nadia’s birth imaginary became disrupted. As she states,

I guess it was obviously not what we were expecting at all...

Following this scan finding, Nadia was required to receive regular monitoring so the health practitioners could track her baby’s condition. The obstetricians requested Nadia be induced and she initially resisted. However, after this request, Nadia stated that her body “kicked into gear” and went into labour without the need for induction. The delivery was difficult and traumatic for Nadia because her concerns for her baby were growing. She shares her fear,

...Every time I was having a contraction her heart rate was dropping, it got scary because she was too low to do a caesarean and I had no pain relief, but we had to get her out because she was so little and not dealing with the contractions. So, they were like ‘we have to do ventouse and episiotomy and all that stuff, and I had no pain relief or anything and...there was about eight doctors in between my legs, everything just goes out the window. (Nadia)

This experience was frightening for Nadia to go through, especially for her first labour and delivery. It was frightening because she could recognise the tense atmosphere and raising concerns for her baby’s health at each contraction. Therefore, not only did she have to deal with the discomfort of labour contractions, she also had to contract with the knowledge that they were causing stress for her baby. The statement, “everything just goes out the window”, describes how she felt that she had
to completely forsake her imagined birth plan and relinquish her control to the health care practitioners for the sake of her baby.

7.1.2 Preterm labour and deliveries

Another example of a reality that differs from the birth imaginary is preterm labour. Preterm labour can be a distressing situation for hapū wāhine because it disrupts the birth imaginary or plan. Two wāhine (Ashton, Waiata) were first time mothers who went into preterm labour and expressed similar feelings of unfamiliarity, fear and unpreparedness. Ashton and her partner said they had not expected to go into labour prematurely, so they saw no need to change any previously booked trips. As a result, Ashton’s partner was away on a fishing expedition when she went into labour. Ashton and her partner own a local supermarket and she was checking on a new staff member when her water broke. She continues to outline the events of that day,

And that morning I went to work early, and I was training a checkout girl and felt normal as...I did a quick store walk to make sure everything was alright and then I was standing outside the milk chiller and my waters broke...it was weird, everything was going so normal and okay so it was such a surprise! (Ashton)

Her shock is expressed further as she continues,

My waters broke and I had no idea what was going on, I just ran to the loo. It wasn't until I was lying on the floor in the toilets at work that I realised, because I couldn't move, that’s when I thought, ‘oh my gosh I think I’m in labour’. But still at that stage I didn’t think that I would actually go into labour, I just thought that it would be a hiccup on the way. And so my aunty and I were trying to get to the car but I just couldn’t get myself out of the disabled toilet...it all just happened so fast. I said to my aunty that I felt like I need to push and that was about ten minutes after talking to my midwife. (Ashton)

Ashton described that learning a calm birth technique in her antenatal classes helped her overcome her anxiety about being unprepared to give birth. This was utilised as a coping strategy.

It’s all about breathing techniques to teach you how to have a really calm birth...So I said to myself you need to start using those things that you’ve learnt, so I started practicing my breathing. Yeah so that was pretty crazy but the whole time I was just focused on my breathing and in the calm birth I learned to relax my hands, feet and mouth so I did that too and yeah it was a really amazing labour. (Ashton)

Utilising this technique allowed Ashton to remain in control during a time that can be fraught with stress and anxiety. Ashton also reflected on how she relied on her LMC during this time. When Ashton went into preterm labour, she rang her LMC to alert her of the labour. Ashton was initially concerned that she could not get in touch with her LMC but was reassured that there was another that made herself available.
This back-up LMC made a timely effort to be at Ashton's rapid labour and delivery to offer her professional and emotional support. Ashton shares her appreciation for the LMC,

So I tried to ring my midwife and I couldn’t get a hold of her so I rang another midwife and she was like ‘ok I'll meet you at the hospital’, this was at 4pm, and she said she will meet me at the hospital at 5.30pm, she said to go home and pack your bag and then we’ll check you out, she said, ‘you’re pretty early still’. I checked my phone to see what time I had rang my midwife and that was at 4.06pm and then he was born at 6.06pm. (Ashton)

Before moving on to the next section, the ‘silence’ Ngahuia had regarding her whānautanga journey is worth exploring. Ngahuia had delivered her baby preterm. Prior to this delivery, Ngahuia had already experienced preterm births with each of her previous seven children. Preterm births had therefore become her ‘normal’ imagined birth and shaped her expectations of how her current pregnancy would progress. This accepted normality of births may be the reason behind Ngahuia’s silence about her whānautanga journey. The care pathway provided for Ngahuia may also be questioned here too. It is known that if a mother has a preterm birth, her likelihood for another is high; therefore high-risk care pathways should be put in place for those women. Therefore, it may be questioned if Ngahuia was placed under appropriate specialist care during her hapūtanga and/or whānautanga journeys because she experienced another preterm labour and birth.

7.1.3 Experiencing loss

Two wāhine experienced the loss of their baby. Kristen lost her baby at 8 days old. Justine lost her baby at 19 weeks pregnant. The loss of a child is perhaps the greatest alteration to one’s ‘imagined birth’ and it was found to be a traumatic experience by Kristen and Justine respectively. The strength of these two wāhine and their whānau amazed me, and I was greatly humbled that they were willing to share their journey with me. We can honour their babies’ short-lived lives and lost potential by learning from their experiences.

At the time Justine experienced her loss, she was out at a rural coast camping with family. In the middle of the night, she became overwhelmed with intense pain and bled heavily. Her family rang the ambulance, and this is how Justine shared her story. The night of her loss began as follows,
I just got this overwhelming pain and I thought I might need to go to the toilet...and I could just feel this bulge and I just sucked it up because I knew straight away that something was happening and I went to my mum and saying ‘mum my baby’...The pain was all up my back, stomach, and my legs wouldn’t move...and my mum made me a bed in the back of the truck and I just lay there miscarrying, having hard out contractions, so I had to go through labour for about five hours. They called the ambulance and they came and got me and Mum was like 'she needs an ambulance'.

The trauma Justine was experiencing became evident when she became concerned for her life and her baby’s. Her thoughts were with her family who relied on her as a mother and wife.

I actually thought I was gonna die, and so I was just praying to god and saying you can’t take me and my baby, I’ve got too much going for me...

The next sequence of events involved her transfer via ambulance to the nearest hospital. This was a stressful journey because she was determined to get to her home hospital where her husband could join her. She was stressed for him because she knew he would be worried about her. The fact that Justine was considering the thoughts and concerns over hers while she was in great pain and physical trauma is a reflection of her strength. The journey was also made stressful because the paramedics were limited to the stages Justine progressed with her delivery to where they could take her. This resulted in her fearing that she would deliver prior to reaching her home hospital and instead be dropped off at the nearest medical center. Her journey continues,

And then the ambulance came, and they said that if I had baby by the time we got to a nearby medical centre they would stop there and I would have to get out there even though it was far from home. And I was like, na, I gotta get home because [husband] was home and I knew he would be freaking out. And they were like, ‘if you get to a certain point then we’ll go to the next stop’, like they had all these checkpoints...and my will power was just telling me to make it home. That’s all I was saying too, I was just asking for them to take me all the way to home, but they were just like ‘sorry we can’t take you that far if you’re gonna have baby’. Then we made it to the zone [just before home zone] and I made it to about three minutes in that zone and then I had baby...and [husband] turned up from work there and then my whenua came. So I think that was me as well cos I was just thinking there is no way you’re turning me around to a medical centre when my husband is coming to [hospital] and not with me. (Justine)

The stress of wanting to get to the hospital where her husband could meet her, which was over a two-hour drive away, fuelled an already difficult situation for Justine. The paramedics were focused on the safety of Justine and her baby. While they knew she wanted to get to her home hospital, they were required to follow guidelines and potentially ignore her request if required. This illustrated the challenging position health care practitioner can find themselves in. This difficult situation, compounded by
Justine’s severe miscarriage and loss of blood, might have been eased by a helicopter ride to respond to both her physical and emotional transfer needs.

The other wahine who experienced loss in their journey was Kristen. Her son had suspected congenital anomalies that would severely limit his lifespan, to the point where Kristen’s maternity care practitioners indicated that she would be delivering her son into palliative care. Kristen spoke openly about her disappointment that the reality of having to deliver her son into palliative care was starkly different to how she imagined the birth of her final child to be.

I was sad because my reality was so far away from what I had expected; like I had expected for our last baby to be home delivered, with all my family around, no interventions, just my midwife there. (Kristen)

Kristen’s birth imaginary became invalid at this point because she was required to stay in the tertiary hospital to receive specialised medical care (for herself and her baby). She therefore saw out the remainder of her pregnancy isolated from her home and whānau. Kristen shared the difficulties she faced during this time,

...you kind of just go on automatic and try to focus on the next thing. And we had polyhydraminos and so we were getting huge, I looked like full term and I had two months to go. And a week to the day later, my waters broke, and it was one of the scariest moments ever because my midwife told me that if I had too much fluid that could all come out in a gush and that could be detrimental to bubba. (Kristen)

The emotional trauma Kristen bore was indicated by her description of her waters breaking as the “scariest moment” because she feared the safety of her baby. Yet, amongst all of her stress, Kristen went into her labour and delivery with a positive frame of mind because she had just finished reading a book provided by her LMC that offered supportive advice.

When I was able to give birth to my boy, I could enjoy the moment because there was a quote in the book that said, ‘I will make the most of every moment because I can spend the rest of my life grieving you’. So that was the frame of mind that I went into it with. (Kristen)

Wishing to abide by this and make the most of this birth experience, Kristen reached down to grab baby when she could feel him coming, however the health practitioners prevented that moment by taking baby before Kristen had a chance to touch him,

I went to reach down for him as he was being born…I can still see my hands doing it now, and they just picked him up and put him over there straight away…it was such a horrible feeling. (Kristen)

The action of removing baby straight away is another example of where health practitioners follow guidelines at the expense of patient aspirations. It demonstrates a disconnection of needs and understandings between health practitioners and patients.

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19 Palliative care is specialised medical care delivered to those with serious illnesses, and is particularly characterised as being end-of-life care.
Consequently, this moment is etched in Kristen’s mind and is a difficult and surreal memory for her to reflect on.

7.2 Access to Whānau Support

As with the hapūtanga period, having a strong network of support assisted all the wāhine with their labour and delivery. This support was identified by the wāhine as an essential component of them enduring the challenges and difficulties they faced, as their whānau were a readily accessible form of emotional, mental and physical support. This section explores whānau support that was accessible during whānautanga.

7.2.1 Implications of accessing whānau support

At times, their whānau support enabled a difficult situation to be transformed into a more positive experience.

Aroha shared her appreciation of her whānau support during her labour and delivery, particularly the support of her partner, daughter and aunty.

I would relive the moment again…I had good family support, I had my aunty, my partner and my daughter and they all had their own jobs…it was awesome. (Aroha)

Teina reflected on the support she had from her female cousin who was familiar with the health care system and had great health literacy. Teina relied on this cousin for not only emotional support, but also as an advocate for her to the health practitioners because she felt that she did not know how to communicate with her health practitioners in the “proper” way. This was expressed,

I was lucky I had [cousin] there cos she knows how to talk to them [the practitioners] properly whereas I’m like F this and F that, but she did it the proper way. (Teina)

For some of the women, being transferred away to secondary or tertiary hospitals to deliver limited their whānau support because of the distance between their home and the hospital. This is another reflection of rurality being a social determinant of health because the distance required to travel to the hospital to be with their loved one(s) caused stress (financial and emotional) on whānau. As a cousin of Teina explains,

One of the things I noticed too was like when you have to have your baby away from here [home], you’ve got no one…it’s too far for whānau. (Teina’s cousin)

Ashton’s access to her whānau support was lessened due to the unexpected onset of preterm labour at 33 weeks. When she went into labour, her partner was away on a fishing excursion, so she was supported during her labour and delivery by her
close female relatives again, namely her nana and aunty. She was happy that her partner also had good support when he learned what was going on,

So he had no reception and we had to contact him through the radio; we know the lady that runs it so they organised her and I was on the phone to her and she said that we could either wait until he’s in reception and call him myself or broadcast it over the whole radio, and I was like, ‘oh well, he needs to know’ so she let them know over the whole radio (laughs). They were meant to come in on the Saturday morning and so they were heading home already and they were sitting down having a few beers and he was with my younger brother and his two other best friends so it was really cool, I mean considering the circumstances at least I had my nana and aunty with me and he was with his close friends… (Ashton)

Justine particularly appreciated having whānau support during her loss. She sought support and advice from her mother as soon as she suspected something was happening with her baby. Justine’s mother provided the comfort she needed during this traumatic time,

We went back to the toilet and my mum came and we were sitting on the toilet (long drop) and she told me to get off cos she didn’t want bubba to drop, and I went to try get up but I was just weak and couldn’t walk…and my mum yelled out to my brother-in-laws cos [my husband] was working on night shift in [home], and they had to come carry me. I was in such intense pain that it took over my body. (Justine)

The experiences shared by the wāhine showed that they mostly had support from their partners and from female relatives (mothers, cousins, aunties).

7.3 Maternity Health Care

In this phase of the whānau journey, the main maternity practitioners of health care that were spoken about were the LMCs, hospital-based midwives, and obstetricians. In the views of the wāhine, the provision of good health care had its foundation in two key Māori principles: whakawhanaunga and manaakitanga. These are described below.

7.3.1 Engaging in whakawhanaunga

In Te Ao Māori (the Māori world), whakawhanaunga is the act of building relationships with others (see Chapter 5). To translate the word, it is useful to break it down to its components. The prefix whaka is used to mean causation, and whanaunga is used to mean relationships and connections. Therefore, whakawhanaunga is the act of building and engaging in meaningful relationships. Whanaungatanga is the end result whereby there is a flourishing of energies between those interacting.

The wāhine who said they were able to whakawhanaunga with their health practitioners reflected positively on the care that was provided to them. This suggests
that building and maintaining good relationships with health practitioners can support the whānau journey. Waiata particularly alluded to this. As a first-time mother, labour and delivery was a novel experience for her. She expressed feeling shy and wary of exposing her body to unfamiliar people. As stated,

I didn’t want everyone down there looking and feeling around… (Waiata)

Waiata also went into labour preterm, which required her to be transferred to a secondary hospital two hours away from her home. While this caused her stress, it was manageable because she became familiar with the secondary hospital and the midwives working there through the regular monitoring she underwent during her pregnancy. Her care pathway facilitated many opportunities for maternity care practitioners to whakawhanaunga with Waiata and build trusting relationships with her. For example, she acknowledged the trusting relationship she shared with one of her hospital-midwives,

One of the midwives looking after me [in hospital] was great. She just let me be and let me dictate how everything went and she didn’t push me into anything I didn’t want to do. I’m very thankful for that cool midwife. (Waiata)

The relationship Waiata shared with this “cool” midwife enhanced her labour and delivery journey. As Waiata’s journey highlights, with whakawhanaunga, the wāhine and their whānau were more likely to trust the health practitioners. Building trust can alleviate the disconnection that is often present between practitioners of care and wāhine by breaking down unfamiliarity and perceived power imbalances through free and meaningful communication. As a result, wāhine were more likely to agree with the treatment recommendations of practitioners and continue their whānau journey with the health practitioners by their side. As some wāhine voice,

I was just too big, and I was quite out of it too because I had just been drained, I was really sore and I was just following instructions, like you guys tell me what to do and I’ll do it, I trusted them [the health practitioners]. (Kristen)
I trusted my midwife there [hospital], she was really good and let me be me. (Waiata)

Nadia’s example of trusting her numerous practitioners to the point that “…there were eight doctors in between my legs” (Nadia) is also relatable here.

7.3.2 Engaging with manaakitanga

Manaakitanga is another key Māori principle that is derived from the Māori worldview. As with whakawhanaunga, it is useful to break down manaakitanga to its components, so it may be understood. Firstly, it is important to understand that all physical, non-physical and spiritual things that are derived from atua have mana (Hall et al., 2012). Mana is the spiritual power gifted from atua to enhance the betterment of the collective. Aki means to uplift. Tanga is the suffix that is applied to make verbs a
noun. Therefore, manaakitanga is enacted through positive qualities such as caring, sharing, loyalty, generosity, hospitality, and meeting obligations that uplift one’s mana. Health practitioners who offer care with respect for others, sharing information and resources, and fulfilling their professional obligations as health practitioners will be practicing manaakitanga. Providing care with manaakitanga is positive for all involved because the mana of the wāhine and their whānau is uplifted while the practitioners of care will be simultaneously uplifting their own mana.

Some of the wāhine and their whānau shared examples of how their health practitioners engaged with manaakitanga. Nadia provided an example of how she felt her LMC demonstrated manaakitanga through offering emotional and professional support. As has been stipulated in earlier chapters, LMC’s are often relied upon by wāhine and their whānau to not only provide the professional clinical care, but also compassion because they are an essential part of the whānau journey. Having a LMC that can offer manaakitanga through the dual supporting roles then was found to be a positive aspect of maternity health care. As Nadia shares,

Our midwife was awesome. She said the other day that she kept on thinking about the birth, because it was quite traumatic. My body went into shock afterwards and she was just making sure I was okay and stuff. She said ‘your birth was quite rough but your body responded very quickly, but if you ever need to talk, we’re here’. So, the midwives have been amazing the whole time. (Nadia)

Kristen’s delivery journey demonstrates how her midwife expressed manaakitanga. Immediately following the delivery of her son, Kristen was emotional because she could not hear her son crying. This made her fear that he had already passed. She was uplifted with strength through the actions of her midwife offering her support and mana in this time.

It was so hard. And then I couldn’t hear him crying, and my midwife could see that I was starting to get upset and she came and gave me a cuddle and told me I was strong and that I could do it, and your boy is strong and he can do it too. (Kirsten)

The manaakitanga offered by Kristen’s midwife in this circumstance not only uplifted Kristen’s mana, it also uplifted her baby’s mana and provided both with the strength to get through this difficult time. His mana and strength were demonstrated through his eight days of life.

The experiences shared here by the wāhine offer the finding that good maternity health care is inclusive of offering professional guidance as well as demonstrating manaakitanga.

Conversely, an absence of manaakitanga was linked by wāhine and their whānau to the provision of poor health care. This absence of manaakitanga left the wāhine feeling like a “number” within the hospital environment, receiving what they felt
was impersonal care. They felt this way because the practitioners of care were unknown to them because of the lack of whakawhanaunga. When they compared that environment to their local, home hospital they were aware of the absence of hospitality, generosity, and kindness were they were. In their home hospitals, which were often smaller, the wāhine were familiar with the space and people. They were often friends with some of the health practitioners (for example Teina developing friendships with the hospital midwives during her hapūtanga scans). Wāhine participants spoke of how they found the larger, higher-level hospitals as being impersonal and clinical environments. For example,

I found that everyone here [home hospital] was good, and [secondary hospital] was good, but it was just impersonal. (Becky)

Becky alluded to the impersonal nature of the hospital due to the health practitioners not interacting with her, consequently leaving no space to whakawhanaunga with her. While she was at the secondary hospital, she recalled only one midwife making an effort to build a relationship with her. Becky acknowledged that the care she received during her labour and delivery was adequate, but it was care that came across as cold because the practitioners of this care did not observe whakawhanaunga. This is supported by a similar experience shared by Kristen,

We had to get drained so I stayed overnight in [tertiary] hospital and I felt more like a number there. (Kristen)

Kristen did not develop any relationship with these initial health practitioners at the tertiary hospital and felt unwelcome in the foreign environment. Health practitioners disregard for whakawhanaunga impacts negatively on the journey experienced by the wāhine and her whānau.

For Teina, she felt there was an absence of manaakitanga throughout her postoperative care because she described receiving an inadequate explanation by her health practitioners of what her medications were or how they were to be correctly taken. Unlike the examples shared above by Becky and Kristen, this absence of manaakitanga did directly impact on the care of Teina because her health practitioners did not meet their professional obligations to explain her medication in an understandable manner. Teina was left to self-medicate her pain relief (the box Teina refers to) without adequate education, which resulted in her wooziness. Teina shares this impact,

This is why I thought that [secondary hospital] was shit because I woke up in the morning and they...gave me this box with a button hooked up to medicine so I was just pushing that all night cos I didn’t know what they were or what to do...so I was like really, really woozy. And I was trying to tell them but they were just like get up but I was like I can’t, I was high for the first time in my life. (Teina)
As the earlier section illustrates, manaakitanga can be offered in a number of ways. For example, engaging in whakawhanaunga, offering food, and showing respect and kindness. It was found that providing manaakitanga can positively impact a whānau journey and wellbeing, which should be the ideal goal for all health practitioners. Similarly, the opposite was found to be true. The absence of manaakitanga demonstrated by health practitioners had a negative impact on the journey of the wāhine and their whānau.

7.3.3 Whānau perspectives

Two pāpā (fathers/partners) offered their perspective of the whānautanga journey and openly shared their disappointment in relation to the care that was provided to their partners and baby during the whānautanga journey. Reports of poor health practitioner care came mostly from those who had to witness, rather than experience first-hand, the care the women and their babies received. By contrast, the wāhine themselves often could not remember the exact events of their labour and delivery. For example, Becky felt that “everything was a blur” due to her continually passing out as a result of being exhausted from her prolonged labour. Her husband had a strong recollection of the events from supporting Becky the whole time. He, who was becoming a father for the first time, was quite upset about his difficulty in getting his wife into the secondary hospital while she was in labour, sharing,

The stupid girl at the hospital reception sent me round to the back entrance and then they wouldn’t let me in because they were asking who I was and I was like, ‘Look I have a pregnant wife!’ So we went back round to the reception and said fuck you lady and went in. (Becky: it was so bad). We went down in the middle of night and I had to wheelchair you through the hospital but yeah everything was locked up cos it was 11pm, but they knew we were coming down. (Becky’s husband)

Being alone with minimal communication or support left the fathers vulnerable and some of the wāhine expressed their sympathy for their partners during this time.

I was just thinking it would have been worse for their dad cos he saw everything. I was knocked out, luckily. (Teina);
A lot of what happened to me I don’t remember, [husband] is the one who tells me what happened… (Becky)

These statements are consistent with other themes of the whānau journey whereby the wāhine are often thinking of the needs and feelings of others over their own. Fathers who shared their kōrero with me also felt helpless during this time because they could not protect their partner and baby. They were made to resign their roles as protectors to the maternity care practitioners. During that time, their
vulnerability increased because they were made to watch their partner and baby with minimal support being offered. Justine’s husband reflected on this,

It’s just about keeping informed…and communication and transparency guys. (Justine’s husband)

Justine adds to this,

Yeah hard out. It’s about keeping them informed, like because I know how I am, I know that the doctors just say he’s fine but I know that he’s not fine, like you know everything isn’t fine when there’s three paediatricians, four specialist nurses and all of that in the room, you can’t tell me my baby is fine. But you know with some people they believe it because they put so much trust in those doctors and nurses. (Justine)

This example indicates the communication issues that were present at this time, whereby Justine’s husband was not informed of the health status of both Justine and their baby. It also returns to the issue raised in Kristen’s journey, whereby the presence of unspoken communication raises concern and discomfort for the wāhine and her whānau. The unspoken communication in both Justine and Kristen’s journeys were the number of health practitioners present in the room when they were informing the wāhine of their baby’s health status. In both cases, both wāhine judged something was not right by the number of specialists in the private room. From the point of view of the wāhine, it may be argued that health practitioners need to review how they inform wāhine/whānau of adversities, as being left in a private room and being asked to meet with numerous medical specialists invokes stress and anxiety for wāhine. However, from the viewpoint of health practitioners, being able to deliver adverse and difficult information with the support of various colleagues may be helpful for them. Regardless, being misinformed and unsupported were recognised by ngā pāpā as aspects of poor provision of care.

7.4 Biomedical Health Care System Environment

The current health care system is derived of and based upon biomedical values and practices. Given that whānau are the functional unit of wellbeing (Elder, 2017), health care services must be shaped and delivered in a way that allow whānau to provide healing and wellness to those admitted to a health care service. Instead, biomedical systems and procedures continue to dominate health care service delivery (and design). These systems prefer individualism and universal approaches to health care that are often hard-pressed to include whānau (Wilson & Barton, 2012). This creates an environment that whānau often feel alienated within because there is often a cultural disconnect between whānau and the clinical system. The cultural
disconnect(ion) was found to be particularly evident by a poor awareness of mātauranga Māori maternities and an absence of manaakitanga.

7.4.1 Poor awareness of mātauranga Māori maternities

As explained in earlier chapters, through the influence of colonisation, mātauranga Māori maternities were discouraged and replaced by non-Māori maternities. The impact colonisation had on mātauranga Māori continues to be substantial today because the Western approaches are still maintained as the norm. For example, Western approaches continue to be normalised is the position of lying down to deliver. While this approach remains normalised, it is important to note that many health care practitioners today have become more accommodating to how a woman wants to deliver. Waiata shares a piece of her journey that is reflective of this discussion,

They tried making me lie on the bed to push at first, but I don’t understand that way, like gravity doesn’t go sideways! So I stood up and squatted to have baby. And I just used my partner and dad to hold and support me, that was cool as. (Waiata)

This is an example of Waiata expressing her tino rangatiratanga because although she was initially asked to deliver lying down on the hospital bed, she determined a delivery position that was an appropriate way for her.

Aroha also reflected positively on her labour and delivery, largely because she had the support of her partner and had exercised her tino rangatiratanga to deliver in a way that was optimal for them.

Yeah, being in the pool was amazing cos all of my contractions were in my back so the pool just took a lot of the pressure off. I had my partner get in and support me, so he held my back. If I did it again I would do it that way. (Aroha)

While the examples provided here have positive end results, they express how the first option of delivering that was suggested to them was the biomedical designed delivery position. Waiata and Aroha resisted this position and were able to exercise their tino rangatiratanga to determine how they would deliver their baby.

Continuing with the topic of deliveries, a significant event that contrasted to mātauranga Māori maternities was the immediate removal of Kristen’s baby from her when he was delivered. Prior to his delivery, Kristen was told she would be delivering her baby into palliative care due to his suspected congenital anomalies. Kristen was induced and her baby was delivered. Immediately following her baby’s birth, the obstetricians and neonatologists removed Kristen’s opportunity for skin-to-skin.

Skin-to-skin is when the mother and baby are in direct contact. Immediate skin-to-skin following birth is encouraged to help mother and baby bond.
because they took her baby straight away to be placed in intensive care. This is understandable because the health practitioners’ focus was on the health of baby and doing all they could to improve the chances of his survival. However, Kristen described how difficult that was for her.

They took him and they put him in the incubator and I was still kind of out of it because I still had all my placenta and everything to deliver, and then they rolled the incubator over to me and I had to put my hand through to try to touch him (cries), and it was so surreal, it felt like a movie, I felt like I was in an alternative place because this is not how I do things and not how our other kids were done, you know, we were given them and you always hear how kangaroo cuddles and skin to skin is good. I didn’t get to have that initial bonding with my boy when he was born and looking back over it, I only had four cuddles and when I say cuddles, he was attached to tubes and everything, and my fifth cuddle was my final (cries). Sorry. (Kristen)

Being denied the opportunity for immediate skin-to-skin with her baby was unnatural and surreal for Kristen. The grief of not having her birth imaginary met can be recognised in her statement.

Another cultural clash that was described in the experiences related to the health practitioners being unaware of wāhine whakamā. Many of the wāhine shared feeling shy and wary of exposing their body to unfamiliar practitioners of care during their labour and delivery. For example, during the labour and delivery of her baby, Becky continually fell in and out of consciousness due to exhaustion. She recalls one time coming into consciousness and feeling shame when she noticed how many people were looking between her legs waiting for her baby to be delivered.

All I remember is waking up on the bed and then everybody was on that side and I just yelled out ‘what are you all doing down there, get up to this side of me!’ I was like ‘how long have they all been down there for, the whole time I was zonked out?’ (Becky)

Becky describes her shame and also her sense of vulnerability. She was unsettled during this time because she was unaware of how long she had been exposed to people while she was unconscious. Asking Becky how she would like to be assisted to birth her baby, and by whom, while she was conscious could have been a way of demonstrating respect for Becky and her whakamā.

The lack of introductions by health practitioners can also be insensitive for those who are whakamā within the hospital context. It is also a breach to the tikanga best guidelines held within DHBs that stipulate that practitioners are to introduce themselves at their first point of contact. He kanohi kitea (the seen face) is also an important Māori cultural value and involves introducing oneself and one’s objectives so that connections can be made. However, this was not always done in the clinical environment. As Teina’s cousin shares,
Yeah so all these people [practitioners] were just coming in, and I just said everyone, please just stop and tell me who you all are and what do you do, one at a time. I just got overwhelmed with the amount of people just coming in to the room… (Teina’s cousin)

This is an example of how Teina’s cousin resisted these biomedical norms, and insisted on the practitioners engaging in whakawhanaunga. Showing respect for wāhine and their whānau, especially those who are delivering for the first time, should be a priority for health practitioners. Respect and whanaungatanga are effective ways of overcoming cultural ignorance and obtaining positive end results.

7.5 Chapter Summary

This chapter shared the whānau experiences during their whānautanga journey, including how they had imagined their whānautanga, their labour and delivery, would be. For the first-time mothers, how they imagined their labour and delivery to be was developed through messages consumed from antenatal programmes, other whānau members, and various media sites. Many wāhine in this study were disappointed when their labour and delivery did not go as they had planned or imagined. As such, it was interpreted from the shared whānau experiences that the quality of the labour and delivery for many of the wāhine was significantly lower than that of their hapūtanga experience.

When a birthing experience differs from a birth plan or ‘birth imaginary’ it can be upsetting for the mother and her whānau. This is especially so if the health of mother and/or baby is compromised. This suggests that there is a link between the physical experience of the pregnancy and delivery (whether it be positive or negative) and the non-physical, mental, emotional and spiritual, wellbeing of the mother and baby. As a result of their disrupted labour and delivery imaginaries, the wāhine encountered stress and anxiety because they were made to enter the maternal-infant health care system under unanticipated circumstances. Often this was accompanied by the need to transfer away to higher-level hospitals.

The decision to transfer can be difficult for the wāhine and/or whānau to make, therefore reluctance to do so can be evident. The two main reasons why the decision to transfer was difficult for wāhine to make that came out of the interviews included the vulnerability of becoming isolated from their home and whānau; and accepting the implication that normality had ceased and the health of themselves or their baby were at risk. When wāhine were required to transfer away from their home and whānau support to deliver their baby, their wellbeing was often compromised. This is because although the higher-level care may be required, it came at the expense of losing their
social support and connection to place through being removed from whakapapa (of people and whenua).

Whānau support was found to be beneficial for wāhine during their whānautanga journey. This finding should encourage the health care system and practitioners to facilitate a space where this support can be provided. This is particularly so when wāhine are required to be transferred. This may allow for less isolation of whānau and home for the wahine, and allow for an enhanced whānau journey.

Developing relationships through whakawhanaunga with their LMCs and hospital midwives was found to be a positive way of alleviating stress and anxiety within the maternal-infant health care system. For some wāhine, they reported receiving poor communication and little manaakitanga from their health practitioners. These poor accounts raise concerns about the cultural responsiveness of the maternal-infant health care system.

The following chapter provides experiences of Piripoho, the journey encompassing the newborn and immediate postnatal period.
Chapter 8: Piripoho

This chapter explores the wāhine and whānau experiences during their piripoho journey. This phase of the journey follows the birth of their baby and their postnatal experiences. As Figure 6 pictured in the introduction of Te Whaiao wāhanga demonstrated, many of the whānau described encountering difficult experiences during their piripoho period. Only one wahine talked about having a positive piripoho experience. This chapter explores these experiences and how they impacted on the wāhine transitioning to motherhood. Also explored are: the women’s access to whānau and formal provider support, the care they received, and how mātauranga Māori was, or was not, represented within the postnatal environments such as NICU and SCBU. Table 5 below outlines the themes and subthemes found in piripoho.

Table 5.
Themes and Subthemes of the Piripoho Journey

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8.1 Motherhood Imaginary versus Motherhood Reality

As the previous chapter outlined, it was common for the wāhine to have an imaginary about their labour and delivery, evidenced in a birth plan or idea. Linked with the imaginary of labour and delivery was their imaginary of motherhood. These imaginaries informed their view of what it means to be a mother, and how they would transition into motherhood following the birth of their baby. The imaginary of many of the wāhine was shattered during their labour and delivery. Consequently, they also experienced a shattered motherhood imaginary.
One wahine out of the ten was able to meet her imagined transition into motherhood - Aroha. She reported enjoying her hapūtanga and whānautanga because she had strong whānau support and a positive experience with her maternity practitioners. She believed her baby received good clinical care that addressed his immediate respiratory needs. When Aroha was discharged and able to return home with her baby, she was well supported by her LMC and wrap-around services (for example a social worker, and Well Child/Tamariki Ora\textsuperscript{21}) services. This also contributed towards Aroha having a smooth transition into motherhood and having her motherhood imaginary met.

The transition to motherhood for the other wāhine was in stark contrast with what they had imagined. They experienced prolonged hospital stays while their baby (and for some wāhine, themselves) received necessary acute clinical care; had to deal with the loss of their baby in the hospital context; and/or received ongoing care once they were discharged from hospital. An example of an imagined view of motherhood that was not met lies with Nadia’s journey. Nadia’s SGA baby was admitted to the Neonatal Intensive Care Unit (NICU) following her birth, which was a contrast to Nadia’s motherhood imaginary. Nadia’s baby remained in NICU care for many weeks. As a first-time mother, Nadia stated that she had no other birth to compare this experience to, therefore only had her imagined view of motherhood as a reference. She shares,

I’m actually quite thankful that she is our first bubba and this all happened, because we don’t have anything else to compare to. (Nadia)

This statement implies that Nadia was relieved that it was only her motherhood imaginary that was challenged, and not a prior motherhood experience. Nadia framed her experience this way to help her accept her imagined view of motherhood being shattered.

The motherhood imaginary of other wāhine was challenged by a ‘dictated’ motherhood reality they experienced. Dictated motherhood was the term I decided to use in this project to capture how the wāhine described what it meant to be a mother in the clinical context. These mothers felt that the NICU and/or SCBU policies, procedures, and practitioners controlled how their baby was cared for. Common features of dictated motherhood included medical interventions, such as nasogastric feeding\textsuperscript{22}, temperature regulators and respiratory support, put in place without whānau

\textsuperscript{21}Well Child/Tamariki Ora is a free service that is offered for all children in Aotearoa New Zealand from birth to five years of age.

\textsuperscript{22}Nasogastric feeding involves placing a special tube through baby’s nose that enables food and medicine to be carried through to the stomach.
consultation; and with the health care practitioners having control over what was done, how it was done and when it was done. This felt “foreign”, “clinical”, and “emotionally challenging” to the wāhine. Although the health care practitioners had the control for various good reasons (i.e. to provide optimal care), this control could clash with an imagined view of intuitive motherhood that was held by the wāhine and their whānau. The NICU and/or SCBU environments and procedures are referred to as being foreign and/or clinical throughout this thesis because that was how they were described by the wāhine and whānau. This section will explore this notion of motherhood imaginary and dictated motherhood reality. It will also explore the challenges to and enablers of wāhine having a good transition to motherhood, with a particular focus on certain influences that impacted on their sovereignty as mothers.

8.1.1 Loss of motherhood sovereignty in dictated motherhood

Of the ten wāhine and their whānau who participated in this project, two had their baby admitted to a NICU (Nadia, Ngahuia), and four had their baby admitted to a SCBU (Ashton, Tahlia, Waiata, Teina). A NICU provides the highest level of care for sick or premature newborns. A SCBU provides secondary level care with a focus on respiratory support, feeding support, and transitional care following baby’s discharge from NICU. Accordingly, both NICU and SCBU are highly specialised, clinical environments.

Wāhine who had their baby admitted to NICU or SCBU expressed having a complex, and sometimes traumatic, piripoho experience because the clinical environment felt foreign to them. For these wāhine, the unfamiliarity of space was coupled with a contrast to how they imagined motherhood being; thus challenging their transition to motherhood. Ashton and Nadia both were first time mothers who had their motherhood imaginary challenged by the SCBU and NICU clinical routines. For example, Ashton felt that the SCBU promoted a dictated approach to motherhood because of the clinical focus it placed on aspects of motherhood that she had imagined would be intuitive,

The biggest thing that I struggled with at SCBU was that it was so routine, you fed them at this certain hour and this certain mls, and then learning to go from that to feeding off you where there’s no measure, like you don’t know how much they’re getting, you don’t want to give them too much because they’ll spill it but you don’t want to give them not enough because then they will lose weight and then we won’t be able to go home”. (Ashton)

This statement highlights how Ashton’s view of intuitive mothering was challenged by the clinical routines of SCBU. Ashton imagined motherhood being ‘normal’ whereby she would be at home with her baby and breastfeeding him comfortably. This
imaginary was challenged by the SCBU routines (and practitioners) because they informed Ashton how and when her baby was to be fed. In this way, there was no space for Ashton to practice her intuitive motherhood. Nadia shared her similar experience whereby clinical measures were put in place to feed her baby, thereby limiting Nadia’s ability to transition as a intuitive, breastfeeding mother.

It was pretty trying times ay…Yeah it just felt like a big tick box exercise there and that’s probably why they don’t like you breastfeeding because they can’t tell how much baby is getting whereas with bottles and syringes and NG tubes, they know exactly how much baby is getting. (Nadia)

The feeding measures put in place for her baby were poorly explained to Nadia by the health care practitioners, which made her feel disconnected from and frustrated with the clinical feeding process.

Ashton and Nadia’s experiences provide a sense of how the medical care babies require can differ from ideas of intuitive mothering. In both cases, the clinical feeding routines may have been necessary to ensure their babies were receiving the optimal levels of nutrition. However, these came at the cost of the mothers losing their sovereignty over their breastfeeding aspirations. This adds to the difficulty for mothers adapting to motherhood because it means they are required to accept a new view (and practice) of motherhood that they had not imagined.

Nadia continues to share how the clinical environment further challenged her transition into motherhood,

It’s just so foreign up there, everything is so clinical and every 8 hours you have a different nurse telling you what they think you should be doing. So we got the night shift telling us what to do, then the day shift nurse and then the afternoon shift nurse, and we were just like ‘Oh my god, this is our baby!’ And they were like, ‘you need to go home and have time out’ and we were like ‘if we had a newborn at home we would not get time out, we’ve got nowhere else we’d rather be than sitting here on this ward with our baby’. It was so bizarre. (Nadia)

The combination of the foreign nature of the NICU environment and being dictated how to be a mother instructed in how to be a mother seemed bizarre to Nadia and is once again a reflection of poor communication from the NICU practitioners. Nadia felt that she was being spoken to and being told what to do, rather than having the opportunity to have meaningful discussions with her baby’s health care practitioners to offer her input to the conversation. As a result, she became frustrated with the environment and the people within that environment. Nadia’s frustration with the poor communication offered by health care practitioners in this context was evident as she continued,
It makes sense from their [practitioners] point of view because they're trying to get them [babies] better and feeding them helps them do that, but at the same time…they don’t explain very well…it’s like they’re sedated with food the whole time and if they cry they just chuck some more food down there. (Nadia)

This statement expressed Nadia’s frustration with how the clinical care of her baby was asserted (nasogastric feeding in this case) with little explanation of why they were feeding her baby in that manner. Nadia was frustrated with this poor explanation as her struggle to develop her intuition as a mother was being further challenged by the clinical feeding and consequent sedation of her baby. Even though this was her first baby, having to rely on clinical routines, such as feeding, rather than developing and following her intuition as a mother felt very strange to Nadia.

Ashton and Nadia’s experiences demonstrate that the SCBU and NICU environment can be frustrating for parents. They felt their motherhood aspirations were challenged when they were required to follow clinical routines that have been poorly explained and derived without any whānau input.

8.1.2 Bonding with Baby

Whānau who had to have their baby admitted to a SCBU or NICU shared a common concern about being separated from their baby. Initially, being separated from their baby was difficult because the whānau aligned this separation with their fears of not bonding with their baby. Nadia expressed how she was “massively scared” of not bonding with her baby when she was admitted to NICU. Her fear was compounded by feelings of disappointment every night when they had to drive home from the NICU without their baby. The pressure her and her husband felt because of this fear and not being able to be the parents they had imagined is made clear as Nadia states,

We were under so much pressure, I mean driving home from the hospital every night with an empty car seat in the car and crying my eyes out, and then having to set my alarm to get up in the middle of the night to express whereas you should be getting up to a crying baby. (Nadia)

The look of an empty car seat was a daily reminder for Nadia that she was not the mother she had imagined she would be and that others were in charge of caring for her baby. Nadia and her husband longed to be with their baby as much as possible to utilise the opportunity to bond with their baby. However the health care practitioners instructing them how to appropriately care for their baby tarnished their time spent bonding with their baby. They share,
And the nurses were saying ‘don’t pick her up, you’ll make a bed for yourself further down the track’. (Nadia) She wasn’t even a week old and they were saying that to us. But my baby was crying man, we’ll sort that out later. (Nadia’s husband) Yeah, I want to cuddle my baby, she’s been inside me for the last nine months! (Nadia)

While the advice offered by the health care practitioners may have been well intended, it was advice that frustrated Nadia and her husband because they felt that the health care practitioners were dictating how to care for their baby, rather than helping them to be the parents they had imagined they would be.

The size of the tertiary hospitals also posed the challenge for parents in locating the unit their baby was being cared on. Ngahuia brought our attention to this,

Yeah especially in [tertiary hospital]. I got lost in their hospital, just walking around and looking for where baby was because she was on the other side of the hospital to me...

Another example of geographical separation that was difficult to navigate is derived from Teina’s journey. It was expressed by her cousin that,

It was just hard and there is a disconnect between the acute ward and the maternity, there needs to be better connectivity there and the fact that you have to walk right around the hospital to get from one side to the other and we couldn’t take the babies down, it’s just a mission. And it’s really quite jarring I think because she was a first time mum, it’s not like she was a pro”. (Teina’s cousin)

These experiences illustrate how foreign these clinical environments are for wāhine and their whānau and how difficult they can be to navigate. Having this added layer of complexity to navigate was an additional challenge for mothers who were attempting to bond with their baby and adapt to dictated motherhood.

Another related problem was when the systems exacerbate the separation of mother and baby by quickly discharging the mother from the maternity ward even while their baby remains in a SCBU or NICU. This causes difficulty because the mother now has to find accommodation support in an area that is unfamiliar and isolated from whānau support (because of the need to transfer to a higher-level hospital away from their home) in order to stay near their baby. This was an issue faced by Teina and her whānau,

So when we got shipped to [second secondary hospital] … the SCBU there wasn’t at capacity and they also had mother-craft rooms, so they had three mums in those rooms and 3 babies on the ward. And then our babies came in to the SCBU but they didn’t have a mother-craft room for [Teina] so she couldn’t go stay in the SCBU with them, so she got stuck in maternity. So the babies were born on the Monday, on Monday night she was on the ward and was there for three nights, but by the weekend, they were so busy on the maternity that it was kind of like that slice and dice metaphor, just get them in and get them out. For us, because we had our babies on the SCBU, they were trying to discharge [Teina] from the ward but I said no, you’re not discharging us because we’re not leaving our babies here alone’. (Teina’s cousin)
This example depicts the disconnection between whānau needs and the capacity of the current maternal-infant health care system. The whānau needs are to be with their baby, however in the context of this project, the system did not view their baby as part of a whānau unit. Rather, the baby was seen and treated as an individual patient. Enforcing the baby’s separation from whānau is a significant disconnection between the whānau needs and the maternal-infant health care system. This separation is culturally wrong as babies embody whakapapa and should therefore be surrounded and cherished by whānau.

Culturally responsive health care should be provided throughout the entire journey of dictated motherhood/parenthood. For the wāhine and whānau in this project, culturally responsive care facilitated familiarity of and trust in the clinical environment (and all within it). This familiarity and trust, in turn, led to greater acceptance of the necessary separation from their baby. Waiata’s journey exemplifies this. Waiata, a first-time mother, had accepted the SCBU environment as her baby's temporary ūkaipō (place of nurturing).

She was where she was needed to be, so I was OK. (Waiata)
Waiata believed that accepting this separation at the time also helped quicken her baby’s recovery by allowing the SCBU practitioners to care for her baby,

We were only in SCBU for three weeks. That to me shows how well she was looked after by the nurses and doctors there. (Waiata)
The perception Waiata held that her baby received good care was critical to her accepting her baby’s three weeks in SCBU. Other examples of how adaptation and bonding with their baby in an unimagined context was achieved are shared below (see section 8.1.4).

8.1.3 Ūkaipōtanga

Ūkaipōtanga can mean mother or a source of sustenance. If we break the word down, we can understand how Ūkaipōtanga has been defined this way. Ū means the breast, kai is food, and pō is the night, and -tanga the suffix to mean the act of doing. Therefore, Ūkaipōtanga can mean the night-feeding breast. I have used this term to describe the breastfeeding experiences that were shared by wāhine and their whānau because it encompasses the nurturing nature of breastfeeding, and recognises the breast as a source of sustenance for babies. Aligning with a source of sustenance, Ūkaipō can also mean a physical place of nurturing, for example one’s homelands. Due to their baby’s SCBU or NICU admission, the wāhine were removed from their whānau and their Ūkaipō and were instead placed within a foreign, clinical environment that
often challenged their breastfeeding aspirations. This section explores these two aspects of ūkaipōtanga.

Receiving inadequate guidance on how to breastfeed reflects poor health care provision, and can have harmful impacts on the wellbeing of new mothers. Becky’s journey outlined both the physical and emotional harm mothers can develop from not acquiring the skill of breastfeeding. Physically, Becky developed mastitis, a painful infection of the breast. Emotionally, she was stressed and felt she had failed as a mother because she struggled to enact her view of what a good (breastfeeding) mother was. Nadia and Ashton experienced similar emotions from not having their ūkaipō aspirations met.

Wāhine shared how breastfeeding was imagined as being a part of natural motherhood; therefore they sought advice and guidance from the health practitioners to meet that imaginary. However, in the clinical environment they found themselves within, these mothers felt that their ūkaipō desires were often unsupported by the health practitioners. This is illustrated by Tahlia,

And another thing that I think they need to work on in SCBU is helping mums how to breastfeed properly, because it’s still really painful for me to breastfeed and it shouldn’t be. Like the first couple of days it should be sore but not now; but because I never breastfed my [first child], I kind of did for a couple of days but after that she was a full-on formula baby, so now I don’t know… (Tahlia)

Tahlia was disappointed that she did not breastfeed her first child. Possibly in an effort to overcome this, she was determined to breastfeed this baby. The lack of support from the health practitioners to meet this goal heightened her disappointment about not breastfeeding confidently once again.

Teina said she felt she had lost her opportunity to breastfeed because she became ill during her hospital stay and was admitted to the ICU. She shared her disappointment regarding this disruption to her breastfeeding goal, and still felt the ache of it sometime later when she shared her kōrero.

It was so good giving them titty kai [breast milk], and then I got sick. Yeah so they had to have a bottle, and by the time I got back from ICU they were bottle feed…It was sad because they had those feeding tubes in and I was just starting to get them both on the titty. (Teina)

When Teina recovered from her pneumonia she felt discouraged about trying to breastfeed her babies again because she assumed it was too late following their exposure to “bottle kai” and clinical feeding routines (Nasogastric (NG) feeding). Teina told me that this was her own feeling. However, I question whether or not she received support or information from her maternity practitioners regarding whether or not she could try breastfeeding again. If she did, she may have held a different feeling towards breastfeeding once she had recovered. That being said, although Teina lost her
motherhood breastfeeding imaginary she was thankful for the support she received from her partner, who helped with feeding their babies. Becky claimed she received inadequate guidance from her health care practitioners and therefore struggled with breastfeeding her newborn baby from day one.

The nurse woke me up at 2am to feed and I was so weak and tired, I just finished over 40 hours of labour, and she goes, ‘there’s your seat’ and just walked off and I had no fucking idea how to latch baby. Then I latched him wrong and that was it, it was all downhill from there… Becky blames her poor breastfeeding experience on this first night. Consequently, her breastfeeding aspirations were not met and her situation worsened. She continues, It wasn’t until the next day [that baby was born] in the afternoon that they had the lactation consultant come round, and it was about five minutes if that…and my midwife was delivering babies so by the time I got to see her which was four days later, my nipples were so raw like red, [pus-like] and bloody and the nurses were still trying to get me to latch baby. I just couldn’t latch him, honestly it was so sore… It was not until five days post-birth of her son that Becky felt supported by her health practitioners in hospital. However, at this point, Becky was in pain and was becoming increasingly stressed that she was ‘failing’ as a mother. Her health practitioners had not prioritised her aspirations to breastfeed even though she had requested support. While her requests were eventually responded to, Becky shared that she was near breaking point before she was heard.

And then I think it was day 5 or something, the midwife finally gave me a shield and it was the best thing ever and the lactation consultant that eventually came was really good and helpful, but I was like, ‘why didn’t you talk to me about this and give me the shield sooner?’ So you know they push people to the limit, to the point where they don’t want to feed anymore. (Becky)

Following this support, Becky was discharged home even though she said she was feeling unwell and in pain.

And then I started getting chills and fevers, honestly I was just so weak, even I knew that I had a fever. But what did they do? They just said that it was losing my hormones so they down-played it, so I just thought that it was normal and that everyone goes through this… (Becky)

The following day her LMC visited her and noticed that she was very sick. She immediately had Becky admitted back to hospital, where she was later diagnosed with mastitis. Becky shared that her LMC said she was less than a day away from needing surgery because the infection had become so severe, and “then she got it another fucking three times, it was a horrible time” (Becky’s husband). It is this experience that she was most disappointed with throughout her entire journey. Becky’s husband continued to share his perspective on the matter,
That was probably the biggest thing that went wrong for us, and that's the first thing that I tell anyone who is pregnant now, don't worry about labour because that'll just happen no matter what, what you want to know about is breastfeeding cos that's the hard part. If it goes easy for you straight away then sweet, but if it doesn't then fuck. I was surprised at this as a dude, the amount of women that were no help and they all had kids. (Becky’s husband)

Becky’s husband now knows that breastfeeding is a skill that must be learnt; it is not a natural occurrence for some mothers.

Contrasting to Becky’s experience, Ashton’s preterm son was medically fed for some time during his SCBU journey. This posed challenges for Ashton reclaiming her breastfeeding aspirations. A part of that challenge was learning how to return to her motherhood imaginary and trust her intuition amongst the clinical SCBU environment.

...Probably the most confusing bit of it all was the transition from tube feeding to breastfeeding because it went from being so medical to just trying to follow your gut. I wish that I had followed my gut more at that part instead of worrying about it being so time routine, like it has to be every three hours you know, I wish someone had just told me to just feed him on demand when you start breastfeeding because he'll tell you when he’s hungry but I was so used to doing it on time and amount that it was a little bit confusing.

Ashton proceeded to share a positive angle of her difficult situation. She continued, …yeah and learning to breastfeed, like when you've got all those visitors and everyone else’s visitors in the room as well, it’s a bit full on. But I actually think that might have helped my breastfeeding experience because I didn’t know what it was going to be like, but I think because everyone was in there, you just get used to having to feed with all these people around you so it helped when we got back home because I wasn’t bothered about feeding in front of people. (Ashton)

Ashton alludes here to how SCBU visiting hours can be a busy time for parents as this is the only time allocated for whānau to access their support. The impact of this was that Ashton had to learn to be comfortable with breastfeeding amongst the presence of numerous people, thus encouraging her to overcome any whakamā she had about breastfeeding in front of people.

As mentioned above, ūkaipō can also be defined as one’s original home or place of nurturing (Gabel, 2013). Many of the wāhine in this project found themselves removed from their place of nurturing and instead within in a foreign, clinical environment due to their baby’s admission to a NICU or SCBU. These environments clashed with their birthing and motherhood imaginary which included them being able to return home soon after the delivery with a healthy baby. For some, being removed from their ūkaipō added another layer of complexity with breastfeeding. Not only were the wāhine made to deal with being in an environment outside of their ūkaipō, as in their nurturing place, they also had to try pursuing their breastfeeding aspirations with inadequate support. Nadia faced this scenario, as she continually requested support
and guidance from health care practitioners to breastfeed her preterm baby in NICU. These requests were unmet and the NICU practitioners insisted on feeding her baby via nasogastric (NG) feeding, which caused frustration for Nadia and her husband. However, Nadia decided to exert her sovereignty as a mother and resist the clinical demands of the health care practitioners by resisting unnecessary NG feeding and insisted on gaining the breastfeeding support she required. Nadia reflected on her journey,

"I wanted to be there to try feed her as much as possible, but she wasn’t latching on fully to the breast and they were saying her mouth was too small and she’s tiring too much so they were like ‘do you want to give her a bottle?’ And I was like ‘no I want to breastfeed’. So I just tried persevering and they got me to wear a nipple shield and she was suckling on that alright and one of the nurses got her latching perfectly and we got a really good breastfeed so we were like yes this is awesome! And then no one else came and helped me or showed me how to do it again so I couldn’t get her back on. So that was on day 2, and they were just topping her up with the NG tube...so that was all with expressed breast milk and we did that for a couple of days and then I was like ‘I really want to breastfeed’ so I was really determined to and I kept on asking for a lactation consultant but they were like oh na we’ll just get a nurse to come in and I was saying that I really wanted to do it...so she came in and saw us and did an assessment and got her properly breastfeeding finally but that was day 8! (Nadia)

Nadia and her husband expressed that they were disappointed at the lack of support they received in NICU for breastfeeding their baby, especially after requesting numerous times for assistance. This makes Nadia and her husband feel suggests that unheard or unacknowledged by the practitioners even though Nadia’s continually voiced her desires and concerns. Nadia’s persistence and efforts to reclaim her sovereignty is demonstrated here,

"So anyway, on day 8 we got to room in with her, and naturally she hadn’t been breastfeeding and she had been getting pumped full of feeds, so when we did try breastfeed her she would just get tired way too much and not getting a full feed, then she would be wide awake and miss all her sleeping times, it was hellish. But you don’t want to call the nurse because if you do it looks like you’re not doing your job so you won’t be able to go home...it’s like a bloody health lesson where you have to prove yourself as parents! As soon as you can get the weight up, basically you’re allowed to leave. But in the meantime, if you want to breastfeed your baby, I dunno it was like everyone gives in to bottle feeding just to get out in the end, and like for a hospital to be pushing bottles like that I was pretty mortified. (Nadia)

In this statement, it is noticeable how breastfeeding was used by Nadia as a site of resistance and a method of reclaiming her sovereignty as a mother. However, it is also noticeable how she remains in fear that she would be seen as a failure had she not successfully became a breastfeeding mother ("you’re not doing your job"). It seems she evaluates her failure as a mother on having to rely on dictated, medicalised
cares rather than being able to intuitively feed her baby as a breastfeeding mother. This statement by Nadia also provides an insight into the extent some parents are willing to succumb to dictated care (for example, bottle-feeding) just so they can return to their ūkaipō, their home. An environment that pressures parents into changing their parenting ideas and aspirations is not one that enables whānau wellbeing.

8.1.4 Rangatiratanga in dictated motherhood

Rangatiratanga in dictated motherhood involved mothers repositioning themselves away from their original imagined view of motherhood and accepting the dictated motherhood as their new norm. This adaptation involved learning new ways of caring for their baby and working together with the NICU or SCBU practitioners. Waiata shared that she accepted her new norm as a dictated mother by accepting SCBU being her baby’s momentary ūkaipō. Other wāhine eventually accepted dictated motherhood by finding ways to work through their emotions and develop a path towards adapting positively. For example, Ashton shared how she found it beneficial, although difficult, taking time out from the SCBU to alleviate the stress that accompanied being in the foreign and clinical SCBU environment.

…I hated leaving him there and going out for a lunch time, but I think for your mental state you have to get out of there, even though baby can’t leave, you kind of have to. When I look back at it I do see all the positive sides of it, but at the time it was an emotional roller-coaster. (Ashton)

This break allowed her to get the mental break that she needed at that time to recollect herself for the sake of her baby. Teina was also encouraged to do this while her twins were in SCBU,

There was one nurse there who had been there for like 30 years (laughs) and she was like ‘right you need to go home and have a break or go out and get some fresh air, your babies need this’, she was real bossy so at the start I was a bit hōhā [annoyed] with her, but once we got to know her she was cool as. (Teina)

Although taking themselves away from their baby seemed unnatural and difficult, it was encouraged by health practitioners as a good strategy for them adapting as dictated mothers because it gave them a break from the stressful clinical environment.

Being granted autonomy through the NICU and SCBU practitioners teaching wāhine (and their whānau) how to provide some of the cares for their baby was also noted as a positive mechanism. This co-construction of care assisted their adaptation to dictated motherhood/parenthood in two ways. Firstly, it enabled the wāhine to reclaim their mothering sovereignty within the clinical environment and to bond with
their baby. Secondly, having more education and opportunities to be with their baby built whānau confidence. Ashton shared,

It was interesting being in SCBU…they [nurses] were so under-staffed in there. I remember one night, there were so many little babies in there and they were all working so hard, and that’s why I felt good and confident that I could do most of his care, like I did most of his feeds and temperature checking and all that sort of thing, so it was nice that I was just up the hallway so I could do all of that…

Ngahuia reclaimed her sovereignty as a mother by providing her baby’s cares on a daily basis and familiarising herself within her context. Similar to Ashton, this daily routine increased her confidence,

Yeah, we spent every day there doing her cares, and adventuring [exploring the hospital and city]. Especially in big places like that because we’re used to the country, and in big places like that you get lost. (Ngahuia)

Kristen’s son was severely ill with complicated congenital anomalies, and through her adaptation to dictated motherhood, Kristen became familiar with his condition and medical needs. In this way Kristen demonstrated her mothering sovereignty and cherishes these precious moments as she never thought she would be able to get with her baby. She reflected,

He did make progress yep and they started to feed him through a tube…and we were having cuddles while he was feeding and my husband was coming to have cuddles…I gave him his bath, which was awesome because that was my first and last bath with him, it’s those small things that you can be grateful for. (Kristen)

This section has focused heavily on the loss of mothering sovereignty; however, it is important to acknowledge the loss of fathering sovereignty that was experienced as well. Some pāpā had to relinquish their role as protectors of their partners and baby to the health care practitioners in NICU or SCBU, and they acknowledged the difficulty of this. When the health care practitioners involved the fathers in the co-construction of care, they were able to reestablish some of their sovereignty as fathers. They also had more opportunities for the fathers to bond with their baby. Teina shared how her partner was able to bond with their twins when the SCBU practitioners showed him how to provide the required cares for his babies,

[Partner] got real close with them [the twins] because the nurses let him draw up all the babies’ medications and their food and change and bath them and everything…which was cool. (Teina)

Teina’s partner said to me that being able to “bond with them” was what helped him find strength and wellbeing during a time fraught with illnesses for his two babies and partner.

Similarly, Ashton shared how her partner was able to bond with their preterm son within the SCBU environment by providing cares.
Lots of the nurses were all really surprised at how hands-on [partner] was cos there’s not many dads that are, like [partner] was there all the time so that was really cool. He was really hands-on, did all the feeds during the day and letting me rest… (Ashton)

The practices and support of health care practitioners within the NICU and SCBU played an important role in facilitating parents’ adaptation to dictated motherhood/parenthood. For example, the co-construction of care with whānau enabled whānau bonding opportunities, greater confidence through greater education and literacy development. These enabled the reclamation of mothering/parenting sovereignty and contributed to the strengthening of whānau wellbeing.

8.2 Regulation of Whānau Supports

Shaping the NICU and SCBU environments are policies and procedures that regulate whānau support networks because they limit the visiting hours of whānau, dictate the number of people allowed at the bedside during those specified visiting hours, and govern whether or not partners are able to stay overnight. The whānautanga chapter (see section 7.1.1) explored how wāhine often resisted being transferred away from home and their whānau supports. In this section, the effect of being isolated from whānau support is made evident.

Many whānau described the strict visiting hours and visitor policies in place in SCBUs and NICUs as being challenging. Nadia shared her experience,

Following her birth they chuckled us on the postnatal ward and that was about 4am, [husband] had to go home cos hubbies aren’t allowed to stay- that was so hard, I was balling my eyes out saying don’t leave me cos I just had this new little baby…So we’re in this room, this little jail cell in the hospital, like you’re not allowed to leave the room with your baby apart from going to the communal area during visiting hours, if you have visitors. (Nadia)

Nadia likens the NICU environment to being in a “jail cell”. This speaks volumes of how she perceived the environment as being restrictive and controlling of her access to her whānau support. This statement also flags the communication issues that were present in Nadia’s journey. She states that she was admitted on the postnatal ward, when in fact her daughter was admitted to the NICU ward. Nadia was unaware of the severity of her preterm daughter’s health because of this miscommunication from her health care practitioners. This point is revisited below in section 8.3.

In Nadia’s description, health practitioners and the system itself were seen as the gatekeepers that regulated whānau visiting access. Nadia felt controlled as these gatekeepers were dictating who, when and how many whānau could visit with her and her baby. Nadia continues her journey,
But as it is you’re not even allowed more than one visitor in the room at all times anyway… One day they didn’t even let my mum in and she had come up from [city four hours away] and the receptionist was like nah. This was on our day 2 or 3 and I was upset and was saying ‘she’s my mum’, so that was real hard not being allowed visitors, well you are but only during those time frames. Which you can understand because there’s all those babies in the room and if everyone had all their friends and family visiting it would be hectic, but at the same time you can’t even have both your parents in the room at the same time, it’s pretty hard.

The policy that was spoken about most was the restrictive visiting hours for the pāpā. Nadia’s snapshot provided above illustrated how distressing it was not having the support of her whānau, especially because she was entering the NICU environment for the first time (when she realised it was NICU and not an ordinary postnatal ward). Her husband adds his perspective on the matter and how upsetting he had found it not being allowed to stay with his wife and baby. He shares,

I wasn’t allowed staying on the night of the birth, I felt real bad cos I had to leave {Nadia: that was horrible}. But I guess they’ve got those rules for a reason cos there are some crazy ass people walking around those corridors but that felt hard, I went home for an hour then came back straight away as soon as visiting hours started again. (Nadia’s husband)

Nadia adds,

It’s interesting, like obviously [husband] didn’t want to leave, I didn’t want him to leave but then you do hear all those horror stories of the nurses having to deal with unlikeable men roaming around at 3am, which you can understand but at the same time, all you want is your husband there. And he didn’t sleep, he came home and then was back a few hours later as soon as he was allowed back on the ward… I guess that’s why people go to the birthing centers because your husband can stay with you. If we had a normal everything then we would have been there. (Nadia)

The end of this statement once again refers to how Nadia’s experience differed to how she imagined a normal birth and motherhood journey being. It also signifies how there was a lack of clarification (“I guess…”) provided to her regarding the need for strict visiting hours and numbers. This lack of clarification is perpetrated by messages about the need to control visiting hours to protect the babies from infection (as shared to me by a former NICU nurse) and from threatening individuals (as stated by Nadia’s husband).

Becky was also distressed about being separated from her husband, especially following a long, exhausting and difficult labour and delivery,

The staff are so hard out ay… I thought he [husband] was avoiding me, cos you know how they’re not allowed staying with you, and as a first time mum you get really anxious… (Becky)

Waiata also had a difficult labour of her preterm baby, and as a first-time mum, she missed having the support of her partner.
I didn’t like that he couldn’t stay, it was hard doing things on my own. (Waiaata)

Ashton had a more positive experience of her husband visiting her because some SCBU practitioners were more lenient with his visiting hours,

They [SCBU nurses] were really good with him, like he wasn’t allowed staying up there but they were pretty lenient with him in the evenings, they usually let him stay until I was ready to jump in to bed and when baby was all settled. (Ashton)

Having the support of her partner in the evenings to settle baby and get herself comfortable helped turn a difficult experience of being separated overnight, to a more positive experience for Ashton. This is perhaps also a reflection of the different clinical environments between SCBU and NICU, whereby NICU is an intensive care unit. It also highlights how individual practitioners can be relaxed about enforcing the strict visiting hours policies. Justine adds to this argument of individual practitioners demonstrating leniency,

It makes the experience for us so much more tolerable, because he hates leaving us at the hospital, every kid that we’ve had he’s made us go home, that’s just him. But with this kid, [husband] was allowed to stay. (Justine)

Wāhine who had other young children found the gatekeeping of whānau supports especially difficult because it separated them from their children. The strict NICU/SCBU policies prevent young children entering as a means of (infection) control in the environment. This was the case for Ngahuia,

With all the kids there, it meant that we couldn’t stay in with baby for long and it was hard because these kids [younger children] weren’t allowed in there because they have a strict rule that kids under 5 ain’t allowed in the NICU. We ended up dropping them off in the next few days back to my Mum and them. (Ngahuia)

Tahlia also shared her view regarding the gatekeeping of young children.

I think it’s silly how your family can’t come and visit from the other door—because there is another door that you can access the SCBU but to the room where you don’t have to be by all the babies. So with that, you’re only allowed two visitors even in that common room, and when you’re family is from up here and has travelled all the way down, it’s dumb. Yesterday was so annoying because I went to visit my brother’s baby in SCBU and I couldn’t even take my baby around to the other room to get a coffee from the day room. (Tahlia)

Tahlia’s view was that her visiting whānau felt alienated by the SCBU environment as they had to take turns being in the room instead of experiencing the visit together. It is also apparent from these experiences that whānau were not being adequately informed of the visiting restrictions within NICU or SCBU, and/or why these restrictions were in place.
The feeling of isolation in the foreign environment of SCBU was exacerbated by the physical location of the SCBU being some distance away from the whānau home.

I think there needs a lot of improvement when it comes to having whānau support, cos that was one of the things that I struggled the most when I was down there- being so isolated. And because when my family did come down [two-hour drive by road], it was like they’d have turns coming in for 15 minutes and it was like, not get hōhā, but it was weird cos we couldn’t all sit down together. (Tahlia)

Supporting this,

It's kind of hard when you've got other kids and your whānau so far away. (Ngahuia)

The examples illustrate how the physical location of a hospital also plays a role in regulating whānau supports within the NICU and SCBU environments when wāhine have been transferred away from their whānau and whenua as part of their baby's care (and/or their own) requirements.

8.2.1 ‘Kaupapa Whānau’ support

The definition of whānau can be extended to include relationships with those who are in similar situations as you or who have similar interests but without whakapapa connections. This level of whānau is what Tā Mason Durie termed ‘kaupapa whānau’. To remedy their poor access to whakapapa whānau support, some wāhine developed kaupapa whānau through the social connections with others who were facing similar circumstances as them in the NICU or SCBU. Unifying through their adversities was a way these wāhine were able to support each other in the absence of their whānau.

You got to share your stories with the other people you had met in the unit and lounges and you realise that you’re not the only one who is going through the struggles, and you sort of become overwhelmed that everyone is so kind to you, people leaving food everywhere. (Kristen)

As Kristen explains here, she was grateful for the opportunity to speak with others in similar situations to gain reassurance and support for what she was going through. Speaking with this kaupapa whānau allowed her to realise that she was not alone in this experience and journey. This level of support was different, but complementary, to the support she was receiving from her whānau. This is because her whānau were also going through this journey with no prior experience of congenital anomalies, so it was also a unique experience for them too. That restricted their ability to provide Kristen with the same level of similarity and reassurance that this kaupapa whānau could offer.
The social networks were particularly useful for those who were first time mothers. For example,

I’m still friends with three girls I met in SCBU…and at the start when we first got home we would message each other and just see how one another was doing and learn from each other. (Ashton)

Ashton continues,

...It was so good having her because…we’ll be up in the middle of the night breastfeeding and it’s just having that support person because [partner] wasn’t allowed staying there, so she was cool and we’ll just look out for each other.

Teina, another first time mother, shares,

We had another bunch of twins come onto the SCBU with us…and we were on the ward all the time, like we never really needed the nurses for much, they just had to show us what to do once and then we did it and helped each other.

These examples speak of the beneficial outcomes of developing support networks with wāhine and whānau who were going through similar circumstances as they provided a sense of connectedness for the wāhine when their access to whānau was restricted.

8.3 Health Care Provider Communication

Interactions (relationships, communication) with their health practitioners were a large component of the shared whānau piripoho journeys. Health care was largely noted as being provided by midwives, NICU or SCBU specialist nurses, pediatricians, and social workers. Consistent with the preceding phases of the whānau journey, some wāhine reported having positive interactions and linked this with receiving good care from their health practitioners. Others said they had disappointing interactions with health practitioners. Correspondingly, the provision of substandard care was perceived as a result of these poor interactions. This theme explores the positive and negative aspects of health practitioner communication.

Some whānau experienced good communication from their health care practitioners. These were, however, scarce examples among the predominantly negative encounters. Ngahuia states,

With her, we’ve had our ups and downs with the nurses. The doctors are just great, especially the ones with the accents…they explain things really well…

Ngahuia’s experience of her doctors being good explainers influenced her positive perception about her health care practitioners. Ngahuia continued to share that she thought there had been a positive change in the communication of health practitioners, compared with her first NICU experience in 2006. Yet, her “ups and downs” with the nurses indicated that she had experienced communication issues with other health practitioners. She felt that some continue to act in a way that was perceived as being
rude. When she shared this piece of her kōrero, Ngahuia became annoyed at how those few nurses made her feel uncomfortable during her journey because of their disrespectful manner.

But with her, in 2016, they’ve kind of improved. Their communication skills are good, they filled me in on everything that happened through my stay with her, like any mishaps, when she stops breathing they rang me straight away just so I could be there to ask questions for when the doctors came. But then you get some that are pretty like (pause) they come off rude. (Ngahuia)

Despite her familiarity with the NICU environment, Ngahuia still experienced communication breakdowns. She was left unaware of her baby’s progress at times, to the point of not knowing why she was transferred to a different NICU,

They’ll say one thing and then just walk away. That just leaves me (pause and confused) ... because she wasn’t giving me enough information of why baby ended up back in NICU when she was already on the path to go to the next hospital. Because we had her at one hospital, then she got transferred to the next and then transferred to the next. (Ngahuia)

Poor transparency in communication was also linked with poor provider communication, and this was seen in Nadia’s journey. Nadia and her husband were not fully notified of the health status of their baby. As such, they were not told that their baby was being admitted to NICU following her difficult delivery. This links back to an earlier statement made by Nadia where she thought she was admitted to an ordinary postnatal ward, rather than NICU (see section 8.1.3). As shared,

But the thing I was saying to [husband] the other day, even when she got sent there, no one told us…they just said that we’re just gonna put a tube down, and I asked why because we didn’t even get told that NICU was intensive care, we got told that baby was just going to a newborn unit. And I’m pretty up with clinical stuff, but they didn’t explain themselves. (Nadia)

Yeah! I thought that she was going to be in there for 2 days or something and then they’re like this is what’s gonna happen and I was like a wee later, why are we still here? (Nadia’s husband)

No one told us the seriousness of it either…no one was honest or wanted to be honest of why were there…so she was in the highest priority room [when she was admitted] but no one really told us. (Nadia)

In Tahlia’s journey, she stated that she began with an implicit level of trust in her health care practitioners because she viewed them as being professional. However, as her journey progressed, no efforts were made by her health care practitioners to engage in whakawhanaunga with her, and she became frustrated at the lack of transparency in communication. This eventuated in the breakdown of her trust for her baby’s health practitioners. Her frustration is evident as she shares,
I’m not even joking, they never told me what it was. So they found this thing on the left hand side of his head and the first two specialists that looked at the scan never seen it and it wasn’t until the third person that looked at it, cos there was all this weird movement on his right hand side like shaking, and they said that it could have been from that thing touching his brain or something. But they still did nothing. They didn’t tell me if it was a clot or if it was a growth… and sometimes I feel like I don’t have answers and I sit here and think is there actually anything wrong with my son or what. (Tahlia)

Although Tahlia battled with these health practitioners to gain answers to her many questions, she had little success. Being constantly told different things and the breakdown of trust and communication left Tahlia bewildered about her son’s condition. This matter will be revisited in the following chapter (section 9.3). These examples are concerning and remind us of the lack of transparency in communication Kristen received in her hapūtanga period where she was not notified of the severity of her son’s health condition until her fourth hospital visit. This perhaps indicates that poor transparency of communication is occurring throughout numerous levels of the whānau journey.

8.3.1 Communication between health practitioners and wāhine, whānau

As mentioned, whānau did report some positive accounts of the care their baby had received during their stay in either the SCBU or NICU units. Positive care was associated with good communication as a result of demonstrating respect and manaakitanga. Kristen shared her appreciation for the NICU staff that cared for her son. She believed they cared with great respect for him as an individual.

Honestly the NICU staff there, the nurses and everything, none of them I can fault. They were professional and personally great. Great people, and I knew my boy was being loved. They spoke to him as a whole being, like talked to him not through me to him you know… they saw my child as being uniquely him and I appreciated that to no end, and I felt like when I was there [on maternity ward], I felt like I was being treated as part of the daily grind, but the treatment I saw them giving him, wow they really respected the individual he was and his individual cares, so I am eternally grateful for those NICU staff. (Kristin)

Kristen was particularly thankful to one of the NICU nurses who gave exceptionally good care to her son during his final stages of life. Kristen continues,

Actually when I think about it, she definitely gave us another day with our boy, and I rang up [husband] by this stage and said you need to come down and you need to bring everyone down and to tell everyone who wanted to come see our boy that they have to come now… I knew he was going, and it was so hard because they had to paralyse him so that he couldn’t move and it was so hard just seeing him lying there. (Kristin)

Kristen outlines that her son’s carers appreciated his whole being, including his body, his wairua and his whānau. This contrasted with a later example of provider care
where she felt a provider working for Sands (a not-for-profit organisation set up to support parents following the loss of their baby) did not respect her son as a whole being. This example will be shared later in the chapter (section 8.4.2). We can appreciate from what Kristen shares here how difficult this time must have been for her, so the good care that was provided by the NICU staff was well appreciated by Kristen and her whānau. This positive example for the specialist nurses is supported by further examples from various wāhine and their whānau. Ngahuia expressed how her baby’s NICU practitioners demonstrated manaakitanga and good communication,

...they were awesome. Even though they had their old ways too sometimes. There was one old lady who always growled the other nurses to keep on top of what they were supposed to be doing, it was funny. They were awesome there, always friendly, always kept us in the loop. (Ngahuia)

Ashton and Waiata also shared positive reflections of the care provided by the SCBU nurses. They expressed how the nurses demonstrated manaakitanga by being kind and caring not only for their baby but for their entire whānau.

The nurses were so lovely and awesome, they look after your baby like their own...They’re so kind, and they all had different good things about them. They’re pretty special those ladies. (Ashton); Not only was she looked after but they did everything they could to look after us [her and her partner] too. (Waiata)

In contrast to these examples, Teina offered a perspective that highlights her distrust and disappointment in the maternity care she was provided in comparison to the neonatal care that was provided for her twins.

We fucking got out of that maternity unit; the SCBU unit where the babies were though were great. The nurses were cool as, I just wanted to live there, I didn’t want to go back to maternity because the ward was just packed... (Teina);

Teina felt that her health care practitioners were disrespectful and not as caring as what her babies’ practitioners were. Similarly, while Ngahuia felt her baby received good care, there was one exception where Ngahuia perceived one of the NICU nurses was being racist towards her. She shares,

She [nurse] came off racist...she would come over and she was like to our whānau, you shouldn’t be here, only the parents’, whereas other nurses would come in and they were fine with other people’s cousins and family being there, they were like ‘sure you guys can come in’. I thought it was because they were white because when all Māoris walked in they must of thought I was an aunty or something cos they were like ‘sorry you can’t be in here, I’m going to have to ask you to leave’, and I was just like ‘excuse me...I’m the mother to this child and who are you, you’re not the one looking after my baby’, and the nurse who was looking after my baby overheard and came running over and told the racist nurse who I was, and the racist one goes ‘oh well, you can’t be too sure’.
When they reflected on their whānau journey, Teina and her whānau believed they experienced poor care because they were subjected to treatment based on pre-conceived racist judgements. Teina’s cousin and her father share a reflection from their journey and past experiences of the health care system,

I think one of the challenges is though is that there are a lot of assumptions that are made, so when the assumption for us was that we were from [small, Māori coastal town], so you’re all of this. (Teina’s cousin) It’s called pre-judgement…you know since I’ve come back from Australia, the few weeks I’ve been back, you can see the growth and distancing between Māori and Pākehā. (Teina’s father) So they talk about cultural competency in the healthcare system, well it’s everyone that needs it not just non-Māori because the institutionalised racism that exists in our country is really entrenched. (Teina’s cousin)

Teina explained that while there was nothing racist explicitly stated to her while she was being cared for in the maternity hospital following her emergency caesarean section, the tense āhua she gathered from her health care practitioners, and then later overhearing them engaging in covert conversations about her, made her feel that racism was present.

By the time I left there I wanted to burn the place down (laughs), yeah that ward was not good, it was just busy and you could feel the stress, and not all of them but a few of them were (pause) you know. And I could hear them talking about me, or you’d walk into the desk and they would act like they were just caught out by me. (Teina)

These difficult experiences understandably had a negative impact on the piripoho journey experienced by Ngahuia and Teina. Ngahuia described how this unfair treatment affected her,

It’s people like them that makes you drop your mood, because you go in all happy and thinking positive that it’s gonna be a good day, and then they come off like that and then your mood just drops. But yeah, in the end the manager came down and she was awesome, she said that the nurse had a few complaints against her so we weren’t the only ones. (Ngahuia)

Ngahuia felt that unfair treatment worsened her day(s) in the NICU environment. This lack of respect resulted in poor relationships and communication between the health practitioners and whānau, which in turn impacted on how the care was delivered and received. Whānau deserve to be valued and treated with respect by all health practitioners.

In Tahlia’s piripoho journey, she believed she had delivered a healthy baby boy, and as a result, did not question being discharged from hospital that same night. But as she explains, she noticed her baby doing unusual movements when she got home. After rushing her baby back to hospital, he was immediately flown to the SCBU two hours away from her home.
I gave birth to what I thought was a really healthy baby boy. There seemed to be nothing wrong with him when I gave birth and so the next day when I went home, and I got home and I would have been home for about 4 or 5 hours and he started having no joke he looked like he was having epileptic fits. His whole body, his arms and legs. And I rang up the midwives in the hospital and said my son is doing really weird stuff and he’s continuously doing it...like it didn’t stop for about 45 minutes. I took him back to the hospital, and what kind of annoyed me was that the midwife said that she noticed that he was really jittery when he was born, so he could have been having seizures when he was first born! And I said to her ‘but you sent me home, you signed a form and said to me that I could go home while you knew babies shouldn’t be born jittery!’ And then that was even scarier was that once the helicopter got to [home hospital] to pick us up the day after I had him, he actually fully stopped breathing on his own so he had nose prongs for about 8 days because he was just refusing to breathe properly on his own. But what really annoyed me the most was that they sent me home, my midwife...So we got there and they gave him this medication that knocked him out for like 4 days and I thought something seriously was wrong with him, I was like why isn’t my baby opening his eyes and doing what normal babies do... (Tahlia)

This statement portrays the level of stress and trauma Tahlia has been subjected to because she felt she received substandard treatment following the birth of her son. Being discharged is arguably the beginning of Tahlia’s substandard treatment during her piripoho journey. Her midwife sent her home even though she had noticed her baby demonstrating abnormal movements. Being sent home made Tahlia believe that there was nothing to be concerned about over the health of her baby. When she realised for herself that something was not right, she was panicked and this panic remained with Tahlia when I had met her. She believed that if the midwife present at the delivery had acted upon her initial suspicions that something was wrong with the newborn baby, her baby could have received earlier treatment that he had required.

Tahlia also shared how she was disappointed with the care her son received in SCBU once he was there.

I'll be honest, I wasn’t very happy with the SCBU nurses...the thing I didn’t like about the SCBU nurses was that I felt that they were lazy at changing his drips...we had to tell him to change it because the fluid was just making his foot go swollen rather than go in his veins, it was just sitting there...his dad nutted out at the nurses because they just weren’t changing his lines quick enough, and they were yuck. (Tahlia)

Tahlia felt that the treatment provided to her son was not responsive to her son's needs because his cares were done poorly. In this way, she felt that she and her son were not valued and respected by the SCBU practitioners.

Substandard treatment has a negative impact on whānau wellbeing because as Ngahuia states, it brings their mood down, and can make them question their competency as mothers/parents.
8.3.2 Communication between health practitioners

Some wāhine and whānau found themselves in the middle of a health care practitioner hierarchy dispute, which accentuated their stressful situation. As expressed,

It was a good one we got [nurse], but she was too scared to tell us this [nipple shields] incase my midwife told her off because she was a junior. But when I saw her later I said to her that she should have told me and given me those shields and not worried about my midwife because it’s all about me and you’re meant to be looking after me. Her and I are friends but I guess there is a professional boundary that you can’t step over but like what I said to [nurse], mate you saw how bad I was, you should have just made the call and I would have stuck up for you.

(Becky)

Hierarchical issues were also noticed in between the same groups of health care practitioners, and that also caused difficulty for some whānau. Nadia noticed this and shares,

Yeah, I dunno, maybe nurses need to just follow doctor’s orders rather than their own advice. It’s hard, because my mum is a nurse and when we got home I know she was biting her tongue so much to not give us advice because we got so sick of everyone telling us what to do. (Nadia)

During a time fraught with stress and anxiety, the participants expressed how they had no time (and patience) to be caught in between practitioner hierarchical issues. They were in need of the practitioners’ help and support, rather than being caught up in their internal power conflicts.

Additionally, four wāhine and their whānau expressed their disappointment in the lack of consistency across the numerous health care practitioners who cared for them and/or their baby. It was indicated that due to the large number of health care practitioners they were in contact with, poor communication would often result because they would receive conflicting messages from different practitioners. This increased the stress they were experiencing during their piripoho journeys. As explained,

I think the consistency needs to be improved though…the doctor came around and did their rounds each morning. The doctor was nice, like she said that we could try and feed on demand on day 6, but then the nurses came back around and was like no, no, no. I can see two sides of the story but from a parent’s side of the story, it’s pretty hard receiving conflicting messages. (Nadia)

Adding to their already present frustration, Nadia received further conflicting messages when her baby was discharged from NICU,
So the lactation consultant came in on the last day when we were getting discharged and gave me information on medication I could take to increase my milk supply and all I was thinking was just get me out of this stressful situation and my milk will come. And in the end they let us go home with the lact-aid and gave us heaps of syringes and nipple shields...whereas a previous nurse had told us that going home with lact-aid was not part of the criteria and that we need to be fully breastfeeding by the time you go home...so where’s all these mixed messages coming from you know. It was real bad communication. So they sent us home with everything in the end!
This illustrates how Nadia was not in a nurturing space during her time in NICU that allowed her to restore wellbeing. She expressed a lot of frustration and seemed desperate to get out of that environment. These feelings emulated from the conflicting messages and difficulties she received during her time there. Tahlia also received conflicting messages from different health practitioners,

And another thing that was really annoying was that I never saw the same doctor so I’d see one doctor and they’d say he’s having epileptic fits and then I’d see another doctor and they’d say I don’t think its seizure activity, so it was really confusing for me and his dad. In the end I just wanted to go home because I felt like I was getting told different things. It would be nice if the same baby got the same doctor while they were in SCBU, I understand that it probably can’t be every single day but it would be nice to have consistency so that you’re seeing the same person. Because it annoyed me when one doctor came in and said we’re not doing anymore lumbar punctures and then another one would come in and say that we’re gonna try again, and that was so cruel giving my son 8 lumbar punctures. (Tahlia)

Ngahuia expressed her frustration of the communication inconsistency, and how she would gauge the level of clinical interaction she was going to receive when each health practitioner would enter her room,

You could tell who the new ones were because of the colours that they wear in their uniforms, the manager told me, so that helped because you could see who the experienced ones where and the ones who were still learning, so yeah the miss-know-it-all nurse that I had a run in with was one of those ones that still needed experience. (Ngahuia)

From the ngā pāpā perspective, Becky’s husband shared his viewpoint on their similar experience with different health practitioners,

There were a couple down there that were nice but then you’ll get them and then another four or something in between that were either learners or having a bad day or just didn’t want to be there, or who knows. Having poor consistency and making the whānau judge their day “depending on who’s coming on shift” (Justine) was perceived by them as being a display of substandard care and a detached approach to providing care. It was repeatedly expressed by the wāhine and their whānau that improving communication between the numerous health care practitioners would have been helpful for them. Doing this may have helped them feel respected within the health care system by being adequately informed and listened to.
8.4 Access to Formal Support

As the chapter and those preceding it have outlined, many wāhine had to deliver outside of their ūkaipō (as in place of nurturing) and faced numerous challenges from doing so. They required support that often extended beyond the scope of whānau capability, and so formal support services needed to be offered to them. As expressed,

We need their [practitioners] help. It’s not our fault that we end up in these places [hospitals]. People reckon that in [city] we have heaps of family so we'll be alright but na no there’s not, yeah we may have family there but not one’s that we can just rock up to. (Ngahuia)

A cousin of Teina also alluded to this during their whānau interview. She stated that there is a common misconception that all Māori have a vast network of whānau they can rely on for support in adversity and therefore require less formal provider-level support. However, as she points out, this is a false and problematic assumption.

What happens too particularly, I think there is a huge perception that because you’re Māori, you’ve got whānau everywhere, when in actual fact, there’s not…there’s just this lazy attitude that kicks in. (Teina’s cousin)

Coupled with these misconceptions is the assumption often held by health practitioners that whānau are aware of what support services are available for them and how those services may be accessed. However, what emerged from the whānau experiences was that in times of adversity, whānau did not know what was there to support them, and were often not in a clear state of mind to try source such information.

Failing to offer support services for whānau is a breach to DHB stipulated Tikanga Best Practice Guidelines. As explained,

Yea it was hard, especially because we come from so far away and didn’t know what services are out there to support us. In hindsight now I know there’s a lot more available but during moments there is just too much going on to be trying to find them. It would have been great if someone had come in and said ‘boom, here you go this is everything and I’ll take care of this and that’. And that’s what happened when we were saying farewell to our boy, so you know, it didn’t happen prior but it did happen in the end. (Kristen)

Kristen’s example highlights how support services are often provided late, if at all.

8.4.1 Social Support Services

In the context of this project, social support services were largely provided by social workers. The role of the social workers was to provide social services (for example travel aid, and accommodation assistance) to those in the midst of challenging medical circumstances. What was apparent throughout the whānau experiences was that there was poor access to these social support services. This
poor access was aligned with the practitioners having the power to determine the levels of need for support services between whānau. As a result, some wāhine were considered as being better candidates for social support than others. For example,

Yeah so the thing is, we didn’t even get offered the motel support until the very end. It just seemed to happen that the social worker would come when I was out, which wasn’t very often…! (Teina’s cousin)

In this example, the initial withholding of support created difficulty for the whānau who had been transferred to a hospital three hours away from their home. Teina added her perspective to the kōrero, where she felt there was a lack of respect shown by the social worker when she eventually came to visit.

I just looked at her [social worker] and thought nah you’re dumb; I wouldn’t have walked in and said how can I help, you’re from [small, rural Māori town] ay? I would have said, OK you’re away from home so we can give you this and we can give you that…she ended up coming again and that is when she started offering help but that was after she had a tune up. (Teina)

A “tune up” is what Teina described to me as being a telling off. She expressed how angry and belittled this social worker made her feel because of her negative attitude towards her. It was only after Teina confronted this social worker about her attitude that she began to receive support and help from this social worker. This is another reflection of how Teina was not valued and respected by the practitioners during her piripoho journey.

Kristen also shared how she initially had poor access to social support during her journey while her son was still alive and being cared for,

When we were up there we had the social workers come and talk to us but they were very busy and I actually lost touch with them because I never saw them when I was there, I only saw them once. (Kristen)

However, once the health of her son became critical and he was in his final stages of life, Kristen felt that the social support that was offered to her had improved. This is consistent with the perception that support services were delivered late to whānau (if at all). As shared,

Then the social worker came in and gave us everything- travel assistance and kai vouchers, she done all of that and moved heaven and earth to get us all together in the Ronald McDonald house… (Kristen)

Even though she had received poor support during her journey prior to her son’s death, Kristen expressed her praise to this social worker. She was grateful that this social worker worked tirelessly (“moved heaven and earth”) to ensure that Kristen and her whānau were together following their loss. Having someone facilitate her whānau being together was what Kristen considered most important and had appreciated most.

Justine also experienced the loss of her baby. When she was asked if she received any support or follow-up her response was,
Nah they just left me. I don't know how it is if you lose a full-grown baby through the hospital, but it felt like a miscarriage is underplayed, almost like it's not a big deal. And a lot people deal with it in different ways, but for us it was a big thing because it was our last kid, we could never have another one, and for me he was already part of me for 5 months causing me all that grief. I already had that bond with him but there was no follow up or anything, but I knew that the attitude towards it, even in the ambulance when I was miscarrying you know, like if I had baby then that was it, they would have dropped me off and been done with it.

(Justine)

Justine felt that the health practitoners did not consider the loss of her baby at 19 weeks important (“almost like it’s not a big deal”). To her, she felt that her health practitioners did not consider her baby a viable patient yet, evident by the lack of follow-up support that was offered. Instead of providing support following her miscarriage, Justine felt that the health care practitioners relied on providing ‘quick fixes’ to her. She states,

In terms of medical help, I feel that all they kind of do is give a short-term answer…they’ll chuck you on some kind of drug and leave you to it. (Justine)

Justine reported that the loss of her baby was a traumatic loss, yet she felt her health practitioners overlooked this and as a result, she felt unsupported. Kristen’s journey showed how she was only recognised as a worthy candidate for social support following the loss of her baby at eight days. Prior to his death, Kristen and her whānau were not offered adequate social support. These experiences indicated that social support services were not offered in a timely manner, which may be linked to the system not being culturally responsive to whānau needs.

Ngahuia also expressed how she did not feel initially supported by social support services. In her piripoho journey, Ngahuia was required to move to a large urban city five hours away from her home where she had few whānau members living. She shared her initial difficulties she faced in navigating her new environment,

I got put in a motel and I knew that was gonna be hard [to get to baby] because it was a 30 minute walk away, so what about in the night time? Was I meant to leave early, and then they said that the shuttles pick us up, so I asked at reception if the shuttles go from where I was to the hospital and she said no, so I was like hōhā and in a panic because I didn’t want to walk the streets by myself. (Ngahuia)

However, after meeting (“then I met this lady that helped families and stuff”) and developing a relationship with her social worker, Ngahuia gained the social services support she required.
My social worker was awesome. My family was back in the country...so she got my family over, cos I just needed them. It was the first time my partner wasn’t there for the birth and so it was good him coming when he could. He came over by himself while my mum had these kids, and it was good cos my older kids were helping Nan and Koro...yep so every week my partner could come up, he just picked up the gas vouchers every Thursday. (Ngahuia)

Ngahuia shared how the same social worker also helped her and her whānau when her baby was transferred to a second NICU unit, which she was also appreciative of,

She already had everything in place for wherever I went to, it just kept going so that was good. And in [second NICU location] the accommodation was great cos she had it for me, my kids and my partner so that was an extra bonus that we could all stay together.

Another positive example of support from her social worker comes from Ashton,

And the other cool thing was the support we got for [partner] to stay in the house. There was a social worker in the SCBU unit that organized that for him, and he had a car park that he could park there for free, and I think it’s based on how far away you are from home but yeah he could park and stay there...And they also helped fund and accommodate my mum when she came up from [city 6 hours away], which was awesome because it was so nice having mum there. (Ashton)

These positive examples are a stark contrast to Kristen and Justine’s journeys, and show that by relieving whānau of financial stressors, such as transport and accommodation, whānau were able to be together during visiting hours (and did not have to deal with the stress of navigating the hospital environments on their own), which helped strengthen their wellbeing.

8.4.2 Support Organisations

A contributing factor to ensuring seamless health care services would be having support service organisations operating closely and communicating with the maternal-infant health care system. This would allow a unified approach to delivering support services when a whakawhānau journey is disrupted. However, it seems that this is yet to be achieved as evidenced by the experiences shared by the wāhine and their whānau. For example, Teina initially faced disrespectful treatment from the Work and Income service (WINZ) when she sought out financial support following her and her babies' hospital discharge. She shares,

Me and my partner went legit. And then she says to me, the babies are 6 weeks old, and she asked me why we hadn’t been in to come and see her earlier and tell her we were back together. And I was like, ‘oh well we’ve been in hospital for six weeks, and my babies were born premature and pretty much dead and I’ve got clots in my lungs and this is the last place that I want to be at right now’. And she was like ‘oh sorry, I understand’. (Teina)
Although the WINZ provider apologised at the end, when Teina shared her kōrero with me, she was annoyed with how the case worker treated her. She felt that the case worker judged her for presenting late (six weeks later) to her appointment to update her benefit. She was also annoyed that she had to travel to the WINZ office to meet the case worker. She shared with me that she would have preferred the health practitioners being in communication with the WINZ workers so that they were made aware of Teina’s journey and the reasons why she could not present to the WINZ office. Teina’s cousin provided her input and suggested that services like WINZ, and also Māori health services, need to be more proactive.

I think in terms of Māori health services, they need to be more proactive. For me, I just wanted to make sure these guys were okay and make sure all the WINZ forms were done because she should have got extra support for having twins. (Teina’s cousin)

Another example of how support services were not proactive was from Kristen’s journey. Following the loss of her son, Kristen stated that “she had to reach out” to organisations who specialise in supporting families following the loss of their infant. Arguably, Kristen should not have been the one to reach out; it should have been vice versa. Even after reaching out to these organisations, Kristen was disappointed with the support that was offered,

But I’ve reached out to other services like Sands but I didn’t feel too supported…If anything, I would like to start up my own support thing up here, just from a Māori perspective because my boy existed right from conception, he had his own identity, his own mauri right from conception…he will always be a part of our family. (Kristen)

Kristen felt unsupported by Sands for reasons she did not explicitly state. As Sands is a largely non-Māori organisation, they may not have recognised many of the mātauranga Māori values evident in Kristen’s life. For example, Kristen appreciated it when her baby received high-quality care from the NICU practitioners of care because they treated him as a whole being (section 8.3.1). This contrasted with what Kristen felt was Sands lack of acknowledgement of her baby’s whole being, particularly his mauri and wairua.

8.5 Mātauranga Māori in Maternity and Neonatal Care

Some of the wāhine were open to how they would like to see mātauranga Māori more visible and prevalent in the maternity-infant health care system. Some shared how they found mātauranga Māori to be lacking, while others provided examples of where it was visible and active, during their piripoho journey. Firstly, Justine expresses,
I really think [secondary] hospital do it right, they bring in a lot of Māori elements. Like they let me have a big queen bed for me and [husband], so they’re real good in that sense…Yeah you should really have a look at their ways and practice just as a kind of guidance and how it can be incorporated into other DHBs. (Justine)

Simple measures such as providing a queen bed was seen as a way of incorporating mātauranga Māori into the health care system because it was recognised as a way of facilitating whānau support. As this chapter, and those preceding it, has shown, whānau support contributes greatly towards ensuring a positive birthing and postnatal experience and supports strengthening wellbeing. Therefore, finding ways in which the system can facilitate whānau support can improve its cultural responsiveness to whānau needs.

Kristen shares another point of how mātauranga Māori can be implemented in that health practitioners allow for karanga (welcoming call) during the birth of a baby,

Wouldn’t it be awesome if we could have everyone come in, have a karanga make it a happy occasion….because I had these thoughts in my mind, and this is just because I’ve had friends who’ve had it done and had their babies- when baby is born they had someone calling him, ‘Tihei Mauri Ora’. They had someone calling their baby out- ‘Nau mai, haere mai, welcome to this world’. So I held that very important, he was coming into Te Ao Marama and I knew they [practitioners] didn’t know but yeah that was my thing that I wanted. Unfortunately Kristen was not asked if she wanted this opportunity. Allowing karanga would be a special welcoming for the baby, as it welcomes not only the baby but also their whakapapa. Allowing karanga also prioritises tikanga Māori and shifts the foreign clinical hospital ‘space’ to incorporate a Māori ‘space’ as well.

8.5.1 Allowing for Māori ‘space’

When her baby was passing, Kristen shared how she appreciated the doctors allowing her and her whānau to be in the room with him and carry out their final goodbyes together.

I’m sure I heard them [tūpuna] calling him. I believe we were doing his final poroporoaki [farewell] and they were doing his karanga [welcoming] because it is so thinly veiled, you could almost hear what was going on, you could hear us fare-welling him and them welcoming him. I’m sure I know the exact moment where I saw the switch over, and it was so beautiful. I don’t fear that moment, I’m sad of course because I’m letting go of my baby but it was beautiful… (Kristen)

Allowing this space assisted Kristen and her whānau to farewell their baby that aligned with their cultural values and practices. This is an important and positive step towards making the health care system culturally responsive because the whānau were able to engage in tikanga Māori without feeling alienated in the foreign, hospital space. It is also an example of how the wairua of Kristen and her whānau was nurtured.
However, despite this being positive, this space was almost immediately removed from Kristen as her baby was taken away for postmortem procedures. Current postmortem procedures can clash with tikanga Māori because it is a common belief within Māori worldviews that the tūpāpaku (deceased body) should be accompanied at all times. This is because it is believed the wairua of the person remains with the body for some days before it departs for Hawaiiki. Thus, the enforced separation whānau go through when their tūpāpaku is taken away for postmortem procedures can be difficult to deal with because it restricts the whānau remaining with the wairua before it departs. As shared,

So we met the undertaker, oh I don't know what to call her, the person who does the preparations and that was pretty awful actually, sending him there alone. I didn't like that. I thought they would just be in here. It broke me a little bit to have him go there, and I asked if I could go but I can't remember what happened, there was so much that was going on that I just couldn't comprehend what was happening. But yeah I still think about the fact that he was there. (Kristen)

There are practice guidelines within hospitals that explain the tangihanga tikanga and the importance of this for whānau, and this is a positive step towards being culturally responsive.

A different kind of space is offered through allowing the wairua connection. Ashton felt that she had a special wairua connection with her baby and grandfather.

Yeah it was really cool, it was actually really special because my Pop passed away around the same time that we told my nana that I was pregnant, and she is quite spiritual so she thought that it was kind of like one in and one out, and she thought that [baby] would have some of Pop’s qualities and stuff like that. (Ashton)

I find this significant because Ashton talked about how the practitioners allowed the space to have her nana there with her, throughout her labour and delivery, right to where baby had to be admitted to SCBU. This demonstrates that they enabled a space that facilitated that wairua connection.

Facilitating wairua connections is also demonstrated from practitioners allowing whānau to practice karakia (prayer) and/or providing chaplains that can carry out karakia for and with them. This is also a positive step and illustrates cultural responsiveness for whānau needs if karakia is important to them. Surprisingly, not many whānau spoke of practicing karakia throughout their journey (only Kristen, Justine and Ashton). I found this silence interesting and raised the questions of whether or not the space to have karakia was offered to the remaining seven whānau during their journeys; or whether or not karakia was widely used by these wāhine and whānau.
8.5.2 Māori workforce

In the context of this project, Māori were under-represented in health care professions and this was noticed by the lack of Māori health practitioners who cared for the wāhine. While five of the wāhine had a Māori LMC, once they were in the hospital environment, they identified a shortage of Māori health practitioners. From the perspective of Teina and her whānau,

Yeah and the whole time we were in hospital I only saw three Māori people…my midwife, one other midwife who was [LMC’s] friend who looked after me for a day, and one in ICU and fuck she was cool too.

(Reina)

Her cousin adds to this statement,

Yeah but I think the other thing we need is actually more Māori people in the health care system, we need more Māori midwives, we need more Māori doctors, and we need more Māori nurses. Neonatal care to about 3 years of age is the most important time of a child’s development, so if we can give them everything they need in the womb and the first three years then theoretically they should need less down the road.

What Teina and her whānau share here indicates that there is a need for increasing the Māori health care provider workforce. Teina reported having positive clinical interactions with her Māori practitioners. From this, an argument may be made that a greater Māori workforce could contribute towards informing a positive health care journey for whānau. Māori practitioners are beneficial in the health care workforce, particularly when they can speak te reo Māori. Teina added her perspective on this,

My partner speaks hard out Māori to our son. I think it is important because there are people that would appreciate that you know…I think bringing more in would be a really good thing because I have heaps of family that are fluent in te reo and I think that they would really appreciate going to the hospital and having someone that can speak.

And I think it’s a good idea for the babies to have kōrero Māori too. I don’t think it was encouraged enough when we were at school, but in the hospital system that would be a really good idea.

Te reo is a significant part of Māori culture that makes it unlike any other culture of the world. Pushing the use of te reo is important because understanding the language enables a better understanding of culture and practices Māori value and adhere to.

The small number of Māori health practitioners in hospitals should be used as a motivation for all practitioners to make an attempt to understand basic tikanga Māori and te reo Māori. Having this knowledge may help whānau feel welcome in an environment that is largely non-Māori and can help enhance their whānau journey. It may also motivate health care practitioners to consistently understand and meet the
tikanga best practice guidelines that are present within their DHB. An example comes from Ngahuia,

And there is a pediatrician in [secondary hospital] who is awesome! He tries talking Māori to us, I like people like that.

Other positive examples included,

There was about four of us Māori mums in there at the same time, there was no Māori nurses. But they were cool to us…and it was cool because they were Pākehās, Poms, Fijians, there was heaps of different people and everyone got on together, it was cool… (Teina);

and,

I was a little hesitant because I didn't know whether they came from whakaaro Māori as well but at the end of the day it was all about her generosity and support towards me. (Kristen)

These examples indicate that efforts are being made by some practitioners of care to be culturally responsive for Māori, which contributes greatly towards improving the whānau wellbeing throughout their maternal-infant health care journey. However, these examples relate to individual clinicians and their efforts. The maternal-infant health care system needs to support such efforts to enable more clinicians to practice in this manner.

8.6 Chapter Summary

This chapter has shared the range of experiences of whānau during their piripoho journeys. As a result of encountering an adverse delivery outcome, many of the whānau struggled with their adaptation to motherhood because of the challenges they faced with being in a foreign NICU or SCBU environment. In these environments, wāhine and whānau were expected to relinquish their parenting cares to the health practitioners and clinical practices. Health practitioners in the SCBU and NICU environments failing to explain why the clinical routines are in place and what purpose they serve often heightened this frustration. There was also a lack of opportunities presented for whānau to have a role in co-constructing their baby’s care with the health practitioners. This led to further issues that increased their stress and anxiety, including fewer opportunities to bond with their baby, and having difficulty fulfilling their ūkaipō aspirations. It was stipulated by numerous wāhine that the breastfeeding education and support needs to be improved, particularly in the NICU and SCBU units.

Wāhine and whānau also reported on receiving disrespectful treatment because of racism. This is an obvious flaw in the current maternal-infant health care system as it restricts the offering of culturally responsive care for wāhine and their whānau. Unmasking racism by making its occurrence explicit creates the responsibility and opportunity to address racism and improve the system.
It was also found that whānau support is regulated through a series of gatekeepers, across numerous levels, within the hospital environment. At the geographical level, the physical location of the NICUs and SCBUs became a gatekeeper for whānau support. At the systemic level, policies and guidelines were found to be gatekeepers because they were applied as a means of maintaining control in the clinical environment. At the individual level, the health practitioners were gatekeepers and held control within that environment by allowing or not allowing whānau support. The multiple levels of gatekeepers often amplified the feeling of isolation from whānau and whenua for wāhine navigating the NICU and SCBU environments. To remedy the isolation and absence of whakapapa whānau, some wāhine developed kaupapa whānau with others in similar situations as them. This helped them gain the reassurance and support they longed for.

The need for improved support services delivery was also outlined, as many whānau felt they did not receive the required support in a timely manner. Issues around communication and consistency in practitioner care are also a matter of concern in need of remedial action. As Kristen reiterates,

I’m lucky that my case had more adequate care than inadequate care. There is definitely room for improvement, and that’s more so around the area of communication and ignorance.

The positive experiences that were shared were encouraging as they flagged how practitioners provided culturally responsive care. Positive experiences were particularly based around the care provided by certain specialist nurses and social workers; having opportunities to engage in their baby’s cares and bond through providing those cares with their baby as a whānau; and being able to practice tikanga Māori in a foreign space.

The following chapter will share the experiences of the final phase of the whānau journey. It has been named Onāianei, and it explores the experiences of the whānau from the time they returned home to when I went and visited them for kōrero.
Chapter 9: Onāianei

This chapter, Onāianei, explores the final phase of the whānau journey. When I met the wāhine and their whānau, they were within onāianei, meaning the current time phase. The chapter begins with the journey wāhine (and their whānau) embarked on when they returned home from hospital. This journey was reflected upon largely positively, and this was mostly owed to the wāhine overcoming numerous obstacles and adversities (outlined in the prior chapters) and returning home. For some wāhine (Justine, Kristen, Tahlia, Ngahuia), however, there were ongoing challenges during their onāianei experience. These included accepting the loss of their baby, being inappropriately discharged from hospital, and having fragmented access to postnatal support services. Even so, each wāhine demonstrated mana wāhine through their courage and strength, and had adapted, or were on the path of adapting, to maternal life following their adversities. This chapter explores mana wāhine and the overcoming of challenges on the return to life at home.

Table 6. Themes and Subthemes of Onāianei Journeys

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9.1 Hoki atu ki te kāinga - Returning Home

A common theme and reflection that was shared among the wāhine regarded the journey of returning home to their ūkaipō/whenua and whakapapa from the clinical, hospital environment. Many of the wāhine experienced a differed reality at several, if not all, stages of their whānau journey to what they had imagined. Their hapūtanga imaginaries were shattered, which subsequently led to the shattering of their birth and motherhood imaginaries. Before discussing the challenges that corresponded with

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23 Postnatal is the period of time relating to after childbirth.
these disrupted imaginaries and journeys, the positive experiences of returning home with their baby are shared.

The positive experiences had a common thread that included the wāhine being well supported by their whānau and health practitioners. This access to whānau support and postnatal support from their LMC and wrap-around services aided a smooth/er return home from hospital for the wahine, baby and whānau. Waiaata was an example of a wahine who felt her baby was well cared for by the SCBU practitioners, with this reflected in her stating that three or so weeks in SCBU was a quick recovery time for her baby (section 8.1.5). She also said that this quality of care flowed through to her hospital discharge,

Yeah it was great getting home, our whānau helped, but the SCBU nurses were awesome too… (Waiaata)

Waiaata acknowledged the support she received from the nurses who cared for her baby in SCBU, and also the support of her whānau when she was able to transition from hospital to home. She places the support of her whānau and the SCBU practitioners as being equally important as each other during her transition home. This suggests that a good discharge takes the support of both health practitioners and whānau. When I met her to share kōrero, she had adapted to motherhood at home. Waiaata was breastfeeding well, was happy, and her baby was in good health and growing well.

9.1.1 Adapting from clinical to home motherhood

Ashton was another wahine who shared a positive transition experience although she did encounter some minor challenges. She attributed her positive transition to the support she received from having access to good postnatal support that was delivered by midwives and nurses.

Yeah when we were allowed to go home, it was fine because we were really well supported and we had a midwife and a nurse come and visit us, so we had heaps of support. It was actually fine being home, once I got over it and confident that he was warm enough, because that’s such a big deal in SCBU, their body temp. But he’s been a really easy baby. (Ashton)

The previous chapter outlined how Ashton had to adapt to being a dictated mother while her preterm baby was being cared for in the SCBU. In the quote above, she talks about her awareness of the importance of baby’s body temperature in the SCBU. When she returned home, she had to learn to remove herself from these dictated motherhood practices and adapt to being an intuitive mother who could respond to her baby as she might have initially imagined she would. To ease herself back to intuitive mothering, Ashton had to learn to relax her surveillance of her baby and remind herself
that he was discharged from clinical care and was now at home with her in a non-clinical space. The reassurance provided by the postnatal support delivered by her health practitioners helped her get “over it” and relax into being an intuitive mother. She shared how the education she had received about infant cares and cardiopulmonary resuscitation (CPR) from the SCBU nurses before being discharged also built her confidence that she could look after her baby at home. This confidence in her own abilities, and the encouragement of the health practitioners who visited her and baby at home, helped her transition and adapt to intuitive motherhood. Her whānau also spent the first few weeks together at home with their baby, focusing inwards on themselves as a family to re-establish themselves firmly back within their home environment.

Yeah so we got to learn all of that before leaving the hospital. That was cool, I just felt confident being able to look after baby outside of the hospital...But ever since we got home it’s just been all good. We kept him home for the first six weeks and then we started venturing out a bit more. (Ashton)

Not all wāhine shared positive experiences about their return journey home. Nadia and her husband had some difficulty with their transition home when their baby was discharged from NICU. They attributed baby’s disorientation with what time was day and what was night to the lights being on all the time in the NICU,

She was so muddled at day and night when we first got home. (Nadia)

Yeah, she would sleep all day and be up at night. (Nadia’s husband)

And because the lights are on in NICU all the time as well but I know babies get muddled lots from that... (Nadia)

Nadia’s adaptation back to being an intuitive, breastfeeding mother was made difficult from her baby having a lack of awareness of day and night in conjunction with the poor development of a strong hunger cue from being used to nasogastric feeds. These factors made Nadia and her husband’s transition home focused very much on their baby. A big part of intuitive mothering for Nadia was trying to put some regular timezones in place within their home and getting baby to take food orally. The impact of this transition home on babies can be overlooked because the focus is largely on the wāhine coming out of an intensive care environment such as NICU and adapting as mothers at home. In Nadia’s case, most of the attention was on her baby and Nadia and her husband settling into being the parents they had imagined themselves being. Although they had these struggles with baby’s feeding, Nadia and her husband said that they found this transition much easier than being in the NICU. This is shown as Nadia continues to share her reflection,
Yeah so that [being in NICU] was pretty stressful but once we got home it was sweet. (Nadia) We just got into ay, got into parenthood. (Nadia’s husband) Yeah and you actually get to finally become parents… (Nadia)

The remaining wāhine experiences regarding their journey home are shared throughout the remainder of this chapter. Some are outlined below as examples of mana wāhine, particularly for Justine and Kristen who illustrated mana wāhine when returning home without their babies. The more problematic return journeys home are shared when the chapter explores the experiences of being inappropriately discharged from hospital.

9.2 Mana Wāhine

As with many other Māori concepts and values, mana wāhine can be interpreted in a number of ways. I understand mana wāhine as comprising the strength, courage and integrity uniquely seen in wāhine. I say uniquely seen in wāhine because women often show courage and strength in the face of struggles and walk in multiple spaces that men may not encounter (Mikaere, 2017). Notably though, exploring mana wāhine does not take away the mana of the tāne (men), because they too have their unique struggles and spaces to contend with also. Overcoming these struggles and illustrating their strength reminds me of the atua wāhine that are prominent within Māori cosmogony. This section explores participants’ mana wāhine.

Once the wāhine participants could return to their home, they were reconnected with their whakapapa and ūkaipō/whenua. They were also faced with the task of adapting to their new life circumstances. The experiences of Ashton and Nadia shared above speak to some of the complexities involved with (re)adapting from dictated motherhood to intuitive motherhood at home. Other wāhine shared their different experiences regarding how they were adapting to motherhood at home. I interpret these as examples of mana wāhine.

The first example lies with Becky. As with many other wāhine, participants needed to return to work following the birth of their baby. This presented the challenge of balancing work commitments and motherhood. Becky headed her own successful business and felt compelled to return to her work when she recovered from her mastitis. At this stage, her baby was still young and reliant on breastfeeding. Becky was confident in her abilities as a businesswoman and as a mother, and saw balancing both roles as unproblematic. She shared an experience she faced in one of her business meetings. While this experience was humorous to Becky, it also demonstrated her mana wāhine.
Well, I’ve worked on no sleep before I had him, I’m used to long days and long hours. What I’m not used to is stopping and going all day now, like I have to stop to feed and then I’m off again (laughs). I pretty much went to work straight away after I had him, and I’ll never forget this meeting I had with this guy who came up from Wellington and [baby] wouldn’t stop crying so I just had to pause and say I’m just going to feed my son and his face was funny, he got all awkward but I was like either you go back to Wellington and explain to the government that you need another flight up or you can just sit through this for the next 15-20 minutes and it’ll be all over and done. (Becky)

Becky’s story shows how wāhine can fulfill multiple roles in multiple spaces simultaneously. This demonstrates mana wāhine because Becky reclaimed her motherhood imaginary by successfully returning to her business and fulfilling both her roles as a professional and a mother.

The second example of mana wāhine derives from the experiences of Ngahuia and Tahlia. Both wāhine had to adapt to motherhood in the context of their baby’s ongoing health condition(s). When they transitioned home, both Ngahuia and Tahlia’s babies were experiencing breathing issues. Both wāhine sought ways that could allow them to be responsive to their baby’s needs. Ngahuia called upon her previous experience of caring for her preterm babies and she found a way that helped to stimulate her baby’s breathing,

She just keeps having apneas, keeps forgetting to breathe this girl. And to this day, she still does it…so I blow on her face, that stimulates her to take a breath, little egg (laughs), don’t know why she does that, so that’s why I always wake up in the middle of the night to check on her. (Ngahuia)

This is an example of mana wāhine because Ngahuia took upon herself to find a fitting way that would help her baby with her ongoing health issues. When I spoke with Ngahuia she was relaxed about her baby’s breathing apneas, even though it meant she had to keep continuously check on her.

In contrast, Tahlia remained stressed and anxious about her baby’s breathing problems. I put this down to the fact that Tahlia had been inappropriately discharged with a lack of information and support provided. She was not informed of her baby’s health condition and what she could do to help him. In an attempt to help her baby, she has sought out skills to ensure she is prepared to care for her baby in worst-case scenarios.
Honesty they discharged me with nothing and like if I had known, like if they said he’s epileptic or something I could deal with that and know what to do. But now my best friend and I are gonna go do a CPR course and first aid course because sometimes I worry that he stops breathing and I just panic too much, because I couple of weeks ago he stopped breathing and my partner was home and I yelled out to him and I just stood there holding him and crying…so I said to my best friend, I need to do something to learn so that if it ever got to the point of needing to give him mouth to mouth or whatever then I would know what to do…

She continues to share how difficult her situation is,

To be honest, I panic. Sometimes I think that when I panic it stops him from breathing even worse cos I'll try to pick him up fast and pat his back or blow on his face…one of the times I actually thought he was going to die in my arms and that was probably one of the most scariest times ever. Yeah and sometimes I worry, because he holds his breath sometimes until he changes colour, and I worry how that is affecting his brain you know having a lack of oxygen to it. Honestly sometimes I don’t even get any sleep because I just literally watch him to the point where I’m crying because I’m so tired. (Tahlia)

Ngahuia and Tahlia both demonstrate determination to overcome the difficult situations they were placed in as the result of their baby’s ongoing breathing difficulties. They sought ways to empower themselves by becoming aware of their baby’s health condition and treatment needs. Both are examples of mana wāhine and tino rangatiratanga. I liken these examples to the atua wāhine of Hinetitama. In her adversity (finding out her husband was her father), she exercised tino rangatiratanga to determine a positive response for her wellbeing, which involved morphing into Hinenuitepō and forbidding Tāne to follow her to Rarohenga. The strength to exert tino rangatiratanga amongst adversity is an embodiment of mana wāhine. Whakapapa ingrains this mana wāhine within us because it connects us to the atua wāhine in our cosmogony.

The third example of mana wāhine is demonstrated through competence. When I met Ashton, she reflected on her journey and she was proud of herself that she went through the premature labour and delivery of her son without her partner. She felt she handled herself and the adversities that were faced well without her main support construct. Feeling competent in herself as a mother enabled her to focus on the positive aspects of her journey. In turn, this assisted her transition home with her baby, and this was evident in the way that she was caring for her healthy baby when I met her for korero (her baby was three months when I met Ashton). This is an example of mana wāhine and another reflection of tino rangatiratanga.

Like when I look back at it, I’m so proud of myself, considering that [partner] wasn’t there and [baby] was early…so in comparison to other babies in there we felt pretty lucky, but it’s still traumatic. Overall, it’s an emotional roller-coaster but you just have to take out the positives of it otherwise you just get too caught up in the small yucky bits. (Ashton)
Justine and Kristen, who both endured the loss of their whakapapa, shared other examples of mana wāhine when they had returned home.

9.2.1 Mana wāhine in loss

The adaptation to everyday life is ongoing for Justine and Kristen as they continue to work through the loss of their baby. The loss of their baby represents the loss of whakapapa and potential. Understandably, both Justine and Kristen were still trying to comprehend the loss of their baby when I met with them to share kōrero. When I met them, six months had passed since Justine had her miscarriage, and four months had passed since the death of Kristen’s death. I admire the strength and heart of these two wāhine for sharing their story with me and holding a position of doing so for the sake of helping other whānau. This is an ongoing demonstration of their mana wāhine.

As stipulated in the previous chapters (sections 7.1.3 and 8.3.1), Justine received poor communication from the health practitioners that left her with no answers of why she suffered a traumatic miscarriage. The added stress of waiting for her body to return back to normal following the miscarriage also added another layer of difficulty during her transition home.

So I went back to see my midwife and went back for scans on my stomach and because I was so far along in my pregnancy, my uterus was really big so I had to deal with all of that for about six months after I lost baby. I was just waiting for my body to go back to normal after pregnancy. Yeah they said that it’d take a long time because of how far along I was. (Justine)

When I met Justine, the emotional pain of losing her baby was still evident,

But I just take each day as they come I guess. He’s buried with [husband’s] nan so no doubt he’s safe. It’s hard losing a child, I wouldn’t wish it upon my worst enemy…He was a decent size so it was real sad actually, and a medium lady rang me and told me that I have to stop being so strong, and cos I’m busy I just need to give myself time to let it go. Cos I do, like I’m so busy, I go to University for 5 days and then I get home and have to be a mum, so I don’t have time to stop. I need to start focusing on myself and stop being so strong for everyone, and cos that’s what I’m doing because if they [husband and children] see me upset or down it effects them. (Justine)

This is a representation of mana wāhine because Justine’s concerns are for her family’s needs rather than her own. Although this is an example of mana wāhine, prioritising their needs over her own has perhaps hindered her opportunity to grieve and heal from her baby’s loss. Her grief is palpable in this statement she shares. The message from the medium conveys this also as Justine was told to stop being so strong. Perhaps this missed opportunity to grieve was also connected with Justine’s body talking longer than expected to return back to ‘normal’. That being said, Justine
shared that she felt she was on the way to recovery, and I hope that she finds her inner peace and wellbeing.

So now I’m nearly there at the end, yeah it’s been a hell of a ride but that’s pretty much what happened with my poor baby. (Justine)

Kristen is another example of mana wāhine as she illustrates strength through remaining positive, as difficult as it may be, in order to uphold the mana of her son,

I remember when I first found out about his diagnosis or the expected diagnosis. I sort of asked my boy in an internal conversation, I asked him what should I do? And the thing I got back was that you should acknowledge me. So this is the reason that I am doing this because my boy existed, he will always exist, he was part of our whakapapa and that will never change. (Kristen)

This statement shows how Kristen felt connected to her baby through whakapapa while he was in her whare tangata. The answer Kristen received from this internal conversation with her baby guided her towards sharing her journey with me and to always uphold the mana of her son. Having this bond through whakapapa with her son has helped her with her journey transitioning home. This also shows how the link between whakapapa and her mana wāhine, as she draws on whakapapa to work through her loss. Although her son’s physical presence is no longer there, his wairua and whakapapa lives on through her.

It must also be noted that Kristen never received a confirmed diagnosis either for her son’s passing or a confirmed reason for his passing, hence the use of ‘expected diagnosis’ throughout her journey. When I met Kristen she was awaiting an appointment with the geneticist, which she was hoping would provide the confirmed reason. When I followed up with her after the appointment she was disappointed in the outcome as there was still no confirmed diagnosis provided to her. The lack of confirmed diagnosis could act as a barrier for Kristen and her whānau grieving for their baby, as well as hinder them fully transitioning home without their baby. Kristen admits that there will always be an emptiness within her and how she often isolates herself from others because she feels she cannot share her true emotions with them. Kristen feeling guilty as she faces the daily struggle of seeing babies grow reflects this. In her words,
Now it’s really odd because my workmate was pregnant the same time as me. And I had [baby] on the 10th of February and she had her baby on the 12th of February. And that’s probably going to be the hardest thing for me, to watch her growth and that’s really terrible to say…you know, she’ll remind me every day. And it sucks, everyone asks how I’m doing and I’ll answer yep I’m good but it sucks…I’m trying to get to the point where I can see the joy but I’m not there yet. I don’t know how long that takes you. And it’s funny because people say to me, ‘oh you’ll get there’, and I was thinking I don’t know where there is or if I want to be there. On reflection, I look at my kids and see how their impression of their brother are and we always try to talk to them about him…We’ve talked about the fact that as parents we still have a lot of love to give to another child, and there will always be that emptiness because of this experience.

A positive aspect of both Kristen and Justine’s cases is that the health care system was responsive to whenua ki te whenua tikanga. This was illustrated in providing back the whenua of their baby’s so they could practice the tikanga. This is important for many whānau because it grounds their baby forever in the arms of our primeval mother, Papatūānuku. This permanently connects their baby to their ūkaipō to be nurtured by Papatūānuku and their tūrangawaewae. Having this connection better enables the wāhine transitioning home because they know their baby will always be connected with their whakapapa and whenua. Kristen made the comment however that while she appreciated having the whenua of her son returned to her, she was disappointed that it had been “ruined” with formaldehyde without her consent. This was upsetting for Kristen because she was conscious of what that effect the preserving agent would have on Papatūānuku when she buried the whenua. Kristen elaborates on this,

And because I had all my siblings over at the time, everyone had come home, and they all brought their whenua back and around his tree we ended up planting a whole lot where everyone buried their whenua too. So it is really important to us and our family that that happened because it connects him back to his tūrangawaewae and it connects all of us back to it. They [practitioners] didn’t know that or how important this was to my family and me. It should have been an option [to not have formaldehyde put in the placenta] or at least a conversation.

This highlights that positive steps are being made in the maternal-infant healthcare system that facilitates aspects of tikanga Māori. Perhaps this example suggests that there should be continued support and encouragement for health practitioners engaging and understanding tikanga Māori. That may allow them to engage respectfully with their patients so cultural aspirations may be met.

9.3 Inappropriate Discharge

Some wāhine expressed having a more complex journey transitioning home. Issues that contributed to the complex journey were centralised around receiving poor
communication and guidance regarding their baby’s health status and care needs when they were discharged from hospital. Subsequently, the wāhine returned home feeling confused about why adversities occurred. This contributed to the wāhine feeling emotionally unsafe, which impacted on their confidence in being able to care for their ill babies and adapt as intuitive mothers in their home environment. On these grounds, I argue that the wāhine were inappropriately discharged. This section examines two levels of poor practitioner care that contributed to the inappropriate discharges of the wāhine: Poor communication from health practitioners and an absence of support from health practitioners.

9.3.1 Poor communication from health practitioners

Poor communication from health practitioners has been a common thread across all phases of the whānau journey. In this phase, poor communication from the health practitioners may be observed as underlining how wāhine (and their whānau) were not valued and respected within the maternal-infant health care system. Consequently, they were discharged with no answers about what happened to them and their baby, and with little postnatal support offered. A quote from Tahlia depicts this lack of respect and poor communication on discharge,

…I feel sorry for mums who go in [to hospitals] like me, mums that leave with no answers and that don’t get rang up or checked up on. (Tahlia)
When I met the wāhine (and their whānau), some were still uncertain of what happened to them and their baby, to which they felt frustrated and irritated about.

Numerous wāhine expressed these feelings,

I don’t know what it was that caused what went wrong, no one pinned it down in the end. (Becky);
I didn’t know why he came early. At the time I didn’t ask the midwives but when I was in SCBU I was asking the doctors and nurses but they couldn’t tell me why…and that was really frustrating actually. (Ashton);
No one understands what happened… (Teina);
I still don’t know what happened to my baby…I’m still waiting for answers. (Tahlia); and
We don’t know why I lost my baby, no one took any tests and no one gave me any answers why. (Justine)

To expand on Tahlia’s journey, as stated above, she was discharged without any answers regarding her baby’s condition. Consequently, Tahlia did not fully understand why he became so sick in the first place and why her baby repeatedly stops breathing,

…they actually haven’t given me a reason why he stops breathing cos sometimes he changes colour and that’s when I have to take him to the hospital. (Tahlia)
Tahlia was concerned over her baby’s health and felt helpless when he would stop breathing. She has become very observant of her baby and was concerned about the lack of oxygen he may be getting from his seizures. This concern indicates that she has been informed of the health consequences of seizures, which understandably added to her stress and anxiety. When I met with Tahlia (three months after her baby’s SCBU admission), she was still seeking answers and support from the SCBU practitioners of care.

Well actually it should be around about now but no one has rang me up. I’m not joking. Sometimes I just sit here and cry because I think what if something happens and it could have been preventable but no one got in touch with me or took the effort to ring me up to see how my baby was. Because we are supposed to have a follow up appointment when he is 3 months old and he turned 3 months yesterday. And that’s at [secondary] hospital with a proper paediatrician, because I asked the nurse what the other signs of babies having a seizure are and she said that sometimes they just stare and he does that and I put my hands in front of his eyes and he just has no reaction. At one point when I said to her that he was doing that for about ten minutes, that’s a long time for a baby to go without oxygen and sometimes he still shakes and rolls his eyes to the back of his head. I worry how that is all going to affect his brain as well. (Tahlia)

The poor communication on discharge and a lack of follow up care has enhanced the emotional trauma for Tahlia in her journey. She shared with me how she would cry and continually worry about her son, yet she felt her concerns were repeatedly ignored and dismissed by the health care practitioners. This example illustrates how being inappropriately discharged can increase the trauma for wāhine, as well as depicting a health care system that undervalues those interacting within it. It also shows how it can hinder a wahine transitioning home as an intuitive mother following their discharge from the clinical context. Tahlia has shown great efforts to make her voice and concerns heard by continually ringing the SCBU and hospital practitioners to follow up test results and seek answers. She shares this struggle,

They [practitioners] were getting annoyed at me, I’m not even joking, and one of the nurses said to me ‘you rang yesterday, can you just not wait for them to ring you back?’ And I said ‘you guys let me go home after not telling me what’s wrong with my son and now you’re asking me to stop ringing. (Tahlia)

From this it seems that her testimonies were considered by the health practitioners to lack credibility. As a result, the health practitioners downplayed Tahlia’s concerns and requested that she stop repeatedly contacting them. This indicates that the health practitioners were not being responsive to Tahlia’s anxiety and were perhaps thinking she was being over-concerned. Even if Tahlia was being over-concerned, she deserved to be treated respectfully and had her concerns listened to. This may have helped Tahlia relax more, instead she felt isolated, frustrated and
unsupported by the health practitioners. To alleviate these feelings, Tahlia was encouraged by whānau to find alternative means of care and empowering herself to understand how she can help her baby herself. This was touched upon above in section 9.2. She continues,

Because of the lack of information they gave me, I actually thought about going to alternative people. My partner’s aunty messaged me and asked if I was open to alternative ways of finding out what’s wrong with him, and I’ve talked to my partner about going because I really do strongly believe from a mother’s instinct that there is something not right with my baby. (Tahlia)

Finding alternative health care was Tahlia’s way of remedying her feelings of isolation and frustration with the maternal-infant health care system and following her instincts that something was not right with her baby. When I met with Tahlia, she was pleased that she had made a small victory as she was now able to visit a paediatric nurse at her local hospital once a week. Gaining this weekly visit confirmed Tahlia’s instincts that her baby required regular follow-up health care. In turn, this was helping Tahlia on her journey through transitioning home with her baby.

In Justine’s case, the lack of answers given and poor transparency in communication made dealing with her loss even more difficult. She shares,

Yeah like I got a thing to put baby in and the whenua so I could bury him, but they didn’t really give me any answers. Like I said, ‘are you gonna tell me why I lost my baby’, and they didn’t give me any answers. At that time I just thought maybe that’s a good thing because I was really angry, sad and all these emotions, but now...you know, I actually thought that procedure wise, they would take some sort of test, even from baby, just to see what happened, but no. (Justine)

The lack of answers that was provided to Justine and her whānau regarding why she had lost her baby was frustrating for them. This frustration hindered their ability to grieve and heal from their loss of whakapapa. I argue this frustration and difficulty was unnecessary and could have been avoided had the health practitioners being more transparent with their communication. Not only was Justine left with no answers regarding the loss of her baby, she was also left unaware of why she ended up becoming so sick and bleeding heavily following the miscarriage. This is summed up in Justine’s statement,

Yep so really, really traumatic. But yeah they didn’t end up operating, I don’t know why, they probably should of, and they didn’t really give me any answers. Nothing. No answers. And that’s why I turned to the alternative because I was grumpy at the hospital. They just drug me with all this stuff then I had to try come off it, because I try to not even take Panadol and try tolerate pain as much as I can.

The following section explores the experiences where there was an absence of support offered by the health practitioners for the wāhine and their whānau upon and/or following discharge from hospital.
9.3.2 Absence of support from health practitioners

It was also found that consistent with the provision of poor communication was the absence of support provided upon and/or following discharge. Tahlia received poor mental, emotional and professional support as no support services were offered to her once her baby was discharged from the SCBU. Becky’s experience also demonstrated the provision of minimal support and guidance. Upon discharge, she was sent home without adequate breastfeeding support, advice and guidance. The health practitioners did not respond to Becky’s testimonies of pain and swelling in her breasts while she was in hospital. As a result, she repeatedly became ill with mastitis. She reflected on this and strongly suggests that better breastfeeding support is needed in the system.

Better breastfeeding support, not education, is needed. Don’t throw more paperwork or videos at people cos that ain’t gonna work, unless you’re a mum with all the time in the world, which I’m pretty sure is the minority of people. I didn’t have the time to read any books and watch videos… (Becky)

Becky’s husband adds his perspective,

The midwife, I’m pretty sure she did try, I mean she gave us a DVD to watch on it but nobody watches that. It’s like when you give an information pack or something, not many people read it. But yeah I think they need to emphasise it more. Obviously if it goes easy for you then it’s not a big deal, but if you go through what [Becky] did, then fuck it’s hard for everyone.

Perhaps if her maternity practitioners viewed Becky’s testimonies with greater credibility, the development of repetitive mastitis may have been avoided. Also, with greater breastfeeding support, Becky and her husband could have had an easier transition from hospital to home, and an easier adaptation to intuitive motherhood. The discharge experiences of Becky and Tahlia strongly outline the need for greater focus on addressing the epistemic disparity within the health care system so that all who are interacting within it are given an equal voice and all knowledge is seen as valid and credible. Secondly, the need for greater support, not education, should be offered. This means that practitioners need to take more time to help ensure women are latching their baby well and with confidence by being there to guide them, rather than relying on impersonal, generic measures such as information sheets or DVDs. As Becky and her husband indicate, the status quo of information sheets and videos is not suitable for all wāhine and whānau.

Justine was another wahine who received inadequate mental and emotional support upon discharge. While she was in hospital, and upon her discharge one day later, she felt largely unsupported by the health practitioners, even though she had just experienced the loss of her whakapapa. It was fortunate Justine had support from her
husband and whānau because she was able to rely on them for the emotional support that was not provided by the health practitioners.

So I stayed in hospital until (pause), so this was early in the morning it started happening at 1 in the morning, so I ended up going home at night time because [husband] was getting grumpy at the doctors (laughs), old Doctor over there (laughing and pointing to husband) reckons he can look after me. And I left with me not being able to walk and stuff still, he was having to carry me and yeah I was in a pretty bad way. And I was still really sick and losing a lot of blood and I kind of went home because he was like ‘let’s go home, they’re not even doing anything for you’, all they were doing were putting fluids in me and pain relief but that was really it. I was on morphine and stuff like that and I went home with codeine and whatever strong stuff I took, and I just went home and hopped in bed. (Justine)

This experience shared by Justine shows the disconnection between the health practitioners and her as a mother who just suffered the loss of her baby. Justine perceived the health practitioners being unresponsive to her needs by relying on prescribing medical drugs as ‘quick-fix’ solutions to her emotional needs, rather than offering medical treatment in conjunction with support and manaakitanga.

9.4 Access to Postnatal Support

Continuing with the running theme throughout the phases of the whānau journey, access to support in onāianei was found to be an influential factor in strengthening whānau wellbeing following the harm or loss of their baby. It was also found to be helpful for the wāhine transitioning back home from the clinical context they were in. Some wāhine were satisfied with the level of formal postnatal support they had received following their discharge from hospital. However, there remained examples of poor accessibility and availability of formal postnatal support for other wāhine. Whānau support was, however, positively reported on. This theme also explores the experiences of postnatal support that provided by health practitioners, and how particular areas of the health care system was found to be fragmented, which in turn, impacted on the provision of postnatal support services.

9.4.1 Whānau support

As the earlier chapters have shown, whānau support is a significant aspect of the whānau journey. This was seen to be true also in the onāianei phase of the journey. It is often whānau who wāhine rely on to seek support and advice as they transition home and adapt to being intuitive mothers. Whānau support was seen in the way of helping to care for the current baby, caring for other children, providing financial assistance, and helping with transport and/or accommodation. Ngahuia found the
support of her partner and parents particularly beneficial as they provided the help she needed with her other children,

Yeah na but its good having family, especially my partner, he’s mean support, and then my parents are good with the kids too. If something comes up they’ll come here and my kids can go to them...It’s the whānau support that basically gets you through whatever you’re going through. (Ngahuia)

Ngahuia is appreciative of her partner being a source of constant support, as well as her parents for being there to take care of all her children, even with minimal notice. It is suggested that without this support she would not be able to get through her trying times and transition home. Below, in section 9.4.2, it is shared how Ngahuia also had access to good postnatal support from her NICU practitioners that provided check-ups on her preterm daughter. This support provided Ngahuia reassurance that her baby was receiving the postnatal care she required, which helped her be more relaxed with her baby’s breathing apneas (in contrast to Tahlia’s stress and anxiety over her baby’s breathing apneas that was explored in section 9.3.1). This combined whānau and practitioner support helped Ngahuia transition home with her preterm daughter from NICU.

Ashton also expressed her appreciation for her partner's support through their transition home and adaptation to parenthood. As stated,

Yeah and we had nothing ready for him, [partner] and I bought him a bassinet and the stuff we got from the baby shower, but was telling him for weeks to get the spare rooms painted, and that’s all he could say when he got to the hospital, he was like ‘but I haven’t painted the room yet’ (laughs). But he went into full on organisation mode; he went and got all the pram, car seat and everything. So I think it kind of showed us that you don’t really need a lot to be prepared for baby, as long as you have the essentials everything else will just kind of come along as you go. (Ashton)

It seems that Ashton's partner had a sense of guilt felt for not having his baby’s room at home prepared, and showed his willingness to make up for that by going into “full on organisation mode”. However, through their experience, Ashton and her partner learned that things do not always go to plan, and that all they needed was what they considered their essentials to cope.

As shared in the previous chapter, Ashton developed kaupapa whānau support through building networks of support with similar whānau in the SCBU her baby was in. She shared how she was also able to call upon this kaupapa whānau for support once she returned home. Ashton continues,

I also have this friend who had a preterm baby so we were able to connect and share our experiences and help each other out because she was struggling with the feeding thing, so that was nice being able to be there for each other.
This example also shows how Ashton took on the role of tuakana to this friend by offering advice she had learned from her experiences in SCBU. She was uplifted from offering this support and from knowing that there was someone there to replicate the support to her also.

These are positive examples and highlight how often whānau are relied on by wāhine. It was found that if the wāhine had access to both whānau support and formal postnatal services, they reported positively in their onāianei journeys. Waiata shared her positive onāianei journey whereby this had occurred (see section 9.1). Ngahuia also had access to good whānau and postnatal support in her transition home.

However, for others it was found that formal postnatal support services were inadequate and/or inaccessible for wāhine/whānau during their transition home. Social support services need to work in conjunction with whānau so that the financial burden of having everything in place is not completely borne by whānau. This partnership of support may ease the process of wāhine transitioning into motherhood at home.

### 9.4.2 Practitioner postnatal support

Leading up to her son becoming critically ill, Kristen shared in the earlier chapter that she did not feel adequately supported by social support practitioners. This changed once her son passed away, as a social worker was found to offer great support for Kristen and her whānau (section 8.4.1). While this individual practitioner was responsive to Kristen’s needs, she felt that the formal support organisations had failed to offer support according to her cultural values and tikanga, depicted in her perceiving the support organisations failing to acknowledge her son as a whole being.

Contrary to this, once she was home, she reported having improved access to postnatal support,

> So I’m still on maternity leave because I rang up IRD and they said well it’s just as much for you as it is for your baby and there’s nothing to suggest that you need to pop off back to work…that was really good yeah. So I don’t have to go back to work until June but I don’t know if I can. I love kids to bits but I don’t know how emotionally ready I am to go back. It’s just seeing the growth, and I feel really guilty about it but it will remind me. (Kristen)

She was particularly pleased that she could be granted maternity leave still as she remained emotionally unprepared to return back to work as an Early Childhood Educator when I had met her for kōrero. This grief had made her feel guilty that she was isolating herself from work and seeing other parents’ children grow. This maternity leave is a positive example of a legislated right in Aotearoa New Zealand that creates a supportive environment for wāhine.
Becky shared her appreciation for the extra postnatal support she received from her LMC following her multiple admissions back to hospital for mastitis,

They said because I got it so easily and the scar tissue was so bad, so my midwife had told me it could be bad. And you know how they usually come for six weeks; I think she kept coming for like four weeks after that. So that was cool that I got to see her until [baby] was about 11 or 12 weeks, and that just kept giving me comfort in knowing that. (Becky)

This extra postnatal support that was offered by Becky’s midwife provided the reassurance she needed to recover from her repetitive cases of mastitis. Becky claims that this midwife went over and beyond her duties and was appreciative of that.

As touched on above (section 9.4.1), another positive example of practitioner postnatal support comes from Ngahuia’s journey. Her journey involved her preterm baby being transferred to two NICU’s and one SCBU before being discharged home. All three units were away from her home and whānau support. As the earlier chapters have shown, Ngahuia was well supported by a social worker that provided her accommodation and financial support while her baby was in NICU. What is pertinent to this chapter though, is that the good postnatal support she received was continued not only by the social worker but also the NICU practitioners of care once Ngahuia’s baby was discharged. As stated,

She was a young social worker but real awesome. She’ll always ring and check up on us too. (Ngahuia)

When she was asked if she has to take baby for regular check-ups, she responded,

Yep but they [NICU care practitioners] come to me which is even better...It’s all changed now ay because we used to have to travel to either them in [secondary hospital one hour away] or [tertiary hospital 3 hours away]. And that was a mission just for a checkup appointment. But now [tertiary hospital practitioners] comes to you...they’re awesome. It’s good that they’re working around families and knowing that if we can’t make it to them, they’ll come down to us. (Ngahuia)

Meeting Ngahuia in her home to check-up on her baby rather than requesting her to present at the NICU was a positive way these practitioners enabled a responsive health care service for Ngahuia. When she compared her previous examples of going to check-up appointments to this baby and how much of a “mission” that was for her, she was pleased with the changes with her current baby.

Similarly, Tahlia receives some follow up support from a paediatric nurse in her home hospital (following the extensive battle by Tahlia), rather than travelling two hours by road to the nearest SCBU unit. She shares,

And he has a paediatrician that he has to go see every week at [home] hospital, oh she’s a paediatric nurse I think actually, and she follows up with us once a week. (Tahlia)
These two examples of Ngahuia and Tahlia are a demonstration of positive responsive maternal-infant health care. The expectation placed on whānau to travel to receive health care services can lead to high transport and travel costs for whānau, which can pose as major barriers to them accessing this care. Tahlia lives two hours away (by road) and Ngahuia four hours away (by road) from their respective SCBU and NICU practitioners. The health practitioners responded appropriately by going to them rather than vice versa. This is a reassuring change in the maternal-infant health care system, and Ngahuia acknowledging that the practitioners were now working for rural families reinforces this.

9.4.3 Fragmented postnatal services

This seamless and responsive service that is described in the example above was not always evident for other wāhine. Tahlia’s complex journey illustrates how the services can be both seamless (as evidenced in the paediatric nurse visiting her in her local environment), and fragmented. The example of the fragmented service derives from the poor cohesion between postnatal services because when Tahlia and her baby was discharged, she had surpassed the six-week time period of follow-up care that was to be provided by her LMC. She sheds light on this,

Yeah but it’s weird now because I don’t have a midwife anymore, Plunket hasn’t come to see me yet and he’s 3 months old now. So I constantly go to the doctors to make sure he’s OK because no one is checking on him, so I try to at least once a fortnight take him to the doctors, just to get checked. (Tahlia)

This statement points to a fragmented service. Firstly, it demonstrates the lack of cohesion between primary health care, maternity care, and the postnatal care practitioners. There seems to be no communication between these groups of practitioners as Plunket has not been to visit Tahlia and her baby yet, even though they are required to. It is possible that her LMC or GP had not been in communication either because neither had provided follow-up care for Tahlia and her baby. Secondly, it shows that perhaps Plunket remains to have poor outreach to Māori whānau who live in rural areas such as the case with Tahlia. Thirdly, it is a clear example of how the fragmented system design places whānau vulnerable and left without adequate care and support once they are discharged home from hospital.

Bringing about a seamless overall system with greater cohesion can increase the likelihood of better accessible, culturally responsive care. This extends also to services such as Work and Income support. As it stands now, the whānau experiences were that it remains too fragmented and difficult to access,
See WINZ and all that, WINZ should have a partnership with the healthcare system, like in the hospital. How do they expect someone to go to them the clowns when you got 10 people down there acting like God when they should have people going to them to make them accessible? They go to the people not the people go to them- that's how it should be. (Teina’s father)

The difficulty faced by Teina and her whānau to access support services following their health care adversities indicates how the health care services can be seen to not value the people interacting with and within it. Even though whānau are in distress, service(s) fails to remedy their stress at times, and instead the fragmentation of services enhances the distress experienced. This distress may reduce the whānau during their transition home and being able to find positivity and wellbeing.

9.5 Chapter Summary

This chapter has explored the experiences encompassed in the final phase of the whānau journey, onāianei. In this phase, all wāhine had returned home to their whānau and ūkaipō/whenua. While some whānau had reached a stage in their journey where they felt they had transitioned home and adapted to life with their baby, for others their journey was still ongoing with health care services, and/or were grieving their lost whakapapa.

Pertaining to the disrupted whakawhānau journeys that brought rise to wāhine and their whānau entering the maternal-infant health care system under unanticipated circumstances was the requirement to remain in hospital to receive the essential health care for their baby (and themselves). The mothers whose baby was admitted to a NICU or SCBU unit were faced with the task of adapting to dictated motherhood. A common aspect of dictated motherhood was the loss of intuitive motherhood sovereignty to the NICU and SCBU clinical routines and practitioners of care. For these wāhine, returning home to their ūkaipō/whenua and whānau with their baby was their utmost goal, as this meant they could return to their sources of support and wellbeing and retain their motherhood/parenthood sovereignty. It is not surprising then that when their baby had recovered enough to be discharged from hospital, it was, for most, a time of excitement and relief. Clearly, they were relieved their baby had overcome their health adversities, however, for some the link between excitement and relief was short-lived because they were confronted with challenges following their hospital discharge. These challenges were potentially avoidable issues and were centralised around the health practitioners delivering poor communication and support upon discharge. Inappropriate discharges are concerning and something that may be prevented with better communication and support from the health practitioners. The wāhine who were inappropriately discharged
were subjected to unnecessary and avoidable stress and emotional trauma. As the experiences have highlighted, being inappropriately discharged with poor communication and an absence of support can have a harmful impact on the wāhine. An additional impact of receiving no answers, guidance and support is the limitation of transitioning home well and adapting to motherhood. Some wāhine sought solutions to their “emotional roller-coasters” from alternative means. Perhaps this is an indication of their breakdown of trust shown in the health practitioners and/or the maternal-infant health care system.

It was encouraging to find that positive progress had been made whereby postnatal follow-up services were being responsive for whānau needs. That was particularly regarding health practitioners going to the rural communities to provide follow-up care on a regular basis, rather than making the whānau travel to them. The provision of good health care was linked with assisting wāhine and their whānau transition into motherhood/parenthood and enabling whānau to strengthen their wellbeing.

This chapter concludes the whānau journeys as shared by the wāhine and their whānau. Each phase of the journey has brought about important learning points from their lived experiences. The following wāhanga, Te Ao Marama, will discuss these insights further in order to bring about enlightenment. A nuanced framework of health care is proposed that may allow for the maternal-infant health care system being a compatible, culturally responsive partner for whānau. Being a culturally responsive partner for Māori may allow for whānau to journey through the system as Māori following the disruption to their whakawhānau journey that results in the harm or loss of their baby.
Although it is small, it is precious.

This wāhanga moves into the world of enlightenment by contributing to the basket of knowledge about the provision of culturally responsive, quality maternity care for whānau, especially in times of adversity for their babies. It shares how we can influence change by integrating what was learnt from the whānau experiences with mātauranga Māori sources and current legislation (in the form of Te Tiriti o Waitangi/the Treaty of Waitangi). It is in this discussion that māramatanga is sought whereby we awaken to the space that knowledge is shared. The whakataukī I use above has been selected for two reasons. Firstly, it is the same whakataukī that I have tattooed on me in memory of Kiri. Thus, this whakataukī represents me returning to the initial driving force behind this research project. The meaning of the whakataukī that I carry with me is that although Kiri was with us for a small time, it was a precious time. This meaning also echoed with what was shared by the two whānau who lost their babies during their whakawhānau journey. Secondly, I use it to acknowledge that while my contribution to the basket of knowledge may be small, the size becomes irrelevant if what is offered allows for the strengthening of whānau wellbeing.

The following chapter has been named Whakatupu Mātauranga, as the term whakatupu recognises and encapsulates the notions of growth and development (personal communication, Professor Meihana Durie, 2017). Following the mentorship of Whaea Moe Milne and her son Tukaha Milne, it has become apparent to me that mātauranga Māori is more than just an ancient knowledge system (as what it can be interpreted as being). It is a current and ongoing process because it is knowledge that is formed in relation to the time and context we find ourselves in. This is how our tūpuna developed knowledge and practices. Mātauranga Māori is therefore an organic and evolving continuum of knowledge that grows as we explore new knowledge frontiers, and develop our knowing and understanding (personal communication, Professor Meihana Durie, 2017). Through the exploration of new frontiers, this project has aimed to add to the ongoing growth and evolution of mātauranga regarding whakawhānau, and how the maternal-infant health care system can be a culturally responsive partner for Māori to strengthen whānau wellbeing.
The following chapter contributes to the continuum of mātauranga Māori within the academy. Within the chapter, I propose a framework of health care that has been built upon the three principles of Te Tiriti o Waitangi/Treaty of Waitangi and the whānau experiences, and recommends the implementation of three tikanga Māori. The implementation of this framework could contribute to the maternal-infant health care system becoming a more culturally responsive partner for whānau following a disruption to their whakawhānau journey that results in the harm or loss of their baby.
Chapter 10: Whakatupu Mātauranga

This research journey has seen me embark on a consultation journey with key informants that developed a rich foundation of knowledge. From that foundation, Te Pūkenga Mātauranga was developed which informed how I approached and had kōrero with ten wāhine and whānau who had experienced the harm or loss of their baby. Weaving together the analysis of these experiences with the knowledge I gained from the key informants, it was found that the maternal-infant health care system is failing whānau by not delivering culturally responsive care following the harm or loss of their baby. In the context explored, whānau were unsupported and/or unable to journey through the system as Māori. This meant that their mana was diminished, their wairua was not nurtured, and their rangatiratanga was stripped from them.

Additionally, in Te Kore, I provided an overview of the two worldviews that are present within Aotearoa New Zealand; namely, Māori and Pākehā. Beliefs and perspectives were shared regarding the practices of whakawhānau, and how the deficit-based, Pākehā worldview has become dominant worldview following colonial processes. The ramifications of this is that Māori are often blamed for their poor health outcomes because they are looked upon through a Pākehā lens that places Māori as being the ‘problem’ in need of solutions. This lens has been found to be inapt at firstly, explaining why there are maternal and infant health disparities present within Aotearoa New Zealand and secondly, how those disparities may be addressed. I find this lens to be unilateral, meaning it tends to only look at its defined ‘problem’ (i.e. Māori) and does not look back at itself being problematic and/or as an instigator of disparities. I suggest that in order to address the burden of health disparities Māori carry, we need to develop a bilateral lens that may offer culturally responsive solutions for the maternal-infant health care system. To make this bridging possible, we need to bring Māori ways of knowing and doing to the forefront to disrupt the current imbalance whereby Pākehā ways of knowing and doing is favoured.

This chapter is a reflection of the meanings made from the experiences shared by the wāhine and their whānau. In this chapter, a conceptual framework of health care, named Te Hā o Whānau, is proposed to offer a solution to the issues outlined in the findings. The chapter will move towards explaining Te Hā o Whānau framework in greater detail, including how it was developed and how it may be applied. To begin, the underlining sources of the framework- tikanga Māori and three principles of Te Tiriti o Waitangi /the Treaty of Waitangi - are explained. The earlier chapters within Te Kore and Te Pō wāhanga have outlined tikanga whakawhānau. The following section
defines more generally what tikanga Māori comprises of and how it is developed before relating it to how it could be applied in the maternal-infant health care system as policy.

10.1 Tikanga of Te Hā o Whānau

Ani Mikaere (2012) defines tikanga as being “the practical expression of a philosophy that is founded in the experiences of our tūpuna, and has been adapted over time in the light of successive generations’ experiences and circumstances” (p. 25). This definition outlines that tikanga is not a concrete set of rules. Rather, it is an ongoing process that is guided by and developed from kaupapa to inform how to live in a way that would allow for whānau, hapū and iwi to thrive (Mikaere, 2012). I found it fitting that tikanga should inform the maternal-infant health care system because tikanga is built upon two aspects of Papatūānuku that are pertinent to whānau (in its dual meaning of family and birth) health and wellbeing: kaupapa and whakapapa. I found this connection relevant for this project because it outlines the clear link tikanga has with whakawhānau, maternities and māmā.

In the context of this project, tikanga Māori was overwhelmed, relegated, and suppressed by the more dominant biomedical policies and regulations within the health care system (Dow, 1999). This is a demonstration of how colonisation has marginalised, suppressed and redefined tikanga Māori as ‘lore’. Therefore, tikanga was/is commonly portrayed as meaning a body of supernatural knowledge and customs that is irrelevant and inferior to the coloniser’s ontology (Jackson, 2012). The policies that restrict visiting hours and numbers is one example of how tikanga is controlled and relegated within maternal-infant health care system. Even with the advancements made in recognising tikanga within Māori maternities, the practice of such tikanga continues to be on the periphery in relation to the mainstream health care practices in Aotearoa New Zealand (Simmonds, 2014). For example, although the DHBs in Aotearoa New Zealand offer tikanga best practice guidelines to follow, the whānau experiences demonstrated that these guidelines were not being upheld consistently by the practitioners and/or the system. This suggests that the tikanga best practice guidelines are viewed as less important than the biomedical policies and guidelines that shape the maternal-infant health care system. As a result, Māori often view the clinical environment as being an alienating experience (Elder, 2017). This must be disrupted and culturally responsive care that respects and engages in tikanga Māori must become the baseline of the maternal-infant health care in Aotearoa New Zealand.
10.2 Te Tiriti/Treaty Principles of Te Hā o Whānau

Te Tiriti o Waitangi/The Treaty of Waitangi has been outlined in Chapter 2 (section 2.1.1). The Treaty of Waitangi, and the principles that underline it, is acknowledged as being a bicultural template for Māori and Pākehā to work together for better outcomes (Whitinui, 2011). Yet, it was stipulated, there is ambiguity present between the two texts (Tiriti and Treaty). Therefore, to allow for interpretations and use of te Tiriti/the Treaty, principles were developed. This is also a contentious issue because there is controversy linked to the development of these principles. However, it was thought that focusing on the potential positive outcomes of these principles would whakamana the wāhine and their experiences.

The three principles of Te Tiriti o Waitangi/the Treaty of Waitangi that were influential in shaping Te Hā o Whānau were Protection, Partnership and Participation. These three principles were chosen because they resonated with what the wāhine and whānau spoke about what they wanted throughout their health care journey: to be protected, to have a voice, and to have the opportunity to care for their baby. Below outlines the principles in relation to the articles of the treaty that they pertain to. The differences between the two texts (Treaty versus Tiriti) are stated also:

- Article 1: Partnership. This relates to complete sovereignty versus kāwanatanga. Although the two are not equivalent of each other as stipulated above in the different meanings of the two texts.
- Article 2: Protection. This relates to complete possession versus rangatiratanga. This principle outlines also that the Crown, as a Treaty partner, much actively protect Māori interests, rights, and resources.
- Article 3: Participation. This relates to the provision of the same rights and privileges. Therefore, Māori have the right to participate as Māori and to ‘walk in two worlds’. This is an important point, as it relates to Māori having the right to journey through the health care system as Māori (personal communication, Dr. Anne-Marie Jackson, 2018).

These principles are useful because they allow for one’s own interpretation of the meanings and use of te Tiriti (and the Treaty). This was true for me as I was able to interpret the principles to develop tikanga that may inform current maternal-infant health care system. Tikanga that is built upon these principles can provide understandings of illness, and how health care services can be delivered that may enable wellness. Understanding what the underlining kaupapa of Te Hā o Whānau
framework is, the chapter now moves towards further explaining the development of the framework.

10.3 Te Hā o Whānau Framework

Figure 7 below is a visual illustration of the process that was taken to develop the conceptual tikanga-based framework, Te Hā o Whānau, for the maternal-infant health care system. Outlined in Figure 7 is the development phase depicted on the left side. This shows how the tikanga emerged from the kaupapa that included the three principles of te Tiriti/the Treaty and the whānau experiences. In the middle of Figure 7 illustrates Te Hā o Whānau framework, with the three tikanga working in unison with each other. The projected outcomes of applying this framework to the maternal-infant health care system are also shown on the right side of the figure. Although there are already well-esteemed and established health care models available in Aotearoa New Zealand, Te Hā o Whānau is a nuanced framework to this particular context because it focuses specifically on offering culturally responsive guidelines for the maternal-infant health care system when whānau enter the system in an untimely and unanticipated manner.

Te Hā o Whānau framework particularly builds upon the strengths and positive glimpses that were mentioned by whānau during their health care journey. These positive glimpses signpost the important, effective ways the maternal-infant health care system was a supportive partner for whānau and informed the positive guidelines of culturally responsive care within Te Hā o Whānau. In this way, the framework has been developed directly from whānau input to influence the maternal-infant health care system environment to be more culturally responsive. This outlines the ‘whānau-up’ approach to developing Te Hā o Whānau framework, which contrasts to the favoured ‘top-down’ approaches to health care as shown in Figure 2 (see section 2.1.1). Too often health care policies and guidelines are imposed from a mono-cultural, ‘top-down’ position whereby they are derived from mainstream decision-makers and are suggested to ‘work’ for whānau even though they have had minimal or no whānau input (Marsden, 2003). The ‘whānau-up’ approach to developing this framework of health care demonstrated that whānau voice can be incorporated into policy, and while holding a bicultural, partnership stance. The name of the framework itself is an expression of this ‘whānau-up’ approach. Te hā means the breath, to which I take to

24 Current models of Māori health include the Meihana model (see Pitama, Robertson, Cram, Gilles, Huria, and Dallas-Katoa, 2007); Mason Durie’s Te Whare Tapa Whā (see Durie, 1998); and Rose Pere’s Te Wheke.
mean voice, and o whānau is what I acknowledge as meaning both family and maternity. Thus, the meaning I attribute to the name, Te Hā o Whānau, is whānau voices leading maternity care in Aotearoa New Zealand.

Within the framework, the implementation of three tikanga Māori-manakaitanga, whakawhanaunga, and rangatiratanga as policies and guidelines within the maternal-infant health care system is suggested. Being built upon the three principles of Te Tiriti o Waitangi/the Treaty of Waitangi means that tikanga that promotes protection, partnership, and participation for whānau journeying through the maternal-infant health care system are recommended.

Implementing Te Hā o Whānau within this particular context has the potential to contribute towards informing the maternal-infant health care system to become a culturally responsive partner for Māori. As a result, whānau wellbeing may be restored and strengthened as they are entitled their rights to their sovereignty of their health and healing practices, their mana, and their wairua as they journey through the maternal-infant health care system.
Figure 7. The development and outcomes of Te Hā o Whānau Framework.
As the chapter proceeds, greater detail of each component of the framework is provided. The kaupapa (including the relative te Tiriti/the Treaty principle and whānau experiences) underpinning each tikanga is outlined, as well as explaining how the tikanga can be implemented within the maternal-infant health care system.

While each component of Te Hā o Whānau framework are outlined and explained separately, I assume that this would be difficult to do in practice because all three are intertwined and interrelated with each other, as with all Māori concepts and values. Optimal, culturally responsive care will occur in the intersecting space between all three tikanga, as this will demonstrate all three acting in relation to one another.

10.4 Principle of Protection – Manaakitanga

The Ministry of Health defines the principle of protection as involving the government working to ensure Māori have at least the same level of health as non-Māori, and ensuring the safety of Māori cultural concepts, values and practices (Ministry of Health, 2017). This principle is derived from Article 2 of the Treaty and was developed on the premise that Māori would have the right to their tino rangatiratanga, or self-determination to protect their interests, resources, and people.

This principle can also be closely aligned to the Kaupapa Māori theory principle of taonga tuku iho because the two have the aim of protecting taonga of Māori, including health and mātauranga Māori. If we revisit the theory provided in Te Kore, taonga tuku iho means, “Māori language, knowledge, culture and values are normal, valid and legitimate” (Bishop, 2008, p. 442). Therefore, taonga tuku iho acts to destabilise the imbalance of knowledge, culture and practices, whereby non-Māori ontology and epistemology are viewed as superior than that of Māori. It has been acknowledged that Māori are not a homogenous group, however as Fiona Cram and Suzanne Pitama (2008) outline, the collective voice for Māori is now feasible because our diversity has not been protected and is now unnoticed and disregarded. In turn, we have become seen as the ‘Other’ within our own country. I want to contribute towards destabilising this imbalance and assert the position that to be Māori is normal and ‘ordinary’. It is ironic that Māori have become the ‘other’ in Aotearoa, as the meaning of the word Māori is ordinary and normal (Moewaka Barnes, 2000). This imbalance is a representation of how Māori and their taonga, as in their health, have not been protected within Aotearoa New Zealand.

The principle of protection acknowledges that Māori should be allowed environments that allow their taonga, which in this case is their health, to thrive.
The tikanga that I align with this principle is manaakitanga. Manaakitanga “is mana in action...it is founded on the recognition that when we uphold and elevate the mana of others, our own mana is upheld and elevated” (Hall et al., 2012, p. 12). Marsden (2003) reiterates this by explaining that “to serve others is to serve the corporate self. Thus loyalty, generosity, caring, sharing, fulfilling one’s obligation to the groups, was to serve one’s extended self” (p. 42). Mana can be derived from numerous sources as it originates from the various atua within the natural world, and individuals may gain mana through particular actions and achievements (Ka’ai & Reilly, 2004). While mana is a gift from atua, certain actions by us can either enhance or diminish mana. These reasons validate the need for the maternal-infant health care system to review how hospitals and health care practitioners can offer manaakitanga, as uplifting mana can make a difference to whānau experiences and their wellbeing; particularly so following adverse event(s).

10.4.1 Are whānau being protected during their whakawhānau journey?

The experiences shared by the ten wāhine and their whānau showed that whānau health was not being protected during their whakawhānau journey. Each whānau faced challenges throughout their whakawhānau journey that hindered their own, and/or their baby’s wellbeing. In particular, these whānau experienced an absence of manaakitanga, whereby some health care practitioners showed a lack of concern for their cultural practices and beliefs. As a result of this absence, the mana and wairua of the wāhine and their whānau were diminished during their journey because the health care practitioners and system issues did not enable an environment that allowed the whānau to openly thrive as Māori.

Whānau wellbeing and Māori maternities are often negatively impacted in the current maternity care because “practices and cultural concepts that are imperative to Māori health and wellbeing have...often been undermined by dominant Pākehā views on health (Cram, Smith & Johnstone, 2003, p. 1). As a result of the health care services and system being based upon biomedical principles, values and practices, Māori are marginalised and the health care that is provided is often culturally unresponsive (Port, Arnold, Kerr, Gravish & Winship, 2008). Māori are made to adopt Pākehā tikanga and ways of caring because biomedical medicine is positioned and validated as the best clinical treatments (Sneddon, 2005). The dictated motherhood routines that were described in the journeys of Ngahuia, Nadia, Ashton, Waiata and Tahlia are an example of how whānau were required to relinquish their sovereignty and adapt to the biomedical health care practices. These practices posed difficulties for these mothers,
especially the first time mothers because the maternities contradictions was compounded with childbirth being a novel experience.

Māori mothers often miss opportunities to learn or practice traditional Māori maternity practices because the well-promoted benefits of biomedical practices are sold to them (Glover & Cunningham, 2011). This was seen to be true for these dictated mothers because they had to adapt to a style of motherhood that has been constructed from a non-Māori worldview. When the wāhine opposed to these practices and insisted on learning their view of motherhood, they were poorly supported to do so. Nadia’s journey illustrates this struggle. Nadia was a first time mother who was made to relinquish her motherhood sovereignty to the NICU clinical routines, yet she was determined to breastfeed her baby. Breastfeeding is an important practice amongst indigenous communities because it is viewed as being a gift from the mother to the child (Cidro et al., 2015). Therefore, Nadia was disappointed when the NICU health care practitioners ignored her requests for a lactation consultant to assist her providing this gift. Instead, the health care practitioners continually promoted their clinical, nasogastric or bottle-feeding methods of feeding her baby as being the best practice. Although there may have been a real medical need for Nadia’s baby to be fed this way, better communication from the health care practitioners could have been offered to explain the need for nasogastric feeding and how Nadia may transition from dictated to breast feeding in due time. This would have demonstrated their willingness to uplift Nadia’s mana and meet her breastfeeding aspirations. Becky, another first time mother, faced similar struggles during her journey, as she was unable to receive the support she required to learn how to breastfeed.

Manaakitanga is absent in Nadia and Becky’s journeys because the health care practitioners did not nurture their cultural beliefs of being an ūkaipō for their baby’s. As a result, the wairua of the wāhine and their whānau were not nurtured. Manaakitanga was also absent in the sense that there was a lack of kindness and generosity illustrated by the various health care practitioners. While the health care practitioners may believe their practice is the best for the wāhine and her whānau, it comes from a position that does not take into account cultural and spiritual wellbeing. A position that tends to ignore the denigrating impact of denying cultural values and practices has on Māori (Sneddon, 2005). Consequently, tikanga, kawa, and mauri are not respected as valid bodies of knowledge and practices. For these reasons, in contemporary society, maternities have become a conflicted space for wāhine and whānau because they are often caught in the contradictions of a dominant non-Māori health tikanga and their own understandings and aspirations of health and wellbeing (Gabel, 2013). A midwife reflected on her experiences during my consultation journey, where she shared “some
will do it [maternity tikanga Māori] automatically whereas with some they almost feel like they need permission because they come into a foreign environment” (personal communication, Joyce Croft, 2015). This statement highlights how some Māori practitioners can feel unprotected to practice their cultural beliefs and practices within the current maternal-infant health care system too.

Another way manaakitanga was absent in the maternal-infant health care system was the lack of space provided (physical as well as philosophical) for Māori to be Māori during their whakawhānau journey. By that I mean there is limited space where whānau feel they are able to practice tikanga and kawa that uphold their wairua and mauri. I noticed this particularly from the silences within the whānau experiences: the lack of karakia and oriori. No whānau mentioned the use of karakia at birth. Karakia is particularly important because it is used to both “facilitate the movement of the child and to assist the mother in her spiritual and physical journey” (Gabel, 2013, p. 80). Karakia is also important because it offers the space and opportunity for wāhine (and their whānau) to pause and reflect on their surroundings and circumstances. It is shared that “in this pause we...think about our place amongst what is happening in the world around us, about Papatūānuku, Ranginui, Hinemoana, Tangaroa, Tāne-Mahuta, te taiao, te ira tangata, ngā wā katoa, ngā hau e whā, te hunga wairua me tō hunga ora” (Swann, Swann, Davis, Te Wiata, Smith, Crocket & Kotze, 2017, p. 22). The absence of karakia could indicate the possible gap in the mothers’ knowledge of tikanga and Māori worldview. Conversely, it can also indicate the cultural ignorance on the part of the health practitioners and maternity system creating an environment where the wāhine/whānau felt unsupported to practice karakia. Not offering the space to practice karakia or other related tikanga is a demonstration of how manaakitanga has not been offered and a shortfall of not delivering health care that whānau are promised (Bay of Plenty DHB, no date).

The second silence was that no whānau mentioned the use of oriori for their babies. The cosmological narratives of Māori all stress the importance of Māori women and their role in sustaining whakapapa (Simmonds, 2011; Mikaere, 2012). Kristen Gabel’s work (2013) explains that Māori creation stories “engage with the processes of pregnancy and birth…which reflects the prominent and valued role of the maternal body” (Gabel, 2013, p. 59). How this information was transferred throughout generations was often through oriori. The lack of oriori used today is an example of not only the loss of mātauranga Māori surrounding maternities, but also the loss of oral transmission of whakapapa and knowledge passed on to babies. The “orally acquired and orally transmitted knowledge, so frequently devalued and belittled by non-
Māori...is highly valued by Māori” (Bishop & Glynn, 1999, p. 172). The active
denigration of oriori by non-Māori has contributed towards the loss of oriori today.

Whānau also were not protected throughout their journey because of the
gatekeepers of whānau support. Whānau are a potent source of support and healing
(Elder, 2017), yet this is often regulated against within the maternal-infant health care
system. Policies and guidelines limit whānau being physically present in the clinical
context to offer their support and ways of healing. Regulating against whānau support
is another expression of denying manaakitanga. Many of the wāhine spoke about how
they felt alienated within the hospital environment because they were isolated from
their whānau and whenua. Those who were separated from their baby during their
NICU or SCBU admission particularly expressed this. The experiences highlighted that
the baby is not being recognised and valued as a whānau member, and instead they
are separated out as an individual patient. Consequently, biomedical policies and
practices are continually constructed around separating the ‘patient’/baby from their
whānau to provide optimal care. These arguments reflect how wāhine and whānau
often felt unprotected during their journey through the maternal-infant health care
system.

10.4.2 Allowing for Protection: Tikanga Manaakitanga

It was found that the maternal-infant health care system is currently an
incompatible partner for Māori as the environment does not allow Māori to thrive and
be well. Māori ways of interacting and operating in these contexts are too often
institutionalised by the dominant partner’s culture (Holmes, Vine & Marra, 2009).
Examples from the whānau journeys that illustrate how Māori understandings and
practices are disregarded by institutionalised practices within the maternal-infant
health care system included the lack of space or permission offered for karakia or
karanga during birthing; being transferred away from their whenua without the support
of their whānau; and removing tūpāpaku from whānau for postmortem procedures to
be carried out in a cold, lonely mortuary. Change is required whereby the maternal-
infant health care may become a culturally responsive partner for whānau to protect
their health and wellbeing following their untimely and unanticipated entrance to the
system. As part of being a culturally responsive partner, the delivery of good health
needs to be appropriate for all that interact with the system. The biomedical model that
the current health care system is based upon favours individualism and does not easily
translate for other cultures, including Māori (Port et al., 2008). The shared whānau
experiences illustrate how the system can create foreign and clinical environments that are uninviting for wāhine and their whānau due to the absence of manaakitanga.

The positive aspects of the whānau experiences were when they felt the health care practitioners respected their cultural values and practices. Examples shared of this occurring was when the whānau were offered back their whenua to practice whakawhānau whenua ki te whenua tikanga; were offered food and empathy; and provided support through either whānau or social service practitioners. Therefore, they affiliated the provision of good health care with mana enriching practices. All of these positive moments in the whānau journeys are reflections of manaakitanga and demonstrated how their health and wellbeing was being protected. As such, the tikanga of manaakitanga has been developed from the kaupapa of protecting whānau wellbeing, Māori concepts and practices.

A practical change that health care practitioners can enact to address the absence of manaakitanga is to care from a position of humility. This is because humility is connected to the Māori value of manaakitanga; a value which is derived from Māori worldviews (Hall et al, 2012; Royal, 2007). Hall and colleagues (2012) explains, “manaakitanga acknowledges firstly that all things originate from atua and are therefore intrinsically connected to spiritual power” (p. 11). Therefore, if practitioners of care acknowledge the mana of the whānau who are journeying through the maternal-infant health care system and treat with humility, the mana of the whānau may be uplifted. Practicing with humility may also contribute towards dispelling the popular belief that health care practitioners are at an elevated status than the patients (Kidd & Carel, 2017). It is this perceived epistemic disparity that lies at the heart of power dynamics that led to communication issues. Health care professionals need to make the effort to be humble and learn from patients and their lived realities to enable the provision of quality, culturally responsive care. This is particularly important for te whare tangata, as like any household, te whare tangata needs to be in a good condition to keep those within safe and nurtured. Therefore, a pregnant woman who feels valued and receives quality care will be provided the opportunity to create a safe and nurturing house for the baby.

Implementing manaakitanga as tikanga may also shape an environment that is more facilitating of whānau support within the maternal-infant health care system. Whānau support was seen to have a positive effect in hapūtanga, whānautanga, piripoho and onāianei. All ten wāhine in this project had strong whānau support, including supportive partners and husbands. Whānau are an integral part of Māori culture and identity (Smith & Reid, 2000; Cram & Pitama, 2008), and a key indicator of wellbeing (Elder, 2017). This is reflected in the importance Māori place on
relationships based around collectivism; a direct contrast to the individualism frequently found in Pākehā cultures (Te Rito, 2007). Rangihau (1992) explains that kinship is significant in Māori society as it is the “warmth of being together as a family group” (p. 183); it is this kinship that binds the collective cultural practices of Māori. In turn, this collectivist nature shapes the practices, attitudes and behaviours of Māori (Te Rito, 2007). Having this strong support network was highly beneficial for mothers, especially those who had just given birth to their first child. This is because whānau support was noted as being not only beneficial for providing social support, but also psychological support through a convergence with significant others. Thus, social support received from significant relationships can influence wāhine perceptions of and adaption to being a mother (Smith, 1999).

Allowing whānau support in sickness is also important because it allows the whānau to tend to the wairua needs of their ill. Restricting whānau support leaves the patient, regardless of their outcome, culturally compromised (Sneddon, 2005). This was seen to be true particularly with Kristen’s journey. There were periods where her wairua was protected as she and her whānau were enabled to practice karakia and waiata for her ill son. However, there were also periods where her wairua was not protected, especially when her son’s body was taken away from her two times: once when he was born before she could touch him, and second when he had passed and they were separated from his body while he was taken for a postmortem procedure. Both were significant, jarring moments in her journey that continues to unsettle Kristen today. She was denied the opportunity to protect not only her wairua but her son’s, especially on his passing. Māori people believe that the wairua of the tūpāpaku does not leave immediately, which is why it is common for the tūpāpaku to be attended by whānau members at all times (personal communication, Rangitunoa Mollie Stevenson, 2016). They are there to love and support that wairua before it departs to meet Hinenuitepō. Therefore, when Kristen was separated from her son momentarily because of postmortem procedures, her wellbeing was hindered, as was her son’s wairua.

A number of wāhine expressed how stressful they found it being separated from their partners and whānau during their hospital stay. From these journeys, a link may be made between negative birth experiences and being separated from their baby and/or whānau. The hospitals often did not allow whānau to stay overnight with the mother if there were complications for either mother and/or baby at birth. Being separated from whānau highlights a clash in the maternal-infant health care system with Māori culture, where Māori mothers tend to prefer the support of their whānau, especially following a disruption to their whakawhānau journey that results in the harm
or loss of their baby. Thompson (2009) explains that “separation can make it difficult for mother and baby, delaying bonding which can be exacerbated when the parent has to commute because they live a distance from the hospital” (p. 18). This stress may be potentially avoided if the hospital allowed the partner or whānau to be admitted with the patient following adverse events that result in prolonged hospital stays. This would allow the women to receive the support they need and desire, and alleviate financial stress for whānau. Efforts should be made within the maternity health care system to facilitate environments that enable whānau support throughout the entire pregnancy, from conception, birth and beyond if maternal and/or perinatal events lead to postnatal hospital stays. The current “minimised presence of whānau and the Euro-centric perspective on maternity care…have facilitated a practice environment that focuses on the individual woman to the detriment of existing and prospective whānau” (Kenney, 2011, p. 126).

This project also found that whānau support was particularly important when there was financial stress present. Māori are disproportionately represented in the lower socio-economic groups (Abel et al., 2001) and are often subjected to the effects of poverty. A consequence of this is the reliance on whānau to alleviate the financial burden when there is a disruption to their whakawhānau journey that requires them to enter the maternal-infant health care system for treatment. A study from Thompson (2009) illustrated the importance of whānau support particularly for those who live away from the hospital and require travelling to and from the hospital. Similarly, this project found that improvements in providing transport support for whānau is needed because it was especially stressful on those who lived a distance from the hospital and had to find their own means of travelling to and from the hospital. Nine out of the ten whānau had to be transferred by road to a higher-level hospital. Being transferred away comes with affiliated transport and accommodation costs that are mostly borne by whānau. It is stipulated in DHBs tikanga best practice guidelines that practitioners must make support available for whānau (Bay of Plenty DHB, no date). However, it was found that this is not occurring consistently. Practitioners should be engaging in manaakitanga and making support that is available explicit and accessible so the stress of providing assistance does not fall entirely on whānau.

Offering manaakitanga in these circumstances could be achieved by the system allowing more space and resources for social support practitioners so that they may have greater opportunities to engage in conversations with whānau about what services are there to support them, and how those services may be accessible. This may mean that there needs funding to be injected into this area of the maternal-infant health care system so that more social support practitioners are developed and
engaged in the workforce. Social workers play a key role in supporting the whānau because they have the responsibility of being a navigator in the system and delivering the support services required. The journey of Ngahuia particularly illustrates how good support provided by social workers can alleviate financial pressures from whānau. Access to support services is linked with decreasing maternal and infant health disparities; however these support services need to be available in all regions, both rural and urban, and delivered in culturally appropriate ways (University of Waikato, 2015). The findings of this project showed that in many cases, access to support systems (for example transport, housing, and financial aid) remains poor for whānau.

The wāhine in this project found the hospital setting to be a foreign environment that they associate illness and sadness with. Therefore, it was not a favourable landscape of care for them. To change this environment, manaakitanga needs to be implemented as a guiding tikanga within the maternal-infant health care system. This can be done by health care practitioners assuming a position of humility when treating whānau, removing the regulations around whānau support, and by enhancing the access to support services. Implementing manaakitanga as tikanga has the potential to merge Māori cultural values and practices into the healthcare system, and allow for greater protection of Māori health and wellbeing.

Table 7.
Tikanga Manaakitanga – Practice Points and Examples

<table>
<thead>
<tr>
<th>Practice Points</th>
<th>Practice Examples:</th>
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<tbody>
<tr>
<td>Demonstrate value for ‘patients’.</td>
<td>• Provide health care from a position of humility and demonstrate empathy</td>
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<tr>
<td>Provide a space that respects, encourages, and facilitates Māori cultural values and practices.</td>
<td>• Observe appropriate tikanga in situations (for example, karakia during birth, karakia during death). • Respect and facilitate cultural values and practices such as karakia, waiata, tūpāpaku kawa, and oriori. • Understand the kaupapa behind Māori values and practices so these can be encouraged and pursued. • Provide access to kaumātua if requested.</td>
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<tr>
<td>Facilitate the provision of support-both from whānau and social support services.</td>
<td>• Review the two-visitor rule during adverse events to open restrictions from whānau visiting. • Enable the transfer of whānau as support also. • Provide more community outreach services to deliver health care services to the people, rather than waiting for people to come to the services.</td>
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10.5 Principle of Partnership – Whakawhangaunga

In the context of health care, the principle of partnership implies all health care stakeholders working together to develop strategies for Māori health gain and effective service delivery (Ministry of Health, 2017). This partnership principle is derived from Article 1 of the Treaty, which promises kāwanatanga. Thus, it is based on the assumption that “Māori ceded sovereignty or kāwanatanga to the Crown in Article 1 of the Treaty, in exchange for the Crown’s protection of Māori tino rangatiratanga” (Waitangi Tribunal, 2004, p. 130). This promise suggests that upon signing the Tiriti/Treaty, Māori and Pākehā will be bound together in a bicultural partnership. However, this promise has not being upheld and the colonial processes incurred a power imbalance that hindered the intended partnership arrangement. The power imbalance elevated Pākehā to hegemonic status across all domains in society (Orange, 2004). Māori Marsden (2003) argued that the government has continually upheld a monocultural approach to legislation and policies since the development of the 1852 Constitution Act. Being out of balance clashes with the Māori ontology, because as Māori cosmogony has informed us, the Māori world always sought to operate within a state of balance and harmony (Mikaere, 1994). As such, male and female elements would have complementary roles, and power was dispersed across the collective group to ensure the sustenance and wellbeing of all (Marsden, 2003; Mikaere, 2017). When Māori entered this contract with Pākehā, their world of harmonious balance was disrupted.

The legacy of this power imbalance remains prevalent today. The biomedical policies, practices, education, and health care system are all manifestations of how Pākehā remain the dominant ‘partner’ within Aotearoa New Zealand (Whitinui, 2011; Mikaere, 2003). The imbalance has also carried through to health care practice, as it is currently based upon biomedical principles, values and practices (Port et al., 2008). As a result, the wellbeing of Māori is often compromised because they are marginalised from offering their views, knowledge, and practices regarding health and wellbeing. While there has been some commitment shown by the health care system to engage with Māori in more recent times, it may be perceived as being tokenistic at times. For example, Māori are invited to be on advisory committees, yet they are contained to this role as advisors with little decision-making power or influence over policy development (Betancourt et al., 2003). Additionally, Māori health care provider services have been significant in contributing to improving Māori health outcomes, but they operate outside of mainstream health care services which makes them vulnerable to government changes and funding availability (Ellison-Loschmann & Pearce, 2006).
These examples demonstrate how equal Māori partnership is being denied, and justifies the need for systemic change that endorses the development of a culturally compatible partnership between whānau Māori and the biomedical-based health care system model.

10.5.1 Are whānau thought of as partners during their whakawhānau journey?

It was found that the current maternal-infant health care system is an incompatible partner for whānau who experience the harm or loss of their baby. This incompatibility was demonstrated by the amount of whānau who could not journey through the system as Māori. Instead, they journeyed through feeling alienated and isolated within the space. As it stands now, there is a power imbalance within the maternal-infant health care system, with Māori being of the lesser importance. It was found that whānau were provided minimal opportunities to be meaningful partners during their whakawhānau journey. Two influences that hindered the development of partnerships were racism and miscommunication.

10.5.1.1 Poor partnership: Racism

In the Aotearoa New Zealand context, racism towards Māori “involves a history of colonisation, dispossession, marginalisation and unequal power relationships in society and societal structures…and internalised levels of racism in New Zealand are commonly perpetuated by social norms, the media, and institutions” (Bécares & Atatoa-Carr, 2016, p. 8). This outlines that racism often exists as a strong undercurrent in health care and is a key driver of the power imbalances that refutes the development of meaningful partnerships between Māori and Pākehā. The whānau journeys supports this literature as many experienced and/or witnessed the power imbalances throughout their journeys.

Racism was experienced by the whānau via the wider, institutional racism that dictate where whānau live and where institutions are placed. To explain, secondary and tertiary hospitals are often placed in large, urban centers where Māori are marginalised from living within. Nine out of the ten wāhine who were involved in this project required a transfer away from their rural home areas to secondary and/or tertiary level care hospitals. These transfers involved numerous hours travelled by road, which added to their discomfort (if they were transferred while in labour), and stress (as being transferred signaled to them that there had been a disruption to their whakawhānau journey). With so many whānau residing in rural areas, why are the
secondary and tertiary centers commonly placed in cities, and often on land that has been taken or gifted from iwi Māori, that are often difficult to access for whānau? Adding to that, Māori patients are more likely to be transferred numerous time for care, whereas Pākehā get transferred straight to the appropriate level care (Masters-Awatere, Boulton, Rata, Tangitu-Joseph, Brown & Cormack, 2017). Three whānau journeys support this claim- Ngahuia, Teina, and Kristen. With Ngahuia, her baby was transferred to two NICUs and one SCBU during her health care journey, and Ngahuia was provided with no explanation of why her baby was moved between the two NICU units. Teina had to be transferred to a second secondary level hospital to deliver her twin babies, even though an elective caesarean section had been planned for her first secondary level hospital. Kristen was required to receive antenatal monitoring two times in her home base hospital, one time in the secondary level hospital, and one further in the tertiary level hospital before she received any communication regarding the health care practitioners concerns over her son's health status. While there were no Pākehā participants to compare against in this project, it may be argued that it is common for Māori to experience the institutional and covert racism that exists within Aotearoa New Zealand. I argue that this level of racism further feeds the power imbalance present in the current maternal-infant health care system. While moving hospitals may seem as a radical way of ensuring less racism, a more reasonable suggestion would be to improve health care practitioners' communication with whānau. This would allow whānau to understand why they require transferring away from their home for higher-level care.

Within this project, interpersonal racism was commonly reported on by some wāhine and whānau during their journey through the health care system. The literature supports these experiences, stating that Māori are more likely to be treated unfairly because of their ethnicity (Cormack, Robson, Purdie, Ratima, & Brown, 2005; Westren, 2015). Examples of interpersonal racism shared by the wāhine included disrespectful communication, tense āhua, and withholding of support and information. These examples depict racism in the health care system today, and many whānau continue to be subjected to unfair treatment because of it. Racism has negative effects on maternal and infant wellbeing because “pregnant women who experience racism are more susceptible to antenatal stress, potentially explaining some disparities in birth outcomes” (Barnes et al., 2013, p. 28). It was considered important to expose the racism that the participants experienced, as racism is too often made invisible through the lack of recognition that it exists. While I am not suggesting that all health care practitioners are racist, as most are committed to delivering care to the best of their ability. They operate in an inherently, yet covert, racist system (Hardeman, Medina &
Practitioners of care need to be aware of this institutional racism, and demonstrate respect and value to those interacting with and within the health care system through providing informative and transparent communication.

**10.5.1.2 Poor partnership: (Mis)Communication**

The whānau journeys outlined some issues of practitioner care, particularly regarding poor communication and respect. It has been these two aspects of provider care that were regularly reflected upon negatively by the participants. This suggests that practitioners of care illustrated a lack of respect to the whānau they interacted with, which in turn, limited their ability to build trust with the whānau. As a result of poor communication, Māori patients can feel isolated and confused (Thompson, 2009). Poor communication can also lead Māori patients perceiving the health care practitioners as being cold, impersonal and dismissive (Kidd & Carel, 2017). This was echoed in the experiences of the whānau in this project. Poor communication was a significant problem that led to negative quality of experiences reported by wāhine and their whānau. While there were numerous examples of poor communication that were shared by the whānau participants, I particularly want to draw on Kristen’s journey here. There are two levels of inappropriate communication here that showed disrespect to Kristen and her whānau in regards to when she was explained her son’s suspected diagnosis of congenital anomalies. Firstly, she was told in a private room with a number of specialists present who did not introduce themselves when they entered the room. Māori tend to view not introducing yourself as disrespectful because it denies the opportunity of whakawhanaunga. Secondly, she was spoken to in medical jargon that she had to try remember so that she could later Google the meanings of. The manner of how Kristen was delivered this diagnosis left her feeling confused, shocked and isolated. The feeling of isolation and confusion is the result of poor provider health literacy. Health literacy can be described as the health practitioners’ ability to communicate culturally responsive information and services to Māori patients and their whānau (Cram, 2014). Evidently, this did not happen for Kristen during her journey.

Poor communication between the different teams of practitioners within the maternity system, for example: LMCs, hospital midwives, nurses, GPs, obstetricians, and neonatologists was also recognised as being a reflection of a power imbalance between the health care practitioners. This imbalance caused by hierarchical issues and across practitioners of care can lead to communication to whānau being ineffective and erratic. Teina’s journey depicts this type of poor communication. The obstetrician
in charge of her care had confirmed an elective caesarean plan to Teina and her whānau at their nearest secondary level hospital. However, this plan was poorly communicated to the other practitioners at that hospital, which resulted in the SCBU unit lacking the capacity to care for Teina’s babies once they were delivered. As a result, Teina was transferred to a second secondary hospital that was a two-hour drive away from her home and whānau. Poor communication between health practitioners operating within the system can lead to the failure of meeting the needs of whānau who are left without receiving adequate care and respect. As a potential solution to this problem, numerous whānau shared how they would have appreciated having one core staff member taking care of them to ensure consistency in communication and treatment. This solution may alleviate patient frustration because it will promote a continuity of care and it offers a greater opportunity for that core provider of care engaging in whakawhanaunga with the whānau they are caring for. This may assist in developing a partnership between practitioners of care and whānau rather than an imbalance whereby the practitioners are seen to be superior to the whānau receiving the care.

Another factor that hinders the development of a partnership between whānau and the health care system is the environment being alienating and isolating for whānau. It was found from the shared experiences of the wāhine and their whānau that the hospital environment was initially perceived as being foreign and clinical for them. The clinical landscape was regarded as foreign because they were removed from their whānau and whenua and instead placed within a space that lacked familiarity and comfort. It was only when the health care practitioners illustrated whakawhanaunga that wāhine and whānau began to feel more comfortable within their environment. This finding informs that engaging in whakawhanaunga in this health care environment can better whānau journeys through the health care system because whakawhanaunga acknowledges the mauri of the people interacting within it and the space that the system both encompasses and is encompassed within. This will be a positive step towards the maternal-infant health care system becoming a culturally responsive partner for whānau Māori who enter following the harm or loss of their baby.

10.5.2 Allowing for Partnership: Tikanga Whakawhanaunga

The maternal-infant health care system can become a culturally responsive partner by actively engaging in ways that promote the alignment of Māori and Pākehā values, beliefs and practices. Evidence showed that this may be achieved through whakawhanaunga (the act of building relationships) to establish whanaungatanga
(meaningful relationships) with both people and space. Māori are relational beings, and this is a known because of the cosmogony of our world and people deriving from our first parents Ranginui and Papatūānuku. Every living being in between of Ranginui and Papatūānuku has mauri and are tethered together by whakapapa. This makes up the fabric of our universe (Marsden, 2003). Therefore everything has a mauri or a life force to which we all can relate with (personal communication with Tukaha Milne, 2017). How we can nourish and nurture that mauri is through whakawhanaunga. When whakawhanaunga is avoided, we tend to feel unconnected to the place and people within that place. This can create feelings of isolation and unfamiliarity, which are consistent to the feelings described by whānau entering the health care system for the first time in their whānau journeys.

Whakawhanaunga is a relatively well-known tikanga within Aotearoa New Zealand in comparison to other tikanga Māori. However the meaning is commonly misinterpreted to mean building and maintaining relationships with people alone. As stipulated throughout this chapter (and indeed, thesis), everything within te ao Māori has mauri because we are all linked to the cosmogony through whakapapa and wairua (personal communication, Tukaha Milne, 2017). Therefore, with mauri being present within everything, whakawhanaunga extends further than people alone, to include the land, nature, animals, buildings, spaces, and time. In this sense, whakawhanaunga is about being a part of a larger whole and knowing where one sits and fits. It includes the right to belong and participate but carries the responsibility to accord all others the same privilege. For these reasons, whakawhanaunga can support the development of a partnership between whānau and the maternal-infant health care system because it illustrates how Māori are relational people who often seek harmonious, balancing interactions with people and place/space (personal communication, Tukaha Milne, 2017; Durie, M.K, 2012). Furthermore, the core of whakawhanaunga is about interdependence to develop whanaungatanga, and not independence. Within this interdependent relationship are defined roles for all participants. Thereby, engaging in whakawhanaunga does not mean health care practitioners are asked to relinquish their roles as health care leaders to develop a partnership with whānau. They are expected to maintain this role, but add the importance of developing trusting relationships with those they are caring for too.

This section explores how whakawhanaunga, not only with people but also with place and space, can inform a partnership with Māori that may allow for an environment that enriches the mauri of all (animate and inanimate) whom interact with the maternal-infant health care system.
10.5.2.1 Whakawhanaunga with People

A health care service that addresses the needs of Māori requires a “transparent and consultative relationship between the practitioners and users of health care service” (Port et al., 2008, p. 137). This can also be extended as a means of addressing the needs of all indigenous people. Port and colleagues (2008) suggest that at the heart of good clinical service is good communication. The findings of this project highlight that at the heart of good communication, is trust and respect that is developed from building meaningful relationships. Positive relationships and communication is one way of implementing culturally safe practices throughout the health care system and overcoming issues aligned with racism and discrimination. Findings from Thompson’s (2009) study suggested that “Māori mothers, young and old, and their whānau, are more likely to feel in control and empowered when there is positive communication and inclusion in the birthing process, regardless of any medical interventions that may occur” (p. 85). This reinforces the importance of health care practitioners being culturally equipped to provide good rapport and communication so whānau are informed of their health situation in an appropriate and effective manner.

Engaging in whakawhanaunga allows for the development of positive rapport. Positive communication is a by-product of establishing positive rapport, which is important for delivering good health care. Building rapport through whanaungatanga includes “the doctor taking time to listen, communicating in understandable language, taking an interest in whānau health history, and engaging with the patient to deliver a collaborative style of healthcare” (Cram, Smith, & Johnstone, 2003, p. 6). At the crux of these practices is demonstrating respect and value for the whānau who have entered the health care system to develop a relationship with them. During this relationship building, trust may be established between the practitioners of care and whānau, which can lead to the improved provision of communication and care. Aligned with trust is respect. It was found that when the wāhine and their whānau felt respected, they trusted their health care practitioners and this was noticeable by the shift of energy to being comfortable with their practitioners of care and environment. Whānau were inclined to talk more and feel safe within the given space. The labour and delivery of Waiata is an example that depicts this shift of energy. Prior to going into labour, Waiata was tense and whakamā about having strangers internally examine her. A hospital midwife engaged in whakawhanaunga with Waiata and this made Waiata feel safe and more comfortable within the clinical space. This saw her become less tense and nervous as her energy took on a positive shift to trust the midwife. When this shift in energy occurs, that is when whanaungatanga has occurred. It is quantifiable by this
change in energy and comfort, as well as the breakdown of barriers that may exist between health care practitioners and whānau. Thus whanaungatanga allows for culturally responsive communication.

As Waiata’s journey illustrates, some whānau participants did experience these positive practices by their practitioners, with the majority of positive relationships and care being developed with their LMC or hospital midwives. In addition to Waiata, Kristen, Teina (through her second LMC), Aroha, Becky, and Nadia also expressed having a positive relationship with their LMC. The positive expressions may be because midwives are whom wāhine establish the most trust and whanaungatanga with. This is important as, “one of the most important factors for a positive childbirth experience is the quality of the relationship between the midwife and the woman” (Lundgren, Berg, & Lindmark, 2003, p. 322). The emotional support LMCs provide often goes unrecognised and financially unsupported by the maternity health care system. The whānau experiences highlighted the demands placed on the LMCs, in terms of carrying out professional and emotional supporting roles for them. Developing trusting relationships and being the supportive figure for the wāhine and their whānau is what the wāhine constitute good maternity care as being. This demand was taken up by many of the LMCs mentioned in this project. If the wāhine and her whānau had a positive relationship with their LMC and other involved practitioners, they reported feeling well supported throughout their pregnancy. The vice versa could be said for those who did not have such a positive relationship. This suggests that LMCs are establishing positive partnerships with whānau. The issue arises when this partnership is broken by the unanticipated need for the wāhine to enter the hospital environment during or following an adverse event. Upon entering this environment, the wāhine becomes placed under a new system of care, which is delivered by hospital health care practitioners. Thus, this point is a crucial time for hospital health care practitioners taking over the care to engage in whakawhanaunga with wāhine and their whānau. Entering the hospital environment was often a time fraught with stress, anxiety, and isolation for the wāhine and whānau and these feelings were amplified when there was a lack of satisfactory relationships made with the health care practitioners. Whakawhanaunga was found to help alleviate those feelings.

Additionally, a nursing guideline to ensure the provision of cultural safety care in Aotearoa New Zealand stipulates that nurses must recognise, respect and accept that Māori are a diverse population and have worldviews that differ to most health care practitioners. In practice, this means that nurses are advised to develop their knowledge and skills to be responsive to Māori in order to achieve positive health outcomes (Nursing Council New Zealand, 2009). This may mean learning what Māori
cultural values and practices are important for the wellbeing for whānau and facilitating those in practice. For example, facilitating karakia, observing particular kawa when removing blood or body parts, and allowing for whānau support. I argue that this learning and delivering of culturally responsive care may not be achieved without engaging in whakawhanaunga.

10.5.2.2 Whakawhanaunga with Place/Space

Addressing individual practices carried out by health care practitioners is not enough to ensure a healthy partnership between whānau and the maternal-infant health care system. The environment and culture within the system must be addressed also. Mera Penehira (2015) argues that the way we operate in relation to the environment impacts on our wellbeing, and the state of our wellbeing impacts on our ability to interact with the environment. When people are alienated from their environment, poor health outcomes may eventuate because the foreign environment fractures their spiritual wellbeing and knowledge systems (Durie, 2004). This was echoed through numerous whānau journeys, as their wairua was not nurtured throughout their journeys within the NICU and SCBU environments. It was a common thread through the shared journeys that the wāhine and whānau felt the hospital environment was clinical and foreign. Underlining that environment seems to be an entrenched biomedical culture of rules and regulations that informs an individualistic, patient-centered approach to providing maternity care. This environment that health care practitioners operate within often influenced how they would interact with whānau. Kristen’s example with her sonographer is one demonstration of how health practitioners may only interact with one person rather than acknowledging the whānau as a whole entity. Kristen perceived the sonographer being rude because she would not acknowledge the presence of her whānau during her scan. Aligning with this is how the health care practitioners would only consult the parent(s) rather than the entire whānau with regards to health care decisions for the baby. This was evident in Teina’s journey where her health care practitioners would ignore Teina’s cousin’s expressions and views during consultations. These examples show how ideologies within the biomedical model of confidentiality and individualism contrasts against Māori ideologies of consultation and collectivism (Port et al., 2008). This individualistic approach perpetrates the environment that is contained within the current maternal-infant health care system.

In addition to this individualistic approach, the current environment is designed to provide health care that “is based upon principles of efficiency (and in some cases
financial profit) and designed to meet the needs of health specialists rather than patients" (Kidd & Carel, p. 176). This approach and atmosphere of health care limits the presence of wairua in the health care environment (Simmonds, 2014), which may make the environment seem ‘lifeless’ and clinical. This was particularly evident in NICU and SCBU units whereby the lifeless machinery or clinical routines are favoured to deliver efficient medical care over intuitive mothering cares. It also seems that the regulation of visiting hours and number of visitors is another systemic design that suits the needs of health care practitioners rather than whānau. Through these regulations, the health care practitioners are enabled to retain control within the environment. As such, health care practitioners can dictate how many people are allowed in that environment and when they can be in that environment. For these reasons, the NICU and SCBU environments can be controlling of and alienating for whānau. Also consistent with these environments is the time constraints during consultations, and the use of standardised protocols and guidelines (Kidd & Carr, 2017). These features portray little flexibility for customised and responsive care for whānau.

Given that whānau will likely be placed in these foreign environments more frequently because the rate of admission to NICU or SCBU are higher for babies of Māori women than babies of non-Māori women (Ministry of Health, 2017). How do we encourage an environment and culture that enables safe and trusting relationships between whānau and health care practitioners? Perhaps by changing the environment to being more open to Māori cultural understandings and practices. To explain, it is common for new encounters faced alone to cause a range of responses for Māori – stress, fear, anger, resentment, disengagement, resistance- that all attribute to being either unaware or uncomfortable within that surrounding. It is through whakawhanaunga that these feelings begin to dissipate and we become more comfortable and open to engage freely. For partnership to occur between whānau and the health care system following adverse events, whakawhanaunga needs to be actively engaged in with people and place to change the maternal-infant health care system being an environment that is individualistic and task-focused to being whānau wellbeing-focused. Positive health outcomes can arise by non-Māori health care practitioners acknowledging their different cultural position to Māori, as well as the cultural heritage of the whānau they are caring for, and choosing to practice in a way that allows for the merging of both non-Māori and Māori elements (Vance, McGraw, Writhe & Rayner, 2016).
Table 8. Tikanga Whakawhanaunga – Practice Points and Examples

<table>
<thead>
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<th>Practice Points</th>
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| Alleviate power imbalance within the maternal-infant health care system | • Be patient-centered. Which may mean being whānau-centered.  
• Improve interprofessional relations and communications to work as one perinatal team, rather than separate midwifery, obstetrics, and neonatal teams. |
| Engage in meaningful relationship building with whānau | • Take the time to build rapport.  
• Introduce yourself and your role. |
| Change the environment from being task-focused to being whānau-focused | • Greet and/or converse in te reo if that is the preferred language of whānau.  
• Care for visiting whānau and make them feel welcome within the hospital environment.  
• Encourage and facilitate whānau having a role in the recovery of the health and wellbeing of their loved ones.  
• Add cultural needs to the standardised care guidelines. |

10.6 Principle of Participation- Rangatiratanga

The Ministry of Health defines the principle of participation as compelling Māori involvement within all levels of the health care sector, including in decision-making, planning, development and delivery of health and disability services (Ministry of Health, 2017). This principle has been derived from Article 3 of the Treaty. The implication of Article 3 is that health care structures have the obligation to support Māori patients on an equal level to non-Māori. Additionally, Ōrietetanga, as guaranteed by Article 3, promised Māori to have the same rights and responsibilities of non-Māori (Orange, 2004; Wyeth et al., 2010). This means that Māori have the right to participate freely in both worlds of te ao Māori and te ao Pākehā.

I align the principle of participation with tino rangatiratanga. Tino rangatiratanga has been a long-standing feature of Māori culture; it relates to sovereignty, autonomy, self-determination, and control (Mutu, 2010; Orange, 2004). Prior to European contact, iwi and hapū leaders held rangatiratanga over their territories. These leaders held great mana and practiced their leadership with tikanga and kawa that were collectively agreed upon by all in the community. Following European contact, Māori community structures such as whānau, hapū, and iwi were broken down and Māori have had continual struggles for their rights of tino rangatiratanga since then (Maaka & Fleras, 2005; Mutu, 2010; Reid & Robson, 2006). The Māori community structures were
changed due to breaches of the Treaty of Waitangi and colonisation processes that enabled large areas of raupatu, assimilation tactics and the loss of Māori authority over their resources and people (Maaka & Fleras, 2005). The maternal-infant health care system is such a context whereby there has been a loss of and an ongoing struggle to reclaim tino rangatiratanga.

As the section 10.5 above has outlined, the current health care system is comprised of power imbalances that restrict the whānau Māori developing a compatible partnership with it. Correspondingly, those power imbalances also prevent equal participation of Māori in the health care system, particularly in leadership roles. Watson (2007) explained that participation in leadership roles “by ethnic minorities in New Zealand is sometimes hindered by the structures put in place by the dominant culture” (p. 787). Māori are an ethnic minority in Aotearoa New Zealand in comparison to the dominant Pākehā culture and structures. As a result, Māori are more often the recipients of health care rather than the leaders of health care (Whitinui, 2011).

Social determinants of health, in particular poverty, are also a major driving force that hinders Māori participation in all levels of the health care sector (Cram, 2011). Poverty increases the vulnerability of a whānau and simultaneously limits the whānau ability to participate fully in society (Cram, 2012). Due to a lack of resources available to participate, whānau are marginalised from accessing the same levels of education and training, which limits their influence over decision-making and policy development. Consequently, whānau input into the health care system is scarce, which supplements the current health care system remaining steeped in biomedical philosophies and practices. Without whānau participation in the provision of health care, poor Māori health outcomes will remain (Ellison-Loschmann & Pearce, 2006).

Allowing for equal participation is important because enabling a position where “Māori not only self-determine or self-manage their own health affairs but are conscious of decisions made…” is affiliated with achieving greater health outcomes and Māori participation in the health care setting (Whitinui, 2011, p. 146). At the interpersonal level, participation may occur when the health care practitioners consult with the whānau as an entity rather than one person of that whānau; when practitioners genuinely want to develop trust and respect with those they are engaging with; and when practitioners allow whānau to be active participants in the communication by listening and supporting their ideas and concerns. At the systemic level, participation may comprise of removing barriers that restrict Māori engaging in health care leadership roles.
10.6.1 Are whānau being entitled participation during their whakawhānau journey?

The experiences of the ten wāhine and their whānau largely support the literature that claims there is a lack of participation and tino rangatiratanga of Māori upon entering the maternal-infant health care system. Too often whānau were placed in vulnerable situations with little or no rangatiratanga to exert and participate as Māori. This loss of tino rangatiratanga was represented in a number of ways, including, the loss of sovereignty as mothers, as fathers, and as a loss of mātauranga Māori maternities.

The loss of motherhood tino rangatiratanga was represented in two significant ways: loss of sovereignty over their intuition as mothers, and the loss of sovereignty over their epistemological capabilities. In respect to the former (the latter point will be discussed as the chapter proceeds), motherhood sovereignty was relinquished to health care practitioners and the medical and dictated routines and practices that exist within the clinical environments (specifically SCBU and NICU). Nadia, Ngahuia, Waiata, Kristen, and Tahlia experienced this loss of control as all had their intuitive mothering practices discarded and replaced with the favourable clinical practices congruent within NICU or SCBU. The loss of mothering sovereignty was perpetrated through the lack of efforts made by health care practitioners allowing for whānau participation in the development of the co-construction of care for their baby. These experiences can be contrasted against Ashton’s SCBU experience in particular because she was given the opportunity to co-construct her baby’s care plan with the SCBU practitioners. This allowed her to participate with decisions regarding his health care, which allowed her to reclaim tino rangatiratanga as a mother.

Ngā pāpā were also asked to relinquish their sovereignty in two ways: as fathers and protectors of their partners and/or baby. This loss of father sovereignty is enforced through policies and regulations that restrict their time and physical presence with their whānau to allocated visiting hours. There is limited literature that has explored the fathers’ experiences of the maternal-infant health care system. I gather from this lack of evidence that fathers are seen to be less important as the mother and baby, even though they are an integral part of the whānau journey. The experiences shared by ngā pāpā in this project supports the claim that minimal support is made available for fathers. Having inadequate support places fathers susceptible for feeling unprepared for parenthood, and this may be compounded following an adverse perinatal event where his partner and/or baby may require his assistance more. In one study done on first time fathers during their childbirth experiences, it was found that fathers felt they needed “support, explanation, acknowledgement and reassurance,
and to feel that their humanity was recognised” (Howarth, Scott & Swain, 2016, p. 8). The ngā pāpā involved with this project echoed this, saying that it would have been nice to have that support offered to them. Instead, they were often isolated without adequate communication regarding the health of their partner and/or baby.

Tino rangatiratanga regarding mātauranga Māori has also been lost within the maternal-infant health care system. As Naomi Simmonds shared in her Doctoral thesis (2014), the introduction and imposition of the Tohunga Suppression Act 1907 and the Nurses Act 1977 were one of the greatest attacks on wairua because they restricted Māori access to their cultural ways of knowing and doing. Today there is often an absence of the acknowledgement of tikanga and mātauranga within the underlying philosophies of health care practice (Kenney, 2011). We see this by the absence of many traditional Māori birthing practices in contemporary society hospitals. However, there has been a growing resurgence of some traditional practices, for example the whenua tikanga (Pihama, 2011).

In respect to the latter point above that gives attention to the epistemological capabilities of mothers. It was found that the sovereignty of wāhine and whānau was ceded from the health care practitioners assuming the right of knowledge holders. Therefore, some health care practitioners exercised that power to compel the wāhine into treatment plans that they had minimal input into and were inadequately informed of. This loss of rangatiratanga may be acknowledged as what Kidd and Carel (2017) claim as being epistemic injustice. This idea is another reflection of how equal participation was restricted for wāhine and whānau throughout their journey in the maternal-infant health care system. The section then shares how implementing rangatiratanga as tikanga can overturn this participation disparity.

### 10.6.1.1 Epistemic injustice = Participation injustice

Colonisation facilitated European control by claiming superiority over Māori as the indigenous population (Smith, L.T, 2006). As part of claiming superiority, Pākehā believed they had the right to replace the Māori culture with that of their own. The implication of this is that is still relevant today is that Pākehā culture, knowledge and practices are superimposed onto Māori. The forced removal of tino rangatiratanga was perhaps the beginning of the epistemic injustice and disparity that remains active today.

Epistemic injustice means to do wrong to someone (or group) and disregard their right and ability as knowers (Kidd & Carr, 2017). This leads to an epistemic disparity whereby the dominant group imposes their knowledge and reality on to the
less dominant group. The episteme of Māori knowledge and practices have been classed as less credible in respect to the dominant, Pākehā episteme. Essentially, the loss of sovereignty over mātauranga Māori has resulted in Māori becoming the ‘other’ within our nation (Moewaka-Barnes, 2000). Edwards (2009) argues that “the concerted and relentless subjugation of Māori worldviews and epistemologies have had debilitating effects for generations of Māori” (p. 27). This has been witnessed within mātauranga Māori regarding maternities, as many of the practices that were evident prior to colonisation have been relegated to a biomedical approach to maternities (Gabel, 2013; Simmonds, 2014). The biomedical practices and programmes are state-sanctioned and often undermine and dismiss Māori maternities because they promote non-Māori ideologies as being superior, while portraying tikanga that has been established within Māori mother craft as inferior (Gabel, 2013). Reclaiming and highlighting mātauranga Māori can empower Māori maternities and perhaps reduce the conflicted space around maternities for wāhine and whānau.

Epistemic injustice also has a direct link with the quality of communication that is delivered within the health care context. As Kidd & Carr (2017) articulate, "since the social and epistemic practices of giving information to others and interpreting our experiences is integral to our rationality, identity, agency and dignity, it is evident that injustice which harms our testimonial and hermeneutical capacities will be a source of deep harm" (p. 175). This means that if one is treated as being inferior and incapable of providing relevant and worthy information to the forum, they are made to feel insignificant in the interaction(s) with others. It is a common notion that the health care professionals are holders of knowledge and the patients are unworthy of providing credible knowledge and information (Kidd & Carr, 2017). This epistemological credibility imbalance is driven by firstly, beliefs held by health care practitioners that patients are emotionally compromised in their situations; therefore their credibility is lessened because ‘they cannot think straight’ (Kidd & Carr, 2017). Secondly, health care practitioners may believe that those they are caring for lack the same medical training and knowledge they have acquired so they are unable to make meaningful contributions. Holding these beliefs infers communication difficulties because the health care provider enters the conversation holding a perceived position of higher power. Acting on that perception means that they do the talking and restrict those they are caring for any viable participation in the conversation.

While these two beliefs are not applicable to all health care practitioners, they were supported at times by some of the experiences shared by the whānau participants. Wāhine often shared how their voice was disregarded and the health care practitioners did things that went against their wishes. Nadia’s example of her
breastfeeding concerns being unsupported by health care practitioners and instead them continually placing her baby on clinical feeding measures depicts this for instance. This is an example of how Nadia, as a first-time mother, was placed in a vulnerable position in NICU because she was seen to hold less knowledge capability; therefore her testimony as a mother was treated with less epistemic respect and credibility. This was also seen with Tahlia as she was dismissed as a 'moaning' mother as she attempted to voice her concerns and testimonies over the health of her baby. Another whānau participant whose voice was disregarded was Justine, as she was unable to express her desires to be transferred straight to the hospital closest to her whānau support. Disregarding the epistemic capabilities of whānau renders them voiceless and heightens their lack of participation within the maternal-infant health care system.

Also related to the epistemic injustice present within the maternal-infant health care system is when the health care practitioners disregard the concerns expressed by whānau because they view the concerns as being medically insignificant matters. The key concern here included being transferred away from their whānau and whenua. Being removed from whānau and whenua hinders whānau wellbeing because it causes isolation for wāhine from their ūkaipō and their sources of support. Feeling isolated within the clinical environment is a direct reflection of the lack of participation enabled for whānau during their health care journey. Health practitioners often overlook these cultural concerns, as their priority is to transfer the patient to the higher-level care that may be required. While there may be a real medical need for transferring, it was found that health care practitioners often do not acknowledge the mana, wairua, whānau and mauri as being influential factors on the wellbeing of the wāhine and her whānau- most likely because they are unable to be objectively measured.

Another significant example is when health care practitioners demonstrate cultural ignorance of particular tikanga and practices that are valued by whānau. Underlying the ignorance demonstrated here is the belief that these practices and beliefs lack credibility against the Western medical practices (Port et al., 2008; Kidd & Car, 2017). Kristen’s experience with her amniotic fluids being discharged and whenua being injected with formaldehyde without her consent are examples of how tikanga are dismissed for medical routines. Health care practitioners operating in Aotearoa New Zealand should be aware of the significance of whakapapa, which includes blood, body fluids, and body parts, and should take the initiative to offer these back to whānau, rather than waiting for whānau to ask. This will demonstrate an understanding of
tikanga Māori and contribute towards improving the cultural responsiveness of the maternal-infant health care system for whānau.

These common examples reflect the epistemic injustice that is seems present in the maternal-infant health care context whereby it has a direct impact on the participation capabilities of whānau within that context. I argue that these injustices are a manifestation of the loss of tino rangatiratanga faced by whānau within the health care context. Without a credible voice, whānau are rendered without their tino rangatiratanga; thereby leaving them unable to equally participate as Māori throughout their health care journey.

10.6.3 Allowing for Participation: Tikanga Tino Rangatiratanga

It is widely documented that colonisation has facilitated the loss of tino rangatiratanga and that the colonial trauma continues to be borne by Māori today (Marsden, 2003; Cram & Pitama, 2008; Mikaere, 2017; Gabel, 2013; Simmonds, 2014). Accordingly, colonisation continues to have an active role in today’s society because whānau were found to be without their tino rangatiratanga and interact with and within systems that are derivative of non-Māori ideologies and processes. The project found that revitalising the Māori voice, and increasing the Māori health care workforce can lead to greater Māori participation in the maternal-infant health care context. Both were facilitators that may be linked with implementing tino rangatiratanga as tikanga.

10.6.3.1 Revitalisation of (Māori) Voice

Offering a voice to whānau means offering them tino rangatiratanga within this health care space. This is a whānau-led facilitator that has been identified from this project. Unfortunately, the opportunity for whānau to have a voice is not often provided during their journey in the maternal-infant health care system. Understanding that, it was the aim of the project to voice the experiences of whānau who journey through the maternal-infant health care system so we can reflect on their lived realities to propose how the system can enable Māori to journey through the system as Māori following a disruption to their whakawhānau journey.

Having the opportunity to share their experience with me was greatly appreciated by all ten whānau in this project. The commonest reason being that they felt valued from having someone listen to their story. This has been aligned with tino rangatiratanga because having a voice implies that they can have the power to shape
their health care experience(s) and wellbeing; thereby providing the opportunity to co-construct care plans and pathways.

When health care was co-constructed with whānau and practitioners, it was positively reported on by whānau who had their baby admitted to either NICU or SCBU. This positivity is due to the whānau feeling they had reclaimed some control and sovereignty within an environment where they had often felt vulnerable. As it has been mentioned above, whānau felt vulnerable in NICU and SCBU environments because they are made to relinquish their sovereignty and control over to machines, health care practitioners, and practices. Therefore, if rangatiratanga was implemented as tikanga within this environment, whānau may feel less vulnerable, as they will have the ability to have a voice and participate in meaningful discussions with health care practitioners to co-construct care plans for their baby.

How health care practitioners enable this to occur is by listening to concerns voiced by whānau and by finding ways to amend the concerns that meet the needs of both the whānau and the provision of health care. Positive examples of this occurring came from Ashton’s journey, as she was able to participate in the clinical cares of her son after she voiced her concern for not bonding with her baby. This contrasted to Nadia’s journey where her voice fell on deaf ears, as the NICU practitioners would not co-construct a care plan that would enable her the same opportunity to provide the clinical cares for her baby. In this way, the health care practitioners did not nurture Nadia and her whānau, and instead maintained their control by restricting Nadia from participating in her daughter’s health care. It was only through Nadia’s ongoing struggle and insistence to breastfeed that she was able to reclaim some control and rangatiratanga during her journey through NICU.

Another way of ensuring the whānau voice is valued and heard within the maternal-infant health care system is by allowing their equal participation in discussions and consultations. Health care practitioners who engage with the epistemic disparity can use their higher power by using language that is incomprehensible by whānau. The use of medical jargon during communication with whānau is a powerful, but subtle, way of silencing whānau and restricting their participation in the conversation. Often medical jargon is overlooked as a means of excluding whānau from participatory conversation and collective decision-making because those who use the jargon are positioned as the perceived knowledge holders. The example that clearly reflects this is Kristen’s journey when a group of specialists informed her of her son’s expected diagnosis of congenital anomalies. Kristen and her husband were excluded from participating in that conversation, and others pursuing it that regarded his treatment plan, because Kristen could not understand the language
they were using to speak to her. She likened the use of medical jargon to hearing white noise because the language was foreign and she was reeling from the emotional trauma she was experiencing at the time. Kristen was made more vulnerable at this moment as she was within an environment that did not nurture her wellbeing and rights to her tino rangatiratanga. Instead of placing the blame on whānau for not understanding what is being spoken at them, health care practitioners should take responsibility and deliver communication in a way that is comprehended by all. Only then, will participation be facilitated in communication between health care practitioners and whānau.

10.6.3.2 Māori Workforce

One way that will assist Māori reclaiming tino rangatiratanga and their voice in the health care context is by increasing the Māori health care workforce. More Māori health care practitioners are required to bring about balance within the health care system and to assist Māori being active participants across the entire sector, rather than being continually marginalised as one of the dominant ‘consumers’ of the system. As stipulated in Article 3 of Te Tiriti o Waitangi, Māori are guaranteed equal rights and representation as Pākehā. This means that they have the right to journey through the health care system as Māori; just as Pākehā have the right to journey through as Pākehā. As it stands now, there is an obvious lack of Māori representation in clinical or governance roles within the health care system that should be addressed (Betancourt et al., 2003; Whitinui, 2011). The implication of these factors is that Māori may receive culturally inadequate care as the system and people operating within it are disconnected from the Māori patients. Therefore, efforts need to be directed towards encouraging increasing the Māori health care workforce.

When Māori health care practitioners treated whānau, the whānau participants reflected positively on the care they received. This was because they felt understood by the Māori health care practitioners and were able to have many of their cultural needs met within the foreign environment. The figure in Te Whaiao illustrates how the hapūtanga period was a relatively positive experience for the majority of the whānau in contrast to the whānautanga and piripoho phases. This was because the wāhine were at home and under the care of their Māori LMCs. Once their whakawhānau imaginary became disrupted and they were made to enter the hospital environment, they noticed a shortfall of Māori health care practitioners, which may have contributed to the decrease in the quality of experiences.
Implementing tino rangatiratanga as a tikanga will involve the training and development of Māori health care practitioners. When I spoke to a prominent Māori midwife during my consultation journey at the beginning of the project, she expressed to me how difficult it is for Māori to be encouraged to engage in training to become health care practitioners. From her experience, the barriers for Māori training as health care practitioners included: the training institutions being placed in large cities away from whenua of many Māori, the course material being difficult because it was derived and delivered from an biomedical perspective, and Māori being discouraged to pursue this level of training because it seemed “out of their depth” (personal communication, Lisa Kelly, 2015). These reasons are perpetuations of the colonial processes that continue to infiltrate today’s society. Exerting tino rangatiratanga as tikanga in the maternal-infant health care system may mean: reviewing the locations of training institutions, perhaps satellite campuses can be placed in areas where Māori are more likely to live to overcome the need of having to leave home to access education and training; review the course material to provide mātauranga Māori in training and education; and raise awareness through kura kaupapa and schools to portray health care leaders as being viable options for Māori. Perhaps these suggestions will allow for greater participation of whānau and Māori within all levels of the maternal-infant health care system, and in turn assisting it becoming a culturally responsive partner for whānau.
Table 9.
*Tikanga Tino Rangatiratanga* - Practice Points and Practice Examples

<table>
<thead>
<tr>
<th>Practice Points</th>
<th>Practice Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise and alleviate the epistemic injustice within the health care system</td>
<td>• Respect and be open to other bodies of knowledge and ways of doing.</td>
</tr>
<tr>
<td></td>
<td>• Become health literate by engaging in meaningful communication that is comprehensible and allows participation by all.</td>
</tr>
<tr>
<td>Value the whānau voice and participation</td>
<td>• Provide whānau the opportunity to share their knowledge, concerns, and ideas.</td>
</tr>
<tr>
<td></td>
<td>• Encourage choice when possible to facilitate the co-construction of care with whānau.</td>
</tr>
<tr>
<td>Increase the Māori health care workforce</td>
<td>• Review education and training to disrupt barriers that restrict Māori participation.</td>
</tr>
<tr>
<td></td>
<td>• Indigenous the education curriculum so health care practitioners are more aware of hauora Māori.</td>
</tr>
<tr>
<td></td>
<td>• Encourage Māori inclusion in governance roles.</td>
</tr>
<tr>
<td></td>
<td>• Make it policy to have more meaningful consultation with Māori during health care policy development.</td>
</tr>
</tbody>
</table>

### 10.7 Chapter Summary

Whakatupu Mātauranga has attempted to grow knowledge and understandings around delivering quality maternity care for whānau following the harm and loss of their baby. It was found that the current maternal-infant health care system was an incompatible partner for whānau who had a disruption to their whakawhānau journey because it was culturally unresponsive to their needs. As a result of weaving together the different strands of knowledge that was collected throughout this research journey—the consultation journey with key informants and my whānau, mātauranga Māori, and the analysis of the ten whānau participants whakawhānau journeys— a framework to inform culturally responsive maternal-infant health care following disrupted whakawhānau journeys has been developed. The framework draws on the whānau experiences and three treaty principles: Protection, Partnership, and Participation as the kaupapa required to develop tikanga policies. The three tikanga that have been developed are tikanga manaakitanga, tikanga whakawhanaunga, and tikanga tino rangatiratanga. All three are interwoven and operate together that may allow whānau to journey through the health care system as Māori. This means that their mana may be maintained and uplifted, their wairua and mauri can be nurtured, and their right to
exercise rangatiratanga will be upheld. Implementing these tikanga as guidelines will assist the maternal-infant health care system to become a culturally responsive partner for whānau.
Chapter 11: Kōrero Whakamutunga

This research journey has involved developing a breadth of mātauranga from a series of processes. The first process was the initial consultation journey undertaken in 2015. Consultation with key individuals such as my whānau, kuia, kaumātua, Māori health care practitioners, and Māori health researchers built the foundational, rich knowledge of the research journey. This foundation led to the development of Te Pūkengā Mātauranga, the methodological model that informed how this research was carried out. Utilising this model, I was able to explore the lived realities of ten whānau from Te Tai Tokerau and Te Moana-a-Toi following a disruption to each of their whakawhānau journey that resulted in the harm or loss of their baby. The purpose of exploring these lived realities was to amend the shortfall of knowledge currently available in this particular context, even though whānau bear the burden of poor maternal and infant health in Aotearoa New Zealand. The title of the research also portrays the purpose of the research project. The whakataukī used speaks of the mana whānau (in its meaning of family and childbirth) and wāhine have. As the whakataukī states, without women and whenua (which refers to both land and placenta, i.e. birth), people will perish. This validates the need to learn from and protect our wāhine and whenua so that the wellbeing of people can prevail. Often this importance is overlooked and/or ignored. I wanted to bring attention back to whānau and wāhine in an empowering way in an effort to learn from their experiences to address the current health disparities that are evident for Māori wāhine and babies.

This project inquired if the maternal-infant health care system was delivering culturally responsive care for whānau following the harm or loss of their baby; and if not, can the lived realities of whānau and mātauranga Māori inform positive change within the maternal-infant health care system? The research questions intentionally placed whānau in the center of the research kaupapa to follow their journey through the maternal-infant health care system. It was the aim to provide wāhine and their whānau a platform to share their journeys, so I could learn from their experiences.

As mentioned, the research was framed and grounded within a Kaupapa Māori framework, which I named Te Pūkenga Mātauranga. This methodology was developed following the consultation journey with those who held expertise within this field and my whānau. Accordingly, this methodology informed how the project was carried out throughout the entire three-year journey. That being immersed within a Māori worldview, under the guidance and protection of those who were considered pūkenga. The practical implications of the methodology were that it allowed me to keep the whānau central to and safe within the project the entire time. As I reflect on where I
started to where I ended this PhD journey, I find that while I have acquired new knowledge and skills, the values that I adhere to within this methodology have remained constant. Such values include whānau: keeping whānau, my own and the participants, central to the project and kaupapa; wāhi haumaru: ensuring safe spaces are created for discussions to be freely shared; whakaaro: positioning myself within te ao Māori to ensure the Māori worldview is acknowledged, respected, and promoted within the project; Kaitiaki and Hononga: being empathetic and respecting the connections made at all times. I believe this research methodology allowed me to carry out this research project in a manner that was culturally responsive; a way that only an indigenous framework could have provided. I encourage other indigenous researchers to develop their own research methodologies that are suitable for their given kaupapa, as opposed to utilising generic (and often colonising) research methodologies (Pittaway, Bartolomei & Hugman, 2010). Based on my experience, the wealth of knowledge that can be found from indigenous, kaupapa-specific, methodologies far outweighs what a generic methodology can provide. The health field has been slow to embrace indigenous research because it is perceived to be non-evidence based; this is in despite of obvious failures of non-indigenous approaches for indigenous populations (Vance, McGraw, Writher & Rayner, 2016). This project was a means to address these issues.

The purpose of this final chapter is to summarise the key findings from the whānau experiences and outline the new beginnings that this project may lead to. As the previous chapter has outlined, there is a need to indigenise, if not decolonise, the maternal-infant health care system to make it a compatible, culturally responsive partner for whānau. This is especially true for whānau who are entering the maternal-infant health care system in an unanticipated and untimely manner following a disruption to their whakawhānau journey. It is their fundamental right to have access to culturally responsive health care. This right has been guaranteed to Māori under Te Tiriti o Waitangi/ The Treaty of Waitangi. As with whakapapa, there is no end, rather it is a continuous series of beginnings. I align this project, and indeed Māori health research, with this philosophy. Therefore, I do not see this chapter as an end to the project, but merely a summary of what has been done to introduce pathways for further research and new beginnings.

11.1 ‘Push’ for Change

After weaving together the strands of knowledge contained within the research journey (the consultation journey, Te Pūkenga Mātauranga, and the analysis of the
whānau lived realities) it was found that the maternal-infant health care system is not delivering culturally responsive care for whānau when they enter following the harm or loss of their baby. The stark disparities Māori babies are burdened with (higher rates of mortality and morbidity) call for the need to develop innovative ways to address these disparities. To offer a solution, a nuanced framework of maternal-infant care is proposed.

Te Hā o Whānau framework aims to make the maternal-infant health care system more accessible and culturally responsive for Māori following disrupted whakawhānau journeys. Through imposing policies that govern the health care system with tikanga Māori, it is envisaged that better outcomes will eventuate for all, not just Māori. Policymakers must have faith in tikanga and the values that underpin it. Tikanga Māori are relevant and always will be. By entrusting in tikanga we will halt the momentum of the colonial philosophy that portrays tikanga as being supernatural, time-expensive and irrelevant. To address the stark health disparities present, we must forge innovative models and strategies, rather than reproducing (less successful) paths that have the less resistance. As Paul Whitinui claimed in 2011, “closing the gap between Māori and non-Māori will not be achieved if as a nation we continue to create health models, frameworks, programmes, initiatives and interventions that are mere reflections of mainstream health processes” (p. 142). As such, Te Hā o Whānau is a framework of health care that is suggested for the maternal-infant health care system to implement as a means of delivering quality, culturally responsive care for whānau who experience a disruption to their whakawhānau journey. This framework been developed from bridging together mātauranga Māori with some of the principles that underpin the bicultural aspirations of Aotearoa New Zealand.

Tikanga was chosen to inform the health care guidelines within Te Hā o Whānau to reduce disparities between Māori and non-Māori wāhine and babies. This was because, as Sneddon articulates, “there is no treatment more patient-centered than ensuring the practice of sound tikanga” (Sneddon, 2005, p. 76). It takes courage to understand and overcome negative activities- for example race relations, health disparities, and imbalance. Equally, it takes courage to implement positive change (Marsden, 2003). Therefore, to resolve poor health and restore balance (health equality) within Aotearoa New Zealand, policymakers must have the courage to make innovative change and resist settling for the status quo, or worse, reverberating back to paths that have already attempted and failed to bring about change. The work of Elizabeth Craig and colleagues (2004) reported that unless ethnicity is taken into account during future policy and planning initiatives, maternal and infant health disparities would persist into future generations. I argue that health policy makers have
not taken on board this suggestion as we continue to have marked maternal and infant health disparities in Aotearoa New Zealand. The lack of positive change justifies the need for culturally responsive change in the maternal-infant health care system.

11.2 Research Strengths and Limitations

I acknowledge that this project consisted of a sample of a particular population as defined by the research criteria (Māori, living either in Tai Tokerau or Te Moana-a-Toi, and who experienced the harm or loss of their baby). The strength of doing so has been the collection of rich detailed lived realities of particular whānau and the meanings behind those realities. These kōrero provide in-depth knowledge of what is experienced within the maternal and infant health care system in Aotearoa New Zealand. With that, the opportunity has been presented to bring about changes to the system that may address current maternal and infant health care disparities.

Another strength of the research project is Te Pūkenga Mātauranga. This methodological model informs how to carry out culturally responsive research with sensitive kaupapa. I welcome other researchers who are examining sensitive research topics through an indigenous lens to use and build upon Te Pūkenga Mātauranga further. It may also offer greater protection for all those involved and will support the purpose of the given research kaupapa. Developing localised, indigenous research methodologies also helps preserve and promote indigenous research practices.

11.3 Personal reflections

When I reflect on this research journey, I cannot help but align many aspects of it to what I imagine childbirth to be. In the beginning, I had a mix of emotions as I embarked on something new and important. I was excited as well as anxious. Reigning in the nerves, I began preparing for what was going to be a life-enhancing journey. There were moments of difficulty and discomfort as I journeyed into the realm of the unknown. The greatest difficulty I had to grasp was the thesis being a Western exercise. I often struggled with the need to separate out concepts, as I am accustomed to understanding concepts and ideas being interlinked and interrelated with each other. I also struggled with the alienating, isolating nature of writing the thesis. Māori are relational people and tend to thrive when we are in connections with others, and this is particularly true for me. To amend this isolation while I was writing, I ensured that the kaupapa and the reason(s) that were driving me to fulfill this kaupapa were kept central in my journey. Doing this allowed me to feel the connectedness that I longed for while writing the thesis. I also felt weary at times of sharing valuable and personal
knowledge in this thesis. This was because the knowledge shared in this thesis is sacred to my whānau, the whānau participants, the key informants, and to me. This was particularly the case with my personal whānau journey and the atua wāhine knowledge. Thus, I wanted to make sure the knowledge was shared in a way that upheld the mana of the mātauranga, and the mana of those who shared it with me.

Working my way through these difficulties, a nuanced health care framework was ‘birthed’. The question now needs to be focused around how we ensure this framework is cared for in a way that allows it to be nurtured and grow so that it may make a positive impact in Aotearoa New Zealand. It is said that it takes a kāinga (village) to raise a child. Abiding by that philosophy, I believe this framework requires the commitment of all stakeholders (maternity health care practitioners, neonatal health care practitioners, DHBs, and the Ministry of Health) to ensure the application, growth and success of this tikanga-based health care framework. As I have mentioned earlier, I do not see the end of this thesis being the end of this research journey. Rather, it is just another beginning that involves nurturing and growing Te Hā o Whānau framework.

11.4 Future Research Opportunities

Another new research pathway that would be of use is to evaluate the guidelines suggested within Te Hā o Whānau framework. Doing so may indicate whether or not the projected health outcomes of the framework promotes eventuate. In Aotearoa New Zealand, efforts should be made to uphold te Tiriti/ the Treaty principles and continually validate and encourage the use of mātauranga Māori, especially within the health care system. We are more likely to achieve better health outcomes by building new pathways that include mātauranga Māori while also enabling the creation of new, appropriate knowledge and practices (Royal, 2009). Our job is to revitalise mātauranga Māori and reclaim the space for tikanga within Aotearoa New Zealand, particularly within maternal-infant health care. Perhaps by indigenising the health care system and integrating tikanga and mātauranga Māori within it may contribute towards fulfilling that job.

To end, I would like to share a beautiful photo that Ashton recently sent to me. It is a photo of her son, who is now walking and leading a healthy life. I was thrilled to see his progress in this photo. To me, the photo depicts the title of this research project and the importance of this mahi: mā te wāhine, mā te whenua, ka ngaro te tangata.

Mauri ora.
**Figure 8.** ‘Mā te wāhine, mā te whenua, ka ngaro te tangata’.
Appendix 1: Rangitunoa

Like the setting sun, I watch you disappear from my sight.
Too fast to stop it; yet on a given day the setting sun seems so slow.
Too fast to remember the energy that we once saw and reveled amongst.
I desperately gaze over the horizon in the hope of seeing the sun again.
Yet I know this day will never be again.
Grateful for this day I had but already missing it.
These feelings are the reflection of the moment you took your last breath and set to rest.
All that is left now is the glowing hue of the sun; the glowing hue of your legacy.
The setting sun brings the promise of a new day.
Yet, your setting brought the promise of eternal aroha and tiaki.
I reciprocate this promise with my own promises:
I promise to care for others like you, as the always nourishing sun.
I promise to rise again from the dark horizon to find my brightness in the new day again.
And at that time, I will be smiling, with and for you.
Appendix 2: Kuputaka

Āhua                      Feeling; intuition
Ako Māori                 Learn, teach; the culturally preferred pedagogy principle of Kaupapa Māori theory and methodology
Aotearoa                   New Zealand; Land of the long white cloud
Aroha                     Care; love
Atua                      God; deity; menstruation
Atua wāhine                Female deities
Atuatanga                 Bodies of knowledge around deities
Au                        Myself
Awa                        River
Hapū                       Pregnant; Sub-tribe
Hapūtanga                  Pregnancy
Hau                        Vital essence; breathe
Hauora                     Wellbeing
Hineahuone                 First human
Hinemoana                  Ocean Maid
Hinenuitepō                Mother of afterlife; Goddess of Rarohenga
Hinetetiwaia               Goddess of childbirth
Hinetitama                 First child of Tāne and Hineahuone
Hōhā                       Annoy/ed
Hui                        Meeting, gathering
Io                         The Supreme Being
Iwi                        Tribe
Kai                        Food
Kāinga                     Home; Village
Kaitiaki                   Guardian; protector; caretaker
Kaiwhakahaere              Birth assistants
Kanohi-ki-te-kanohi        Face to face
Kapa Haka                  Traditional performing arts
Karakia                    Prayer
Karanga                    Welcoming calls
Kāti Huirapa ki Puketeraki A hapū in South Island
Kāti Māmoe                 A tribe in the South Island of Aotearoa/New Zealand
Kaumātua                   Elders
Kaupapa                    Task; agenda; plan; the collective philosophy principle of Kaupapa Māori theory and methodology
Kaupapa Māori              Research by Māori, with Māori, for Māori; a term used to describe traditional Māori ways of doing, being and thinking, encapsulated in a Māori worldview
Kawa                       Protocol
Kawanatanga                Governance
Koha                       Gift; offering
Kōhanga Reo                Māori language pre-school
Koroua                     Male elder
Kōrero                     Talk; speech; story
Kura
Kura Kaupapa Māori
Kurawaka

Mahi
Mahi toi
Māmā
Mana
Mana atua
Manaaki
Manaakitanga

Māori
Maunga
Mauri
Mihi
Mihi whakatau
Mokopuna
Mōteatea

Māreikura
Mātauranga Māori
Mātua
Maunga
Mauri
Mihi
Mihi whakatau
Mokopuna
Mōteatea

Nana
Ngā pāpā
Ngā Puhi ki Whangaroa
Ngahere
Ngāi Tahu/Kāi Tahu
Ngāi Taiwhakaea
Ngāti Awa
Ngāti Kuri

Oriori
Pākehā
Pāpā
Papakāinga
Papatūānuku
Pepeha
Poroporoaki
Pounamu
Pōwhiri
Rangatiratanga

Ranginui
Rarohenga

Reo
Rohe

School
Māori language primary school
Name of the place of where
Hineahuone was made; Most fertile region of Papatūānuku
Work
Art work
Mother
Authority; prestige; power
The authority of the gods
Care; kindness; helpfulness
Caring; thoughtfulness; sharing; uplifting mana
Indigenous people of Aotearoa/ New Zealand; ordinary
The complex living area of Māori that includes the space in front of the wharenui and all adjacent buildings
Significant female(s)
Māori bodies of knowledge
Parents
Mountain
Life essence
Greeting(s)
Speech of formal greeting
Grandchildren; blueprint of tūpuna
Chant
Grandmother
The fathers
A tribe in the Northland region of Aotearoa/New Zealand
Forest
A tribe in the South Island of Aotearoa/New Zealand
A sub-tribe of Ngāti Awa
A tribe in the Bay of Plenty region of Aotearoa/New Zealand
A tribe in the Far North of Aotearoa/New Zealand
Song sung to babies
European; non-Māori
Father
Original home
Mother Earth
Tribal saying
Farewell
Greenstone
Welcoming ceremony
Leadership; chieftainship; paramount authority; self-determination
Sky Father
The 'Underworld'; the dream state of Papatūānuku
Language
Area; boundary; district
Rongamātāne  God of cultivated food
Roopū  Group
Rūaumoko  God of volcanoes and earthquakes
Rūnanga  Tribal council; board
Tāne  God of forests, birds and mankind
Tangaroa  God of the sea
Tangata  People
Tangata whenua  People of the land; native people of the land
Taonga  Treasure
Taonga tuku iho  Treasures handed down from ancestors; the cultural aspirations principle of Kaupapa Māori theory and methodology
Tapu  Sacredness; restricted use
Tāwhirimātea  God of the winds
Te ao Māori  The Māori world; Māori culture
Te ao Mārama  The full light of day
Te ao Pākehā  The European world; European culture
Te Korekore/ Te Kore  The world of void
Te Moana-a-Toi  Bay of Plenty region of Aotearoa
Te Pō  The world of darkness
Te reo Māori  Māori language
Te Tai Tokerau  Northland region of Aotearoa
Te Tiriti o Waitangi  The Treaty of Waitangi
Te Wai Pounamu  The South Island of Aotearoa/New Zealand
Te Whaiao  Glimpse of light; Stage before birth
Te whare tangata  House of humanity; womb
Teina  Younger sibling
Tīka  Correct
Tīkanga Māori  Customs; practices; law
Tīmatanga  Introductory
Tino rangatiratanga  Self-determination; leadership; the self-determination principle of Kaupapa Māori theory and methodology

Titiro  Look
Tohi rite  Birth ceremonies
Tohunga  Expert; skilled person; priest
Tuakana  Older sibling
Tuakana-teina  Reciprocal learning model
Tūmatauenga  God of war
Tūpuna  Ancestors who have passed away
Tūrangawaewae  Home ground; place of standing; a customary link with the land
Ūkaipō  Place of nurturing; breast feed
Ūkaipōtanga  Breastfeeding
Urupā  Cemetery
Utu  Act of reciprocity
Wāhanga  Sections
Wahapū  Harbour
Wahine/Wāhine  Woman/Women
Wai  Water
Waiata  Song
Wairua  Spirit
<table>
<thead>
<tr>
<th>Waka</th>
<th>Canoe</th>
</tr>
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<tbody>
<tr>
<td>Wānanga</td>
<td>Learning forum; formal learning institutions</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Wero</td>
<td>Challenge</td>
</tr>
<tr>
<td>Whaea</td>
<td>Mother; aunty; respected female</td>
</tr>
<tr>
<td>Whaikōrero</td>
<td>Speech</td>
</tr>
<tr>
<td>Whakaaro</td>
<td>Ideas; opinion</td>
</tr>
<tr>
<td>Whakairo</td>
<td>Carvings</td>
</tr>
<tr>
<td>Whakamana</td>
<td>Give prestige to</td>
</tr>
<tr>
<td>Whakanoa</td>
<td>Removing tapu</td>
</tr>
<tr>
<td>Whakapapa</td>
<td>Layers of connections upon Papatūānuku; ongoing process of genealogy; connections</td>
</tr>
</tbody>
</table>

| Whakarongo | Listen                  |
| Whakataukī | Proverb                 |
| Whakawhanaunga | Process of establishing relationships |
| Whakawhānau | Giving birth; birth journey |
| Whānau     | Family; birth; kinship; the extended family structure principle of Kaupapa Māori theory and methodology |

| Whanaunga | Relations; extended kinship ties; interpersonal connections |
| Whanaungatanga | Relationships; kinships |
| Whare ngaro | Lost house; infertility |
| Whenua     | Land (living and non-living); placenta (afterbirth) |
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