Te Mana o Te Wahine:
Young Mothers Healthcare Experiences in Pregnancy, Birth, and into Motherhood

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Dedicated to my Nan

Joyce Elaine Baker

Aroha mutunga kore, haere atū rā

ABSTRACT

In Aotearoa-New Zealand being a young mother is often associated with clinical and societal ‘risks.’ Younger women have higher rates of maternal depression and suicide, complications during birth, and their babies are more likely to be born preterm, and of smaller gestational age and weight (Perinatal and Maternal Mortality Review Committee, 2012; Te Whatu Ora - Health New Zealand, 2023b, 2023a). Research also indicates that young mothers experience stigmatisation and discrimination that they attribute to their age and/or ethnicity (Adcock, 2016; Makowharemahihi et al., 2014; Rawiri, 2007; Ware, 2019).

In discussion with researchers, discrimination was the topic that young mothers at He Puaawai Teen Parent Centre wanted to talk about. They shared a strong desire to see change in the way that doctors, nurses, and midwives service young parents and were passionate about ensuring that future young mothers had more support. Thus, in responding to their call, 22 parents, including two fathers attending (or recent school-leavers of) He Puaawai Teen Parent Centre volunteered to participate in this study. This qualitative kaupapa Māori study employed a series of wānanga, individual kōrero, and an investigator-triangulation thematic analysis. The research questions explored both the positive and negative healthcare experiences of this cohort during pregnancy, birth, and into motherhood.

The aim of this study was to listen and learn about the experiences of these young parents and co-design informational and/or educational materials to help healthcare practitioners better understand and support young mothers/parents. To spread awareness of the experiences of these young parents, the co-design materials and findings of this study were disseminated via various healthcare seminars and meetings around the Waikato region. The findings of this study contribute to previous research that revealed over the last 20 years young parents have continued to report predominantly negative experiences in their maternity journey. Participants of this study reported experiences of unsolicited judgement and advice, a general lack of manaakitanga (care, empathy, respect), communication, and support from doctors, nurses, and midwives. The relatively small number of positive experiences shared in this study emphasises the importance of manaakitanga regardless of age. An unexpected finding was the impact that receptionists had on young parents’ healthcare experiences, as the face and entry point of healthcare services.

KO WAI AU

I te taha o tōku kuia,

Ko Tāpeka te maunga

Ko Ipipiri te moana

Ko Ngātokimatawhaorua te waka

Ko Ngāti Manu (ki Kororāreka) te hapū

Ko Ngāpuhi te iwi

Tētahi taha anō ōku,

Ko Tawhitirahi te maunga

Ko Te Awapoka te awa

Ko Māmari te waka

Ko Te Aupouri te iwi

I te taha o tōku pāpā, nō Tonga ahau,

Ko Ma'ufanga te hapū

Tīhei mauri ora!

Ko Mia Elaine Kolo tōku ingoa

I tipu ake ahau ki te taha o te moana, ki Kororāreka, i te rohe o Te Tai Tokerau. He māhanga ahau, he tuāhine hoki ahau ki ōku tungāne e whā.

HE MIHI

Tuatahi, e mihi ana ki ngā atua Māori, mei kore ake ko koutou, e kore au e tū i te ao e noho nei tātou. Tuarua, ki ōku tupuna, rātou mā i para i te huarahi, hei takahitanga mōku, tēnā rā koutou. He mihi maioha hoki ki ngā mate huhua o tōku whānau kua mate i roto i ngā tau, ngā marama, ngā rā kua hipa. Koutou e tiaki, e manaaki, e arataki tonu nei i ahau i roto i aku mahi katoa, haere atu rā koutou.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1 INTRODUCTION

Fire in My Puku

As a little girl, I loved dolls. Polly Pocket, Cabbage Patch, Barbie, and Bratz were like my babies. In primary school, my fascination with the idea of motherhood continued. My best friend and I talked about having babies of our own, what we would name them, and what they would look like. We were excited about dressing them up in pretty outfits and creating cute hairstyles. At the age of 11, we had already started our list of fun and quirky baby names. Little did we know that a few years later these conversations would no longer be hypothetical. At the age of 17 my best friend was pregnant.[1]

We were so excited about baby's arrival and spent weeks planning for the big day. We shopped for baby clothes, prepared baby's room, and packed her hospital bag. We also discussed some of the tough decisions that might need to be made. First, my friend was highly sceptical of all injections, especially Vitamin K[2] because her nephew had passed away after receiving his injection. Thus, she was adamant that her baby would not receive this shot, no matter what. Second, if anything happened to her or the baby, I was under strict instructions to stay with the baby and protect him at all costs. However, while we had planned for the worst, nothing could have fully prepared us for the birth of her son.

During labour, my friend and her baby became distressed due to complications. Baby had passed meconium[3] in the placenta and had a nuchal hand,[4] which prolonged the delivery process and created significant swelling of his head. When baby was finally delivered, I could see that his head was quite swollen and he was struggling to breathe. The midwives put him in the infant warmer and assessed his situation, then informed us that he needed extra support to breathe and would be transferred to the Special Care Baby Unit [SCBU]. Utterly depleted and physically unable to follow her baby, my friend instructed me to go with him. She also found the strength to remind everyone in the room, twice, that she did not want him to receive Vitamin K. My protective aunty instincts immediately kicked in.

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[1] I share the following narrative with my friend's permission

[2] Vitamin K is normally used in the body to clot blood. Babies are born with very small amounts of Vitamin K in their bodies which at times can lead to serious bleeding problems in early stages of life
(Lissienko, 2011)

[3] Meconium is a newborn's first poop - made up of cells, protein, fats - Babies typically pass meconium in the first few hours and days after birth (KidsHealth NZ, n.d.-b)

[4] Nuchal hand is when babies are delivered with a hand near face/ tucked under their chin which can make pushing more challenging (Terreri, 2024)

I watched over his wee body for three days and three nights. I didn’t really sleep. There were beeping monitors, and I could hear the mechanic breathing sounds coming from the tiny incubators in the dim lit room. It seemed like nurses were prodding and pricking baby every 15 minutes. Despite my haze of sleep deprivation, I vividly remember the multiple cannulas[5] inserted into his little hands and up his arms. I can still see the tiny silver needles beneath his fragile skin. Watching over my nephew my biggest worry was that someone would sneak in and give him Vitamin K. And my fears were partly confirmed. Despite my friend’s instructions, within the first 24 hours three different nurses tried to persuade me to give them consent to administer Vitamin K. They explained the importance of Vitamin K for a newborn, and especially for my nephew given his circumstances. After their third failed attempt, two doctors then approached me. Their explanation was even more detailed than the last, and one of them went as far as to say: “he may die, if he doesn’t get this.”

I remember feeling shocked that a doctor would say this to me. I felt I was being bullied into making a decision that was ultimately not mine to make. They made me feel like I knew nothing and that I didn’t understand what was going on. But we did. We did know what Vitamin K was, its purpose, and the associated risks. We had done our research; we had read about it, talked to family, the midwife, and other health professionals. So, I stood my ground. I was merely the messenger. My friend's wishes were crystal clear - but what was also clear to me was that no one was respecting them.

Over the next three days, baby improved significantly. After being relieved by a family member I then went to check on my friend. I remember feeling exhausted and upset about how the doctors and nurses had approached the Vitamin K situation. However, I knew that I needed to put on a brave face for my friend so she could focus on her recovery and not worry about her baby.

I went to visit her in the maternity ward and when I drew back the curtain, I was shocked by what I saw. My friend was extremely pale with ultra-dark circles and bags under her eyes. She looked three times her age. As I fussed over her, she tried to convince me that she was okay, she had eaten, and was drinking water. She just wanted to see her baby.

Concerned about my friend, I monitored her throughout the night. However, in the morning, she had still not improved – and she agreed that she didn’t feel well. I tried to talk with the

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[5] A cannula refers to a small tube like needle that is inserted into a vein, duct, or vessel for medical purposes (KidsHealth NZ, n.d.-a)

nurses on the morning shift; pointing out that she was still very, very pale and didn't look like herself at all. I was met with 'reassuring' comments like: 'she's fine', 'she'll be good in no time', and 'this is normal.'

Nonetheless, we knew something was wrong and continued to ask for help. The mood amongst the nurses started to change. They were becoming increasingly hōhā[6] with us. One nurse was particularly nasty and said to my friend: "look your baby is fine, so I don't know why you're still here. You're being dramatic and there are other mothers that need your bed, you're taking up space." Yet again, our concerns were dismissed, even more so that we actually began to second guess ourselves. However, the next day, we discovered that our instincts were correct.

On day five of our hospital stay, my friend's Nana-in-law visited. She was a retired nurse with 40 plus years' experience. As soon as she saw my friend, she snapped at the nurses stating my friend needed a blood and an iron infusion immediately. The nurses moved surprisingly fast! A doctor was consulted, and they discovered that her blood count and iron levels were dangerously low and administered both infusions.

This whole incident made my friend and I infuriated. This was not the story that we had dreamt about as little girls. What should have been an exciting and celebratory milestone in her life had turned into an unnecessarily traumatic experience. In bringing this new life into the world, we had been dismissed, looked down on, and disrespected. Retelling this story is difficult because of how traumatic I found it - and I wasn't even the one who gave birth. The staff blatantly ignored my friend for five days. Looking back, I still have so many questions. Was this an isolated incident? Had other young mothers had the same experiences? Did they treat us differently because we were young and/or because we were Māori? Why did it take an older (white) woman to say something in order for us to be taken seriously?

This experience ignited a fire in my puku[7] that has never gone away. So, when the opportunity to hear other young mothers' stories and experiences arose, I took hold of it with both hands.

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[6] Fed up or increasingly annoyed

[7] Belly or stomach

Origins of the Study

In this thesis, I report on the research project: ‘Karanga Atu, Karanga Mai:[8] responding to the call of young māmā[9] who want to share their clinical health experiences and create change.’ Initially, the young mothers of this study were interviewed by Te Whatu Ora Waikato - Māori Health Research Team, as part of a larger study named: ‘The Collaboration Study: determinants of health for Māori mothers and adults with chronic diseases’, in relation to their holistic hauora assessment tool.[10] However, in these engagements, many of the young māmā of He Puaawai Teen Parent Centre were more intent on sharing their stories of dissatisfaction with the treatment they had received at Waikato Hospital. While their concerns did not fit the scope of The Collaboration Study, their stories did not fall on deaf ears. Thus, the opportunity to conduct a study focusing on their concerns presented itself and the project included funding for a research assistant, in which I was later employed. Motivated by the fire in my puku and ignited by my personal experiences, I joined the Karanga Atu, Karanga Mai study to influence change in the treatment of young parents in health and support their voices to be heard.

Significance

The health and wellbeing of teenage mothers has been identified as a high priority, yet the literature shows that they continue to report poor clinical experiences. These poor experiences include discrimination, stigmatisation, and judgement; feelings of exclusion in hospitals (Adcock et al., 2018); miscommunication; and lack of manaakitanga[11] from healthcare staff (Lawton et al., 2016; Makowharemahihi et al., 2014; Rawiri, 2007). Studies have also found that such treatment leads to a general mistrust and avoidance of the health system, and consequently - poor health outcomes (Adcock, 2016; Bealing, 2019; Brown et al., 2021; Lawton et al., 2016). Although there have been attempts to mitigate negative experiences in healthcare, it appears that little effort has been made to educate and inform healthcare staff to better understand and improve services when working with young parents.

A recent report highlights the significance of maternity care in Waikato (Te Whatu Ora Waikato - Health New Zealand, 2023). The birthing population in the Waikato region ranges

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[8] ‘Karanga’ in Te Reo Māori is a verb and means to call. ‘Mai’ and ‘atu’ when put behind a verb is directional; with mai being towards and atu being away. So, karanga atu, karanga mai is the call out and call back (in reply)

[9] Mother(s)

[10] Papers are yet to be published for The Collaboration Study project, hence the explanation and not the direct reference

[11] Care, consideration, respect, kindness, support

between 5,200 and 5,600 births annually. Between 2012 and 2022 Waikato consistently had one of the highest birth rates nationally for women under 20 years of age. In 2022, the Waikato region also had *the* highest number of Māori births (36%) nationally. In Aotearoa-New Zealand, Māori women have the highest preterm birth rate of any ethnic group, their babies are more likely to be smaller gestational age and weight, and the mortality rate for Māori infants is 4.9 per 1000 compared to the New Zealand European rate of 3.2 per 1000 (Dixon et al., 2011; Te Whatu Ora Waikato - Health New Zealand, 2023). Given this situation, it is therefore concerning that there are only few studies that explore the experiences of young māmā in Waikato - during pregnancy, birth, and into motherhood.

Aims, Objectives, and Research Questions

Employing a kaupapa Māori[12] research approach and qualitative methods, the primary aim of this study is to listen and learn about young parents' healthcare experiences (positive and negative) in an effort to improve the way in which healthcare practitioners service and treat young mothers. The key objective of this research is to co-design guidelines and educational materials that will help healthcare practitioners understand how best to work with and support young parents/mothers.

This study has three primary research questions:

1. When caring for young māmā and their tamariki[13] what are doctors, nurses, midwives, and other healthcare practitioners doing well?
2. When caring for young māmā and their tamariki what are doctors, nurses, midwives, and other healthcare practitioners not doing well?
3. What are the messages and lessons you want to get across to improve how health professionals treat and service young māmā and whānau?[14]

Thesis Overview

Chapter 1 explains my connection to the research topic and the origins of this study. It also includes this overview of the chapter, and some key writing conventions used throughout this thesis. **Chapter 2** offers some context and background for this study, including a brief overview of Māori creation narratives, colonisation of Aotearoa-New Zealand, and Māori and

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[12] Any topic, plan, purpose, program, or initiative related to Māori

[13] Child(ren)

[14] Family (in this case) – can also mean birth

maternal healthcare. The purpose of **Chapter 3** is to present my kaupapa Māori methodological framework – Te Ira Wahine. In Chapter 3, I also explain how my framework has been applied to my research process and this thesis itself. Given that methodology is the theory about how research should be conducted, which includes the literature review (G. H. Clarke, 2020), this chapter precedes my review of the literature. **Chapter 4** is the literature review and presents an overview of the existing empirical literature on this topic, during which I also identify gaps that this study will attempt to address. **Chapter 5** describes the qualitative methods and processes employed to achieve the research aims and objectives of this study. **Chapter 6** presents the key findings and themes that have emerged from the experiences of the 22 young mothers and fathers who participated in this project. This chapter will open the reader's eyes to the lived realities of these young parents and showcases their messages and co-designed materials. I will also explain how the findings were disseminated and present my analysis as the researcher. In **Chapter 7**, I present my discussion in relation to the findings of this study and previous literature. I also share my recommendations for future research, implementation suggestions for healthcare services, and the limitations of this study. **In Chapter 8**, I conclude by summarising the key ideas presented in this thesis and synthesise my main points to put this research into perspective.

Writing Conventions

I offer the following to provide understanding and clarity for the reader.

Where Te Reo Māori[15] is used in text and there is no translation directly following, the translation will be provided in a footnote in the first instance, thereafter, please see the Glossary at the end of this thesis. It is important to understand Te Reo Māori words at times have dual meanings and depending on the context have different definitions (e.g. hapū translates to sub-tribe but also means to be pregnant). Te Reo Māori words are also considered both plural and singular, therefore, an 's' at the end of the word is not needed. Only Te Reo Māori words that are nouns/pronouns will be capitalised in this thesis, because the use of Te Reo Māori is normal for me personally and does not need to be emphasised as 'special.'

Throughout the thesis you will also find tupuna (ancestor) names. In relation to these, it is important to note that before the 1800s Māori did not use surnames. Māori were often given names at birth that reflected an event or circumstances of that time. On occasions where

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[15] The Māori language

someone did something noble or a significant event occurred, names were changed or expanded to note this feat.[16] With regards to Māori narratives, it is important to understand that there are multiple versions across different iwi.[17] I was raised in Te Tai Tokerau[18] but have spent many years in Waikato,[19] and therefore, prioritise the narratives of both iwi. Throughout this thesis I also share karakia,[20] whakatauki,[21] pūrākau[22] and mātauranga Māori[23] from my own whānau. This esoteric knowledge is a taonga;[24] it is sacred and should be treated with respect. Finally, when talking about Te Tiriti o Waitangi, I predominantly refer to the principals and definitions highlighted in Te Tiriti o Waitangi, not the Treaty of Waitangi as I believe Te Tiriti is the original document.

For the readers information, as a novice researcher, I have decided to include some personal reflections at the beginning and end of some chapters. I also use the notion 'young (Māori) parents' throughout this thesis to emphasise that both young non-Māori and Māori mothers/fathers/parents are of relevance interchangeably.

Additionally, for clarification the following terms are used to describe slightly different cohorts of health staff. A 'healthcare practitioner' refers to a clinical primary and secondary healthcare member (e.g. doctors, nurses, midwives). A 'healthcare provider/service' and/or 'service provider' refers to a service or person of a healthcare service that provides healthcare or promotion (e.g. Plunket, pathology, Māori health providers). Finally, 'healthcare staff' or 'health staff' refers to both a clinical and non-clinical healthcare staff member or services in a general sense (e.g. receptionists).

In the next chapter, I offer some context for this study, including the creation of Te Ao Māori,[25] colonisation, and the events relevant to the revitalisation of Aotearoa-New Zealand today.

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[16] For example, the name Tāne-tokotoko-i-te-rangi was given to the god of the forest Tāne when he successfully separated his parents in the Māori creation narrative - tokotoko meaning to 'prop up' and i te rangi meaning 'the sky.'

[17] Tribe(s)

[18] Northern most region of Aotearoa-New Zealand - stretches from the North most point of the North Island down to Auckland

[19] Mid-north Island region of Aotearoa-New Zealand – starts at the bottom of Auckland down to Mokau

[20] Prayer or incantation

[21] Proverb and sayings that often stem from auspicious events or cheifs/prominent people

[22] Narratives or stories

[23] Māori knowledge, traditional creative practice knowledge, usually esoteric and may include knowledge of whakakpapa, pūrākau, carving, weaving, or traditional haka (dance)

[24] Treasure

[25] The Māori world

CHAPTER 2 CONTEXT

Introduction

This chapter provides the context and background for this study and comprises four parts. Part 1 begins with a brief overview of the Māori creation story. Part 2 offers a glimpse into pre-colonial Aotearoa-New Zealand, with a particular focus on maternity. Part 3 explores the arrival of settlers and the colonisation of Aotearoa-New Zealand. While recognising the implications of colonisation, part 4 concludes with various success stories of Māori leaders, the revitalisation movement, and recent changes in the health sector today.

Part 1 – Our First Parents

In this section, I offer a version of Māori cosmology, the origin and evolution of Te Ao Māori. This narrative highlights our values and worldview, with an emphasis on relationships and childrearing. My rendition is influenced by the stories I was told as a child and the common pūrākau that were taught to me in school. For the purposes of this thesis, the following narrative is partial and incomplete, meaning that these narratives have been simplified and some details have been left out for the sake of brevity and relevance. Fuller versions and more information is available online and in other texts if the reader wishes to know more (Mead, 2016). Some readers may also notice that I have focused on only six atua,[26] this is purely because I believe these gods were directly related to Te Wehenga.[27]

Te Orokohanga o Te Ao Māori

I te tīmatanga

Ko Te Kore, Te Kore-te-whiwhia, Te Kore-te-rawea, Te Kore-i-ai

Ko Te Pō, Te Pō-nui, Te Pō-roa, Te Pō-uriuri, Te Pō-kerekere, Te Pō-tangotango, Te Pō-tē-kitea

Te Whei Ao

ki Te Ao Mārama,

Tīhei mauri ora!

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[26] Deity or god(s)

[27] The separation of Rangi and Papa - the sky father and earth mother (see full story below)

Above is a version of the Māori genealogical narrative that describes the beginning of the world. This cosmological story explains 'i te tīmatanga' – in the beginning all life began in stages of Te Kore,[28] nothingness. From Te Kore then emerged Te Pō,[29] darkness or numerous phases of night, and that within Te Pō formed a celestial body. This single being comprised two essences - Ranginui and Papatūānuku, our primordial parents - the sky father and earth mother. Within their tight embrace, Ranginui and Papatūānuku produced many children. For aeons, they sheltered and protected their children from the uncertainty of the outer universe. There are varying accounts that describe the number, characteristics, and abilities of these tamariki. However, most narratives typically focus on seven children: Rongomatāne (also known as Rongo), Tānemahuta (also known as Tāne), Tangaroa, Tūmatauenga (also known as Tū), Haumietiketike (also known as Haumie), Tāwhirimātea (also known as Tāwhiri), and Rūaumoko.[30] As the offspring of celestial beings, we refer to these tamariki as atua.

Te Wānanga

In the unyielding clutch of their parents the atua grew restless. They wanted room to grow and were curious about the outside world. Some say that a number of atua snuck out through their mother's menstrual flow and saw a world that was yet to be explored. Yearning to be free, the atua gathered to discuss their situation. This event is referred to as Te Wānanga - meaning the first wānanga.[31] Te Wānanga was a tapu[32] space, a space of contemplation, conversation, and deliberation.

Te Wehenga

Te Wānanga continued for many nights, the atua debated if and how Ranginui and Papatūānuku might be separated. Rongomātāne and Tāwhirimātea wholeheartedly disagreed with the idea of a separation, while Tūmatauenga suggested that they just kill their parents. As tensions rose, Haumietiketike disappeared, saying nothing. Tāne argued that separation would open a new world of opportunities for the atua, but their mother would still be kept close to provide them with sustenance. He also professed that if his siblings agreed, he would be the one to separate their parents. Tangaroa became annoyed at Tāne's arrogance but did not have a solution himself.

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[28] Te Kore directly translates to 'the nothing', this was the first stage in the creation story of the Māori world

[29] Te Pō directly translates to 'the night, this was the second stage in the creation story of the Māori world

[30] See below the relams each atua resides over

[31] Thought space, gathering or meeting

[32] Sacred – a key concept in Māori customs

So, while the decision was not unanimous, the atua who agreed to try and separate their parents took turns in pushing them apart. When their attempts failed, Tāne stood up eagerly to get the job done. He lay his back and shoulders upon Papatūānuku and placed his feet upon the chest of Ranginui. With all his strength he pushed and eventually tore his parents from their tight embrace. When Rangi and Papa were separated, some say light entered the world immediately, while others believe that Tāne then ventured into the heavens to retrieve light from 'Te Whānau Marama' - the family of light.

Separated for the first time, Rangi and Papa cried so much that their tears became a torrential rain. To stop this flood, the atua turned Papatūānuku onto her stomach so she could no longer see Rangi above her. This event, however, trapped their unborn brother, Rūaumoko, within their mother's stomach. It is said that Te Wehenga brought into the world some of the strongest feelings felt by humans today, including anger, grief, and betrayal.

Ngā Atua

Following Te Wehenga there were many battles between the brothers that explain why certain atua now reside over particular realms and natural domains. Distraught by the separation of their parents, Tāwhirimātea sought refuge with his father and together they plotted their revenge. During this period, Tāne ascended the heavens and retrieved the ngā kete mātauranga,[33] then distributed that knowledge to his brothers to help them develop their respective domains. Tāne himself procreated with several female elements/atua to create a beautiful cloak of green and flowering forests, full of insects and birds, to adorn his mother's naked body.

When Tāne's domain was complete, Tāwhiri then descended upon his brothers with great gales and storms. First, he attacked Tāne and his forests. He then pursued Tangaroa and his offspring, who fled into the depths of the oceans. To escape their brothers' wrath, Rongo and Haumie took refuge in the bosom of their mother. Tāwhirimātea then attacked Tūmatauenga. But Tū stood strong against Tāwhiri until his rage had subsided.

When Tāwhiri returned to the skies, Tū then lashed out at all of his brothers for their cowardness. From the forests of Tāne, Tūmatauenga made snares to capture the birds of Tāne's forest and canoes and nets to fish up the children of Tangaroa. He also made tools to harvest the children of Rongo and Haumie from the soil. Tū then recited karakia so that his

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[33] Baskets of knowledge were known to have held several different kinds of knowledge and were collected by Tāne/Tāwhaki to disperse into the world

descendants could be consumed by his brothers' descendants, which introduced the concept of whakanoa[34] and now is the reason why humans can eat fish, birds, and vegetables.

Today, we still know Tangaroa as the atua of the sea, the father and protector of oceans and all sea life. Tāwhirimātea is the god of the winds and continues to live close to his father controlling the weather. He also continues to wage war against his brothers and their offspring - the oceans, the land, and humankind. Tānemāhuta, the atua of nature, protects and shelters life in the forest. In the form of trees, he continues to hold Ranginui aloft to allow light and oxygen into the world. Rongomātāne is the god of cultivated foods and peace and provides guidance and wisdom to his brothers and humankind. Tūmatauenga is the atua of war and of humans – who have taken on many of his characteristics. Haumietiketike is the god of wild and uncultivated foods. Lastly, as he turns and shifts in his mother's womb, Rūaumoko is the atua of earthquakes and volcanic activity.

This origin story lays the foundation for our Māori worldview including our familial relationship with the natural world and provides a blueprint for the way we live, our core values, and cultural practices. Not only does this narrative explain why things are the way they are, but also demonstrates our belief in a physical and metaphysical world. In Te Ao Māori, Rangi, Papa, and their children are the first whānau and this story demonstrates the many trials and tribulations that can occur within a family. This pūrākau also highlights the concepts of sibling rivalry, the forgiving heart of a mother for her children during conflict, competitiveness, ego, and betrayal.

Te Ira Tāngata

There are varying accounts about the origin of humankind. Several pūrākau point to Tāne as an innovator and explorer who led the search for te ira tāngata – the essence of humankind. During his search, Tāne mated with various natural elements and produced a number of lifeforms including insects, rocks, mountains, and fresh water. Unsuccessful in his search for te ira tāngata, he then sought the guidance of his mother. Papatūānuku told him to go to Kurawaka,[35] and there his brothers and sisters would help him to fashion the first woman.

When the woman shaped from clay was completed, Tāne pressed his nose against hers, shared his mauri[36] and she sneezed. To which Tāne said, "tīhei mauri ora!"[37] This woman was

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[34] The act of removing sacristy

[35] The place in which the first woman was created

[36] Life force or vital essence

[37] A common phrase in Te Ao Māori that refers to the 'breathe of life'

given the name Hine-ahu-one - female shaped from earth. Hineahuone and Tāne then conceived their daughter and the first human being - Hinetītama, the keeper of 'te whare tangata.'[38]

From a young age Hinetītama was raised by her mother. Later, Hinetītama married and raised four daughters of her own. However, what she did not know was that her husband whom she had produced children with was also her father – Tāne. Disgusted and embarrassed, Hinetītama chose to leave the world of light to Rarohenga - the underworld, where she assumed a new identity. As Hinenuitepō, the goddess of death, she instructed Tāne to care for their children in life and that she would reclaim her role as mother and care for them when they pass into the spirit world (Higgins, 2011; Mead, 2016).

Hinenuitepō's decision to leave Te Ao Marama is an expression of tino rangatiratanga[39] and mana motuhake,[40] in the sense that she did what was best for her, but at the same time maintained her role as a loving mother. Typically, this story portrays Hinetītama as a victim and focusses on her heartbreak rather than accentuating her strength and self-determination.

This pūrākau is about the significance of women as 'the house of humanity', the givers of life, and keepers of knowledge. It also illustrates concepts of motherhood like protection, guidance, and unconditional love. Tāne goes to Papatūānuku to learn how to create humankind and in another pūrākau he retrieves fire from his aunty, Mahuika,[41] which highlights women as keepers of wisdom and knowledge.

Part 2 – Pre-colonial Aotearoa

In this section I provide the reader with some insight into how Māori lived in pre-colonial times. It begins with Māori arrival to Aotearoa-New Zealand, then highlights how tikanga[42] provided order and supported health and wellbeing in the community. This section then ends with a short description of Māori birthing traditions. It is important to remind the reader that traditions, tikanga, and practices differ from whānau to whānau, hapū[43] to hapū, and iwi to iwi.

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[38] The house of humanity

[39] Chieftainship, right to exercise authority, chiefly autonomy, chiefly authority, ownership

[40] Control over ones destiny, autonomy, self-determination, independence, sovereignty

[41] Goddess of fire

[42] Māori traditional protocol and customs

[43] Sub-tribe

Journey from Hawaiki

As we know, Māori didn't always reside in Aotearoa. In our origin stories, there is mention of a homeland called Hawaiki. There are many perspectives about where the actual location of Hawaiki is. It is often debated as to whether it was a spiritual place or a land that is no longer above water. However, what we do know is that our ancestors navigated the vast ocean and arrived on the shores of Aotearoa sometime between 1300AD and 1500AD (Royal, 2015).

A story commonly told within my iwi of Ngāpuhi, is how our tupuna[44] Kupe and Kuramārōtini first discovered Aotearoa. On their waka[45]- Matahourua, they sailed from Hawaiki in search of new lands. Kupe's wife, Kuramārōtini, named Aotearoa from a distance when she saw the long white clouds that adorned the land. They first landed in Hokianga on the northern-west coast of the North Island (Royal, 2005).

Kupe later returned to Hawaiki to tell his iwi of the land he had discovered. His waka, Matahourua, was then re-adzed to fit more people and mended to prepare for another long journey. He then renamed Matahourua to Ngā-toki-matawhaorua (as we know it today) in honour of the two sacred toki.[46] Nukutawhiti, the grandson of Kupe, returned to Aotearoa upon Ngātokimatawhaorua and created a new home for his people and his descendants who continue to reside there today. Once word spread in Hawaiki that new, resourceful lands had been discovered, many waka begun transporting people to Aotearoa. Aboard these waka were also different food species, natural medicines, and seeds that they would eventually use to grow crops in Aotearoa.

Village Life

Our ancestors were highly adaptable and super intelligent. They established tribes and sub-tribes who lived inland and/or by the ocean. They lived in communal societies that included hierarchical structures and governance systems. Gender roles were balanced, and responsibility was shared. Both wāhine and tāne[47] contributed differently but equally to everyday life. This system was underpinned by cultural customs, beliefs, and protocol.

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[44] Ancestor(s)

[45] Canoe

[46] Adze – and Ngāpakitua and Tauiraata were the names of the sacred adzes that created and formed Ngatokimatawhaorua.

[47] Women and men

Our ancestors lived a self-sustainable life. They had unique ways of telling time, methods of education, collecting and growing food, and healing practices. We connected spiritually to the environment and exercised a reciprocal relationship through karakia and rongoā.[48] Māori cared for the environment so it would be able to sustain humankind for generations. This is why we call ourselves 'tāngata whenua' - people of the land.

Tikanga maintained order within pā.[49] There were separate and dedicated houses for different purposes and activities. Kautā were houses for cooking, whare kōhanga were houses for birthing/caring for children, whare wānanga were houses of learning, and whare tū taua were houses for weaponry and battle training (Schrader, 2013).

Food supply and preservation was critical for survival. Māori hunted and grew their own food and stored it in pātaka kai or raised storehouses to protect it from animals. Depending on where Māori lived, the traditional diet predominantly included birds, kūmara,[50] seafood, berries, fruits, seeds, ferns, and native roots. A number of early explorers and ethnographers noted that Māori were remarkable healthy; we were known to have had strong white teeth, rapid healing ability, and lived significantly longer than Englishmen (Nicolas, 1814; as cited in Hanham, 2003; Hiam et al., 2018).

Hauora Māori

In relation to health, Māori followed a clear system of tikanga that supported and maintained the health of the hapū. Underpinning this tikanga are concepts such as tapu and noa, which are kept separate unless tapu needed to be lifted (as in the exemplar provided by Tūmatauenga). Things related to the body like emotions, sickness, sleeping, birthing, kākahu,[51] and menstruation were/are all tapu and could not be mixed with things that were/are noa such as water, food, and drink. As such, Māori had separate houses for sleeping, eating, cooking, and rongoā. Whare mate were dedicated houses for the sick, and there were/are many rules and customs around death and the dying. When establishing pā, a great deal of thought went into site selection and design. It was important to have easy access to water, the forest, the ocean and fertile soil for food and medicines. Ideal sites also provided drainage, wind protection, and sunlight. Great care was taken to ensure that ablutions and

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[48] Māori medicine or natural remedy, traditional treatment

[49] Fortified village where Māori lived

[50] Sweet potato

[51] Clothing, in the early accounts kākahu related to korowai rather than the clothes we wear today

waste disposal were kept a safe distance from water sources, gardens, and whare (Schrader, 2013).

Birthing Traditions

Māori birthing traditions differ across iwi and hapū, however, the following are just some I have learnt and read about. In the days of old, sex, menstruation, pregnancy, and childbirth were seen as the continuation of whakapapa[52] and therefore sacred or tapū. Pēpi[53] were/are considered sacred as they are the closest to the spiritual world. Whilst women were also seen as special and respected as the keepers and givers of life. The word whānau has a dual meaning that derived from Māori maternity - whānau means family but also to give birth. Hapū also has a dual meaning - it can mean sub-tribe or clan but also means to be pregnant (Tupara, 2011). The duality of these words represents how treasured and deeply loved and cared for women and children were/are in Māori culture.

In relation to birthing customs, Māori traditionally had whare kōhanga, which were specially built and temporary houses in which women laboured, gave birth, and recovered in post-birth. During labour, it was common for oriori[54] and karakia to be recited, asking the atua for guidance and protection. Waiata[55] were sung and taonga pūoro[56] were played to provide relief to the labouring mother. Women would hold on to a pou[57] and swat/lean on another during labour, these pou were called pou-tama-wāhine and pou-tama-tāne.[58] Men also played an important role in birthing children including as essentially the midwife and protector of mother and pēpi. The men also built and supervised steam pits that women stood over to help their cervix dilate. When mother and child were ready to rejoin the hapū, the whare kōhanga was burnt to extinguish the tapu associated with childbirth and to celebrate the entrance of new life. The whenua[59] and pito[60] of the child were buried in a place of significance. This practice recognised/s Papatūānuku as the earth mother and the source of all life. In the days following a birth, a tohi[61] ceremony was then conducted to ask for protection over the child

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[52] Genealogy

[53] Baby/ babies

[54] Special lament or lullaby – usually made for a specific person/baby

[55] Song(s)

[56] Māori carved or fashioned instruments

[57] Pole(s)

[58] "The first (pou-tama-wahine) was for her to hold on to and the second (pou-tama-tāne) was for her to lean against" (Tupara, 2011).

[59] In this context - Placenta of a baby – can also mean land

[60] Umbilical cord or belly button - that that eventually falls off in the following weeks after birth

[61] Ritual ceremony over a child in flowing water while petitioning the *atua* to endow the child with the desired mental and physical qualities

and set intentions for their future. It was common for children to be raised and nurtured by the wider whānau and hapū as the responsibility was shared (Murphy, 2011; Pere, 1994; Tikao, 2013, 2013).

Part 3 – Arrival and Colonisation

In 1642, Dutch cartographer Abel Tasman reportedly 'found' Aotearoa. He initially named the land he saw 'Nova Zeelandia.' When a battle at sea with Māori resulted in fatalities, Tasman and his men left Aotearoa waters without ever going ashore. It was a long 127 years before Captain James Cook recorded his arrival in Aotearoa in 1769. Cook spent approximately three years travelling around Aotearoa-New Zealand, mapping its terrain, learning of its 'inhabitants', and noting the rich resources. He also named places around the North and Southern Island as he saw fit. Many of these place names still exist today and there is much controversy around the matter, as Māori had already named Aotearoa prior to European arrival. It is also said that during Cooks first voyage around Aotearoa-New Zealand, sexually transmitted disease was introduced in Māori communities. This had a negative impact on Māori birth rates and eventuated in many stillbirths (Lange, 2011a; Manatū Taonga — Ministry for Culture and Heritage, 2020).

Utilising Cook's map,[62] whalers, sealers, traders, and explorers began arriving on the northern east coast of the North Island in the late 1700s. Trading and personal relationships with Māori were established. Impressed with early engagements with Māori rangatira[63] who had sailed to Sydney, the first missionary arrived to Aotearoa-New Zealand in 1814. Records indicate that from Cooks first visit in 1769 to 1840 there was an estimated 30% to 40% decrease in the Māori population (Derby, 2018; Pool & Jackson, 2018).

Muskets

With European arrival, also came death. Māori were particularly interested in European technology including muskets, which made inter-tribal warfare a lot more dangerous. The introduction of muskets gave Māori long-range battle options rather than the pre-colonial method of hand-to-hand combat. As a result, many inter-tribal wars occurred between 1818 and late 1830s. The Musket Wars were a significant moment in history as it is estimated that

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[62] See Wilson (2020) for more information

[63] Cheif(s)

20,000 Māori were killed and many others were taken captive (Manatū Taonga — Ministry for Culture and Heritage, 2021c).

Introduction of New Food and Substances

Settlers also introduced a new range of foods and substances, not all of which promoted good health for Māori. In the early 1800s, tobacco and alcohol were introduced by whalers and sealers. These substances spread throughout Aotearoa-New Zealand and became very popular with Māori of all ages. Sugar, pork, and potato were also introduced and upended traditional Māori diet and food customs (Cook, 2013). The introduction of these substances and foods contributed to the decline in Māori health and wellbeing.

In order to trade, Māori moved closer to 'trading centres' and began working and living in areas where they could produce or extract the resources that Pākehā[64] wanted. Hapū established market gardens. They grew corn, wheat, pumpkin, and potatoes, they collected and transported water, timber and grew and milled flax (Wassilieff, 2008). Traditional and communal village life was disrupted as a result. In time, missionaries were also successful in converting Māori to Christianity, replacing karakia and atua with prayers and a singular god (Stenhouse, 2018).

Disease

Māori also struggled with disease. They had no immunity against the foreign sicknesses that settlers introduced, and traditional Māori healing practices were not always successful. This led to devastating outcomes for Māori communities, particularly women and children. Diseases like influenza, measles, typhoid, and tuberculosis swept through whole villages killing thousands of Māori in a matter of weeks (Hanham, 2003; Lange, 2011a).

Māori were made to believe by missionaries that during this time the prevalence of death or disease was because atua Māori had abandoned them and Pākehā didn't get as ill because their god was stronger. These theories aided missionaries in their efforts to convert Māori to a single more 'powerful' god.[65]

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[64] Non-Māori person/people - originating from a foreign country (e.g. European)

[65] This was a narrative told to me by my kuia growing up in Kororāreka

He Whakaputanga o Ngā Rangatira o Nu Tīreni

Māori in Northland grew particularly close with James Busby who had been sent by Britain to keep the peace in between Māori and British settlers. In his role as British resident, Busby also educated Northern rangatira - who were becoming increasingly involved in trading overseas - on the international legalities of trading and helped them to develop a flag and declaration of independence. In 1835, *He Whakaputanga o Te Rangatiratanga o Nu Tireni*[66] was signed by 34 northern chiefs and was a clear statement of their tino rangtiratanga. The following year, the United Tribes flag and He Whakaputanga were both officially recognised by King Williams IV and the British Governor General (Manatū Taonga — Ministry for Culture and Heritage, 2022).

Te Tiriti o Waitangi

By the 1830s, there was an increasing need for law and order in British settlements in Aotearoa-New Zealand. Kororāreka,[67] in the Bay of Islands was nicknamed ‘the Hellhole of the Pacific’, as it became a hot spot for settlers, drunken sailors, prostitutes, and lawlessness. There were also concerns about ‘land jobbing’ and settlers building on Māori land without permission (Bardsley, 2008).[68] During this period, other colonial powers including France and America had set their sights on Aotearoa as well. To address these concerns, the British offered to enter into a treaty with Māori.

Thus, on February 6th, 1840, Māori declared sovereignty by signing *Te Tiriti o Waitangi [Māori Version]*. Te Tiriti o Waitangi gave the British crown permission to create laws to govern **British** citizens living in New Zealand. In the weeks following February 6th, copies of Te Tiriti o Waitangi (the Māori version only) were taken across the country and eventually over 500 Māori chiefs signed, whilst only 39 Māori signed the English version (*The Treaty of Waitangi [English Version],* 1840).

To give a very brief overview of Te Tiriti, Article One declares that governance by the Crown of **Pākehā** settlers is welcome but Māori will continue to have rangatiratanga over their lands and possessions. Article Two guarantees Māori full exclusive rights to all their taonga including lands and property. While Article Three promises Māori equal protection and the same privileges as Pākehā. However, when Te Tiriti o Waitangi was translated into English

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[66] Also known as New Zealand Declaration of Independance 1835 or ‘He Whakaputanga’ for short

[67] Original name for townships commonly known as Russell, Bay of Islands, New Zealand

[68] “Land-jobbing” was of significance of this time, where Pākehā settlers would buy land off Māori for cheap and then sell to their European counterparts for substantially more – making a large profit

there were several discrepancies. In particular, Article One stated in the English version that Māori grant the Crown full power and governance **over** Māori people and declare that Māori **ceded** sovereignty of their mana[69] and all land and possessions (The Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi, 2024).

While contentious, The Treaty/Te Tiriti o Waitangi is referred to as the ‘founding document’ of our nation. In which, the key discrepancies above eventually led to colonisation through political dominance, exclusion and at times violence perpetrated by the Crown with a later succession of settler governments.

Takahi Mana, Tahae Whenua

After the Crown claimed Aotearoa-New Zealand as a British colony, the flood gates opened to British settlers which increased the demand for land exponentially. The first significant confrontation between Māori and Pākehā occurred in 1843 in Wairau when settler surveyors attempted to take Ngāti Toa land. Forty-nine Pākehā and four Māori were killed, including Te Rangihaeata’s[70] wife - Te Rongo (Manatū Taonga — Ministry for Culture and Heritage, 2021d). From 1845 to 1846, Ngāpuhi chiefs and iwi fought Pākehā in the Battle of Kororāreka, Puketūtū, Ōhaeawai, and Ruapekapeka. The British also sacked Ōtuihu, the costal pā of my tupuna Pōmare II, who was unlawfully arrested for supposedly possessing stolen goods. From 1846 to 1847 there were battles in Whanganui, Wellington, and Taranaki where iwi fought at different pā such as Te Kohia Pā, Waireka Pā, Puketekaurere, Māhoetahi, and Te Arei Pā (Keenan, 2024).

Raupatu or confiscation of land was legalised with the passing of *New Zealand Settlements Act 1863*. This Act allowed for the confiscation, without compensation of all land owned by those who were said to be in rebellion against her majesty’s authority. Thousands of acres of Māori land was taken by force, whole villages were displaced, and pā were sacked if their people did not surrender (Manatū Taonga — Ministry for Culture and Heritage, 2024a). In the same year, the *Suppression of Rebellion Act 1863* was passed and facilitated the arrest and execution of “…all persons deemed to be in rebellion against the crown, for the public safety and protection of Her Majesty's peaceable and loyal subjects’ without trial” (ss. 2). Despite

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[69] Prestige, authority, control, power, status, spiritual power

[70] Leader and chief of Ngāti Toa in Kāwhia on the mid-east coast of New Zealand. Prominent in Waikato Wars and worked closely alongside Te Rauparaha.

the promises made in *Te Tiriti o Waitangi 1840 [Māori version]*, these Acts demonstrated the colonial government's determination and assertion of control in Aotearoa-New Zealand.

In July 1863, these laws were used to justify the invasion of the Waikato region. The Waikato is home to the Kiingitanga movement which was established in 1858 and was created to combat the mass inequality seen by Māori. Between 1864 and 1872, the Waikato people defended pā at Meremere, Rangiriri, Ngāruawāhia, Rangiaowhia, Pukehinahina and Ōrākau - many women and children were killed (Manatū Taonga — Ministry for Culture and Heritage, 2021e). Battles also occurred in Tauranga at Gate Pā and Te Ranga, and in Taranaki (Tītokowaru's war) and on the East Coast (Te Kooti's war) (Keenan, 2024).

Although Māori won some of these battles, many Māori lives were lost and extensive raupatu forced Māori and consequently their descendants from their tribal lands. In 1860, 80% of land in the North Island was still possessed/owned by Māori. However, by 1890, this dropped to 40%, and by 1939 Māori possessed only 9% of the North Island (Manatū Taonga — Ministry for Culture and Heritage, 2021b). Unable to live off the land, or forced onto small reserves, great numbers of Māori were separated and forced to seek employment and livelihood elsewhere. These jobs typically included farming, market gardens, working in the forestry, on the roads and railways, and cleaning for Pākehā (Derby, 2011).

Māori were forced into the settler education system that prepared them for labouring occupations. The *Native Schools Act 1867* required English to be the *only* language written and spoken in schools, and required local Māori to provide the land and fund the teacher's salary. If children spoke Te Reo Māori they were often hit or punished physically. This occurred right up until the 1980s[71] (Native Schools Act 1858). To hasten assimilation, school was made compulsory for Māori children in 1894.

Impact of Colonisation

The legacy of colonisation includes a horrific history of systemic and institutional discrimination and has led to continued poor health and wellbeing outcomes for Māori. Māori are twice as likely to experience racial discrimination over their lifetime, three times more likely to have experienced unfair treatment on the basis of ethnicity, and more than twice as likely to have experienced an ethnically motivated physical attack. In 2013, 23.5% of Māori lived in a decile 10 area (most- deprived). Māori make up 52% of the prison population and

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[71] My kuia's first language was Te Reo Māori, and recalls being physically hit for speaking Te Reo Māori at school when she was a child

45% of the offenders convicted but not jailed. Māori have a low rate of school completion and high rates of unemployment. Māori are more likely to receive income support and live in over-crowded rental accommodation. In 2018, it was reported that 28.8% of the homeless population in Aotearoa-New Zealand were Māori (The Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi, 2016).[72]

In 2013, the Māori population was only 14.9% and by 2023, that number had risen to 19.8% (Stats NZ - Tatauranga Aotearoa, 2024). Despite being a minor percentage of the overall population of Aotearoa, Māori are continuously overrepresented in many health statistics. Māori have significantly higher rates of cancer, diabetes, cardiovascular disease, asthma, and experience higher rates of disability. We are more likely to be hospitalised and die from chronic diseases, but less likely to access healthcare for treatment. Māori males are expected to die 7.3 years earlier than non-Māori men, and Māori women die 6.8 years earlier than non-Māori women. We are two and a half times more likely to die from preventable and treatable diseases. Māori are 3.3 times more likely to smoke and have the highest rate of hazardous drinking compared to other ethnicities (Ministry of Health - Manatu Hauora, 2023; New Zealand Ministry of Justice, 2023; The Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi, 2016). It is important to note that although these statistics have been included to highlight the effects of colonisation on Māori, and they do not accurately represent the whole picture. At every step Māori have fought back.

Part 4 – Ka Whawhai Tonu Mātou

Ake, Ake, Ake!

Despite the extensive colonial assimilation that has affected Māori, we have continued to fight for our rights and our culture. Māori continue to exercise traditional values and mātauranga Māori within our communities and revitalise Te Ao Māori for future generations. Modern and contemporary rangatira have led this fight in various sectors and disciplines including politics, land, language, education, and health. What follows is a selection of key moments in our history that demonstrate the extensive efforts of Māori to maintain our rangatiratanga, and mana motuhake in the face of systemic discrimination and marginalisation.

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[72] All of the above paragraph is from this source – WAI2575 claim

Politics

In 1858, the Kiingitanga Movement[73] was established as a 'for Māori, by Māori' governance body to lead and protect Māori affairs. The Kiingatanga has been instrumental in creating unity and a rallying point for Māori (Papa & Meredith, 2012). In 1868, the *Māori Representation Act* gave Māori four parliamentary seats and was the first insertion of Māori into Pākehā governance systems. Māori MPs (members of parliament) such as Apirana Ngata, Māui Pōmare, James Carroll, Matiu Rata, and Iriaka Rātana were instrumental in fighting for equal representation of Māori under the Crown, as promised in Te Tiriti o Waitangi (NZ Parliamentary Library, 2009). In 1962, the *Māori Community Act* established the New Zealand Māori Council as a policy making and advisory body on matters affecting Māori (e.g. Te Tiriti o Waitangi and raupatu). The Council would later take the government to the high court after they announced that they were transferring state assets into state owned enterprises, which would potentially exclude such assets from the Treaty of Waitangi claims (Manatū Taonga — Ministry for Culture and Heritage, 2024a).

In 1980, Matiu Rata left the Labour party and founded Aotearoa-New Zealand's first Māori political party - Mana Motuhake o Aotearoa. The aim of the party was to unify Māori and gain 'political potency' as illustrated in the sections below. In 1989, the government of the day extracted a set of principles from the Treaty of Waitangi. The aim was to clearly define what the Treaty of Waitangi meant for statute law and aided government decision-making. This was particularly relevant as this was the first of many attempts to define what the Treaty meant for Aotearoa-New Zealand (NZ Parliamentary Library, 2009).

Land

During the 1860s, Māori displaced by colonisation and raupatu were drawn to Parihaka, a small but growing Māori settlement established by Te Whiti o Rongomai and Tohu Kākahi in the Taranaki region. This village was the first peaceful protest occupation that stood against the theft of Taranaki land. In 1881, Pākehā invaded Parihaka and men and women were abused and imprisoned without trial. Despite this, the village survived and still exists to this day (Manatū Taonga — Ministry for Culture and Heritage, 2021g).

The Native Lands Act 1862 and *1865* established the Native Land Court and enabled the conversion of communal Māori land into individual title. In time, as more Māori gained

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[73] The Māori king movement/monarch in Aotearoa

higher education, they replaced barristers, solicitors, and judges (Manatū Taonga — Ministry for Culture and Heritage, 2021a; Taonui, 2012). *Te Ture Whenua Māori Act 1993* then created significant restrictions on the transfer or sale of Māori land. This law required the Māori Land Court to promote continuous Māori land ownership for whānau, hapū, and iwi. Raising awareness of ongoing land loss, in March 1975 at the age of 79, Dame Whina Cooper led 5,000 supporters in a land march from the top of the north island to parliament in Wellington. She coined the phrase "not one acre more" and delivered a petition of 60,000 signatures (Manatū Taonga — Ministry for Culture and Heritage, 2021f).

In October 1975, the Waitangi Tribunal was established to hear claims from Māori on breaches of Te Tiriti o Waitangi. As of 2015, Māori submitted 2,501 claims in total, and of these claims 1,028 have been reported on fully or in part (Treaty of Waitangi Act, 1975; Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi, 2020). In 1977, the 506-day occupation of Bastion Point occurred, led by Joe Hawke. The occupation protested the unjust taking of Ngāti Whātua land by the Crown. Other significant protests around this time include the Raglan Protest in Whaingaroa (1975-1978), Pākaitore in Whanganui (1995), Te Kurī a Pāoa near Gisborne (2002), Ngawha in Northland (2003), and Ihumātao in South Auckland (2016-2020) (Keane, 2023).

In 2004, the *Foreshore and Seabed Act 2004* was passed which declared that the Crown owned Aotearoa-New Zealand's foreshore and seabed and created restrictions on the use of these spaces. This sparked an uproar amongst Māori and 40,000 people marched from Northland to Wellington parliament to fight for the rights of Māori as tāngata whenua. It was during this event that The Māori Party was born when Tariana Turia left the Labour Party in protest at her party's deplorable actions. Te Pāti Māori (previously The Māori Party) continues to support Māori in their determination for transformational change (Leahy, 2015). In 2011, after extensive efforts by lawyers and activists to reclaim Māori rights to land, the *Takutai Moana (Marine and Coastal Area) Act 2011* was passed and declared a 'no ownership' regime on the foreshore and seabed. This repealed the 2004 Act and restored the right of Māori to seek customary rights.

Te Reo Māori

In 1970, the Māori activist group Ngā Tamatoa was formed, and were instrumental in fighting for Māori rights. They were advocates against racism and discrimination and led nationwide petitions, walk-out protests, marches, and made many submissions to the government for Māori language recognition and the return of Māori land. In 1972, the Victoria University's

Te Reo Māori Society, the New Zealand Māori Students Association, and Ngā Tama Toa delivered the landmark Te Petihana o Te Reo Māori - The Māori language petition, to parliament. Thirty thousand people signed this petition in support of Te Reo Māori being taught in schools, and broadcast on television and radio. A Māori Language Day was introduced later that year, and in 1975 this was expanded into a Māori language week and continues celebrated still to this year (NZ Parliamentary Library, 2022).

In 1985, the first Kura Kaupapa Māori[74] was established at Hoani Waititi marae[75] without government funding or support. This was a milestone in the Māori revitalisation movement, and the first of many full immersion Te Reo Māori schools that taught and practiced Māori language, philosophy, and customs. In 1983, the first Māori-owned Māori language radio station 'Te Reo o Pōneke' aired. In 1987, Te Reo Māori was made an official language of Aotearoa-New Zealand and in 2004, Māori television began broadcasting (Higgins & Keane, 2013).

Hauora

In the late 1890s, Tā Apirana Ngata led the Māori health movement that pushed for improved health in Māori communities. Alongside James Carroll, they passed the Māori Councils Act 1900 which allowed Māori to have a say in the health functions of local council (Lange, 2011a). In 1899, Māui Pomare (1875-1930) was the first Māori to complete a medical degree. After qualifying abroad, he came home and became the first Māori Minister of Health in 1923. Dr Te Rangi Hīroa (1877-1950) worked alongside Dr Pomare as an assistant of 'native health'. Together they met with rangatira throughout Aotearoa and educated communities on sanitary public health practice and conditions. The involvement of Māori at these levels allowed Māori to make decisions around their own health to better benefit their communities (Lange, 2011b).

Te Puea Hērangi (1883-1952) was a granddaughter of Tāwhiao Te Wherowhero, the second Māori King. There are many stories about what she achieved in her lifetime, including her selfless service to her people during the 1819 flu pandemic. During this time, she and her sister cared for and sheltered over 200 people of Mangatāwhiri village. Following the pandemic, she then gathered and cared for 100 orphans and elderly. Together they built Tūrangawaewae marae, including a carved house named Māhinaarangi that was intended to

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[74] Māori language full immersion primary, intermediate and high school

[75] Open area in front of the wharenui, where formal greetings and discussions take place

be a Māori hospital. Te Puea's dream to open a hospital and reclaim the health and wellbeing of her people has not been forgotten, and inspired the founding of Raukura Hauora o Tainui in 1991, a charitable trust that delivers kaupapa Māori health and wellbeing services (Parsonson, 1996).

During urbanisation in the 1950s, Māori women came together and established the Māori Women's Welfare League to support Māori women and children in health, education, and Māori culture. Dame Whina Cooper (1895-1994) was elected as the first president. This organisation continues to support the health and wellbeing of women and their whānau across Aotearoa. The Māori Women's Welfare League now has over 2,500 members in both Aotearoa-New Zealand and Australia (Manatū Taonga — Ministry for Culture and Heritage, 2024b).

Sir Mason Durie (born 1938) is a prominent psychiatrist, psychologist, doctor, a respected academic and Māori leader. He is well known for his contribution to Māori health and is widely recognised as the creator of the Te Whare Tapa Whā Māori model of health that promotes holistic wellbeing, and Te Pae Mahutonga, a Māori health promotion framework. Sir Mason Durie continues to work tirelessly for better health outcomes for Māori in Aotearoa and was closely involved in the establishment of Te Aka Whai Ora, the Māori Health Authority (see below) (Blake - Inspiring Environmental Leadership, 2024).

Irihāpeti Ramsden (1946-2003) is commonly known for the development of a health-based education framework on cultural safety named Kawa Whakaruruhau (Ramsden, 1993). In 1992, her approach was implemented into the nursing and midwifery curriculum which made it compulsory for healthcare staff and organisations to recognise the historical, social, and political impacts of Māori culture on health disparities in Aotearoa-New Zealand. This patient-centred cultural safety framework was met with much controversy because it challenges the patient-provider relationship but is common practice in nursing to this day and is taught in nursing programs (Ellison-Loschmann, 2003).

Before she retired, Tariana Turia (born 1944) was a politician, a founding co-leader of The Māori Party, and an associate Minister of Health. She is well known for her stance on the *Foreshore and Seabed Act 2004* (see above), and was instrumental in the creation of Whānau Ora, a framework that aims to put whānau at the centre of change to improve better health outcomes for their whānau, hapū and iwi. Concerned about tobacco-related illness and disease, which is highest for Māori, Tariana Turia also brought to parliament the Smokefree

Environments Bill and was/is a firm advocate of the ‘smokefree Aotearoa by 2025’ vison (Lane, 2015).

Current Governments

More recently, Māori continue to forge ahead and are succeeding in many areas. The number of Māori (and non-Māori) speaking Te Reo Māori is increasing. In 2021, the census recorded that 23% of New Zealande first language was Māori, and 3 in 5 Māori agree Te Reo Māori should be taught in schools (Stats NZ - Tatauranga Aotearoa, 2022). In 2023, the Labour government made Aotearoa-New Zealand history compulsory within the education curriculum. That same year, the government established Māori wards, which enabled Māori representatives to be elected on local/district councils to ensure Māori were present at the decision-making table. In 2022, the government passed the *Therapeutic Products Bill* which along with other guidelines, allowed the regulated supply and use of rongoā Māori to support the health of all New Zealanders. In the same year they also passed a world-first *Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Act* which would end the sale of tobacco to anyone born after 2008. They also erected and established Te Aka Whai Ora – The Māori Health Authority. The aim of Te Aka Whai Ora is to make transformational change to the way the entire health system understands and responds to the health and wellbeing needs of whānau Māori. This authority was the first of its kind and was specifically put in place to create more equitable health outcomes for Māori.

However, at the time of writing this thesis (2024), a new National-led coalition government has been elected to power. They have quickly jumped to omit and repeal previous laws that aimed to support and provide equitable outcomes for Māori. Already, this government has disestablished Te Aka Whai Ora, repealed the *Smokefree Environments and Regulated Products Amendment Regulations*, and reversed the names of government agencies to prioritise English names. They plan to repeal the decision to teach Aotearoa-New Zealand history in schools and section 7aa of the *Oranga Tamariki Act (Vulnerable Children's Act) 1989*, which declares that the organisation has a responsibility in regard to the principals of Te Tiriti o Waitangi, which includes connecting tamariki Māori to their whakapapa and whānau. They also intend to pass the *Fast Track Approvals Bill* which will allow environmental development projects to be approved by a government appointed ‘board’ of three MPs, without consultation of tāngata whenua, heritage, and environmental experts. They have proposed the Treaty Principles Bill which aims to redefine the articles/principles of Te Tiriti o Waitangi. Their new principles declare that the government has the power to govern **all** New Zealanders, their property, interests, and land. In doing so, they aim to rewrite the meaning of the original document and the principles defined by the previous government in 1989 (The ACT Party, n.d.).

There has been much controversy and protest against this new government. Their actions portray an anti-Māori agenda that aims to eliminate the rights Māori have as Indigenous people of Aotearoa. The continued attacks on Māori by this government has led to much disapproval by not only Māori but other cultures and ethnic groups in Aotearoa-New Zealand (Davison, 2024). In response, Te Pāti Māori[76] have been instrumental in the orchestration of several nationwide 'activation days' which thousands of New Zealanders have attended. The late Māori King – Kiingi Tuuheitia Pootatau te Wherowhero te Tuawhitu - also called several 'kotahitanga' hui[77] which Māori leaders, iwi, and hapū have attended in order to talk about a way forward for Māori (Stewart, 2024). In this sense, colonisation is still very much present. However, I am proud of how established and equipped Māori are now to continue this fight.

Ka whawhai tonu mātou, ake, ake, ake![78]

Summary

In summary, I believe the history of Aotearoa-New Zealand and the context for this research is complex. The purpose of this chapter was to outline our origin story, the pre- and post-colonial history of Aotearoa-New Zealand, and elevate Māori achievements with a focus on health, well-being, and maternity. I feel that this extensive examination of history was necessary because it hints to the origins of different social and societal norms and concepts that still exist today (and are very present in health). This chapter can be a story of colonisation and death, but it can also be a story of courage and resilience against all odds.

Inspired by the mana wāhine[79] in my life and the values I apply to this research, the next chapter presents my methodological framework - Te Ira Wahine.

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[76] Māori political party

[77] Gathering, meeting, or assembly of many in unity

[78] This is a whakatauki, that has been prominently used throughout history in protests that advocate for Māori rights. The direct translation is: "We will fight on forever, and ever, and ever."

[79] Powerful/self-determined woman

CHAPTER 3 METHODOLOGY

Given that methodology is the theory about how research should be conducted (Merriam, 2002), which includes the literature review (G. H. Clarke, 2020), this chapter precedes my review of literature.

For clarity, the methodology/research approach for this study was established by the Steering Group (see Chapter 5) before I was employed as the research assistant. This group consisted of kaupapa Māori researchers including members of the Te Whatu Ora Waikato Māori research team, therefore, a kaupapa Māori approach was chosen. When I decided to conduct this research as my Masters of Health, I then became the associate investigator, and the lead investigator became my supervisor; stepping back to allow me to design and employ my own research framework.

Introduction

This chapter presents my kaupapa Māori methodological framework – Te Ira Wahine in three parts. In Part 1, I briefly explore the concepts of methodology and kaupapa Māori. Part 2 outlines my inspiration for my framework; where 'te ira wahine'[80] derives from, and the six mātāpono[81] that make up this framework. While Part 3 concludes this chapter with how my framework was applied to the research as a whole.

Part 1 – Kaupapa Māori Methodology

Kaupapa Māori

'Kaupapa Māori' is not easily defined. There are many interpretations of what kaupapa Māori is, and the best way in which to describe it. Professor Leonie Pihama offers one definition that resonates deeply with me, she explains that kaupapa Māori is the basis and foundation of all that is Māori, "...its origins are our origins. Its foundation is our foundation. Its ukaipō[82] is our ukaipō. Kaupapa does not exist separate from all that is Māori" (Pihama, 2022, para. 8). In other words, kaupapa Māori is the Māori worldview and there are embedded beliefs, epistemologies, and protocols that need to be considered. Likewise, Professor Linda Tuhiwai Smith (2011) describes kaupapa Māori as "…a way of being; a way of knowing; a way of seeing; a way of making meaning; a way of being Māori" (p. 10). Moreover, kaupapa Māori

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[80] Feminine essence or bloodline

[81] Principle and values

[82] Source of sustenance

is unique to Māori; an extension and expression of who we are and the way in which we conduct ourselves based on our worldviews.

Methodology

Methodology is the theory about how research should be conducted (Merriam, 2002). L. T. Smith et al. (2016) explain, "…in its simplest form, methodology explains the pathways between knowledge creation and knowledge production – the formation of knowledge" (p. 140). Kaupapa Māori adopted as research methodology brings tikanga Māori and epistemology to the forefront, which is not often brought to light. Meaning that kaupapa Māori methodology provides a vehicle for the application of kaupapa Māori in research.

L. T. Smith (2015) provides five key principals for kaupapa Māori methodology:

1. Principle of Whakapapa

This principle is a caution to researchers that identity is complex, and whakapapa is sacred. Colonisation has led to debates and feelings about who is 'Māori enough' and controversy between iwi. Therefore, it is important to understand the possible political and psychological effects of research with Māori including data collection and funding. Whakapapa is also about trust; when shared between researcher and participant whakapapa opens a wider scope of understanding and connection.

2. Principle of Te Reo Māori

This principle speaks to the importance of Te Reo Māori. Through colonisation there has been a loss of language, knowledge, and identity for Māori. However, through the resurgence of Te Reo Māori and success of Kura Kaupapa and Kohanga Reo,[83] it is now more important than ever to integrate Te Reo into the research process. As an example, L. T. Smith (2015) states, this can be "...exercised in the development of better-quality bilingual resources, consent forms and information sheets and the employment of researchers who are skilled in this area" (p. 49).

3. Principle of Rangatiratanga

This principle is about power and relationships between researchers and participants and Māori and non-Māori in research. L. T. Smith (2015) encourages researchers to think about

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[83] Māori language pre-school

the relationship Māori have to research and how restoring Māori rangatiratanga ensures that Māori are no longer the object or subject in Pākehā research. To help researchers with this, L. T. Smith (2015) encourages researchers to consider the following questions:

- What research do we want to carry out?
- Who is that research for?
- What difference will it make?
- Who will carry out this research?
- How do we want the research to be done?
- How will we know it is a worthwhile piece of research?
- Who will own the research?
- Who will benefit? (p. 50)

Growing out of the struggle for decolonisation, another significant dimension of kaupapa Māori research is the analysis and critique of power (Mahuika, 2008). A common kīwaha[84] is that kaupapa Māori research is 'by Māori, for Māori'- meaning being Māori and Māori ways of being are at the centre of kaupapa Māori research. Kaupapa Māori being at the centre of research stands in contrast to early research and studies that put colonisation and the coloniser at the centre by focusing on what they have done or are doing to Indigenous peoples. More recently, however, some Māori academics such as G. H. Smith (2003) argue that "...putting Māori at the forefront of consideration... takes a more proactive and positive stance in the advancement of Māori aspirations and interests" (p.2). L. T. Smith (2021) also explains that while activism is still important, we need to "... 'let go' of ... the coloniser that occupies our minds, in order to let Indigenous knowledge and values back in" (p.192). With this in mind, through this research I have adopted Chilisa's (2019) approach of being 'sensitive to power' rather than putting the coloniser at the centre.

4. Principle of Mana Wahine: Mana Tāne

This principle speaks to the importance of gender balance, bias, and roles in research. It encourages researchers to recognise stigma and stereotypes that have been prominent throughout Māori history and present today and be aware of hidden agendas (L. T. Smith, 2015). Additionally, an equity-focussed lens may be appropriate to mitigate the marginalisation of women's stories (e.g. heroism narrative of Māui). For example, we invited

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[84] Phrase or idiom

and supported fathers to participate in this study but remained conscious that as carriers of the whare tāngata, the māmā ultimately held the mana in the first instance.

5. Principle of Tikanga

The principal of tikanga refers to the right and wrong way to conduct research. According to L. T. Smith (2015), this is often an area where researchers need training, and where discussions need to be had within the research team. Using tikanga as a guide in kaupapa Māori research is important, however, L. T. Smith (2015) states that there is no one “formula or recipe” (p. 49), because tikanga differs within and between iwi and hapū.

To help guide researchers, however, L. T. Smith (2012) has developed a set of six ethical principles to consider:

- Aroha ki te tangata (a respect for people)
- Kanohi kitea (the seen face, that is present yourself to people face to face)
- Tītiro, whakarongo … kōrero (look, listen … speak)
- Manaaki ki te tāngata (share and host people, be generous)
- Kia tūpato (be cautious)
- Kaua e takahia te mana o te tāngata (do not trample over the mana of people)
- Kia māhaki (don’t flaunt your knowledge). (p. 124)

Summary

To summarise, kaupapa Māori methodology is an approach to research that is conducted for Māori and by Māori. However, not all kaupapa Māori methodologies are the same because not all Māori are the same. The reality of subjectivity and diversity means that kaupapa Māori is fluid and therefore unique, and that is the beauty of kaupapa Māori research. Kaupapa Māori scholars have provided a foundation to support and guide kaupapa Māori researchers in their endeavours.

In the next section, I present my kaupapa Māori methodological framework, which embodies the values that have been passed down to me and the principles of kaupapa Māori methodology. Given the topic of this research – young mothers healthcare experiences throughout hapūtanga,[85] a mana wāhine framework is most appropriate.

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[85] Pregnancy

Part 2 – My Methodological Framework

Ōku Māreikura[86]

He wahine, he whenua, e ora ai te tangata!

This whakataukī speaks of the importance of women and as the givers and keepers of life. It highlights the connection women have to Papatūānuku, and how we together sustain the continuation of life. Many people interpret whakataukī differently, but for me this whakataukī speaks of my whānau, my upbringing, and the values I was raised with – my kaupapa Māori.

I descend from a long line of mana wāhine. Not the 'sign holding, protesting type' or the 'leader of the haka group' type, but the 'doesn't need to say much and everyone can tell what you're thinking so don't mess with her' type. My sister and I were lucky to be raised by three generations: our kuia,[87] our nana, and our mum. There are a lot of wāhine in my family and a very 'maternal wairua'[88] that is often present, meaning there was often no stigma around having children young. It wasn't until my kuia passed that I realised how lucky I was to be raised by three generations of women.

My kuia was the matriarch of our whānau and kept everyone in check. She was strict and sometimes harsh but loved you to pieces. She was the 'slip money in your pocket' and the 'wrap a tin of biscuits for your Christmas present' type kuia. She was the most wise and knowledgeable person I have ever known. My sister and I would sit at the end of her bed for hours just talking about everything and anything. And every now and then she would drop a 'gem' from her childhood or share more whakapapa that we hadn't yet heard before. As little girls, she would take us to Waitangi for the Tribunal hearings and take us to different marae hui. She was sharp, she stood her ground, and often went against the grain – when others said yes, she would say no. She sat on the taumata[89] at our marae and her expressions would tell you if you had done something wrong - no words needed. She loved her family; we were everything to her and she was everything to us. She instilled in all of us, her knowledge, strength, resilience, courage, and mana. These are the things we will never lose or forget.

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[86] Māreikura are esteemed women, very special, and often matriarchs – in this case I am referring to my kuia, nana, and mother

[87] Great-grandmother

[88] Non-physical spirit

[89] A group or bench of speakers that talk and welcome people onto a marae – it is not common that women sit on taumata but my kuia was special

I see these traits in our nana as well, our kuia's eldest daughter. She is the family organiser, and the type of person you go to if you need something done. Like us, she was also dragged along to the Waitangi Tribunal claims hui, often as our kuia's driver or scribe. However, my nana has a softer side than my kuia. She's a great listener, gives great advice, and is always happy when her mokopuna[90] are around. As children she absolutely spoilt us, as any nana does; she'd buy us clothes, lollies, and loved baking for us. She is the caring, protecting, nurturing mana wahine in our whānau.

I believe my mum is a combination of both our kuia and nana; their values are demonstrated in my mum's love for helping people, caring for the moana,[91] and protecting her whenua. She raised my sister, brother, and I by herself and worked really hard all our lives to make sure we never 'went without.' She is the smart, kind, resilient, and adventurous type mana wahine in our whānau.

These three wāhine have passed down to me the values that have formed my worldview and influenced how I live my life. I am an extension of them and the many mana wāhine before them. These wāhine have taught me four key lessons I want to share with the reader; one, you can do anything you set your mind to; two, always do what's tika and pono;[92] three, always spread love; four, always stand up for yourself. They have shaped me into the kōtiro[93] I am today, and nurtured, protected, and cared for me so I am able to pursue my dreams.

"Kia ū ki te tika me te pono" is a phrase that my kuia would say to me, which means holdfast to what is right and true. This to me is a taonga tuku iho - a treasure passed down to me by my ancestors. There are many things that get passed down through generations and families, these can be physical and non-physical; some are chants such as oriori, some are physical taonga such as pounamu,[94] or in my case, values.

These women and the values they have passed down to me have provided the foundation for this kaupapa Māori methodological framework.

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[90] Grandchild(ren) Moko can also mean tradtional Māori tattoo

[91] Ocean, seas, waters

[92] Right and true to your heart

[93] Girl

[94] Jade or greenstone – often lashed with rope to form a necklance

My Stance

My framework emphasises the need for research that empowers and uplifts wāhine Māori. Te Ira Wahine celebrates the essence of mana wāhine, the whare tangata, and the innate nature of women. However, whilst giving birth and child-rearing is important, I acknowledge that not all wāhine want to or can give birth. Whāngai[95] is also a common concept within Te Ao Māori, which allows māmā to nurture pēpi birthed by other mothers.

The collection of mātāpono within the Te Ira Wahine framework highlight the different qualities that we as wāhine Māori possess and those that are unique and represented within my whānau. My position is that we as wāhine possess all the elements that are present in the natural world, however, there are times when some elements reveal themselves more than others, and characteristics will be stronger in some wāhine more than others.

What is Te Ira Wahine?

My Te Ira Wahine Framework is rooted in my lived experiences and the influence of my kuia, nana, and mum. The term ‘te ira wāhine’ directly translates to ‘the feminine/woman gene/essence.’ It also refers to the essence of womanhood, which includes the unique qualities and crucial role of women within Māori society as child bearers, leaders, nurturers, and guardians. Te ira wahine describes the interconnectedness of wāhine to their whānau, hapū, and wider iwi as well as their connection to land, traditions, and tikanga. This lineage concept connects atua wāhine such as Papatūānuku and Hineahuone, to my kuia, and then to me, and emphasises that we as wāhine descend from greatness, pure strength, and divine femineity. In acknowledging the strength of wāhine, this framework is a continuation of Mana Wāhine and Atua Wāhine research methodologies and pays homage to the many scholars who have paved the way for novice researchers such as myself (e.g. Leonie Pihama, Linda Tuhiwai Smith, Ngahuia Murphy, Ngahuia Te Awekōtuku).

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[95] Meaning to feed, nourish, or to foster – usually refers to feeding or looking after a child that you did not birth physically

My Te Ira Wahine Framework

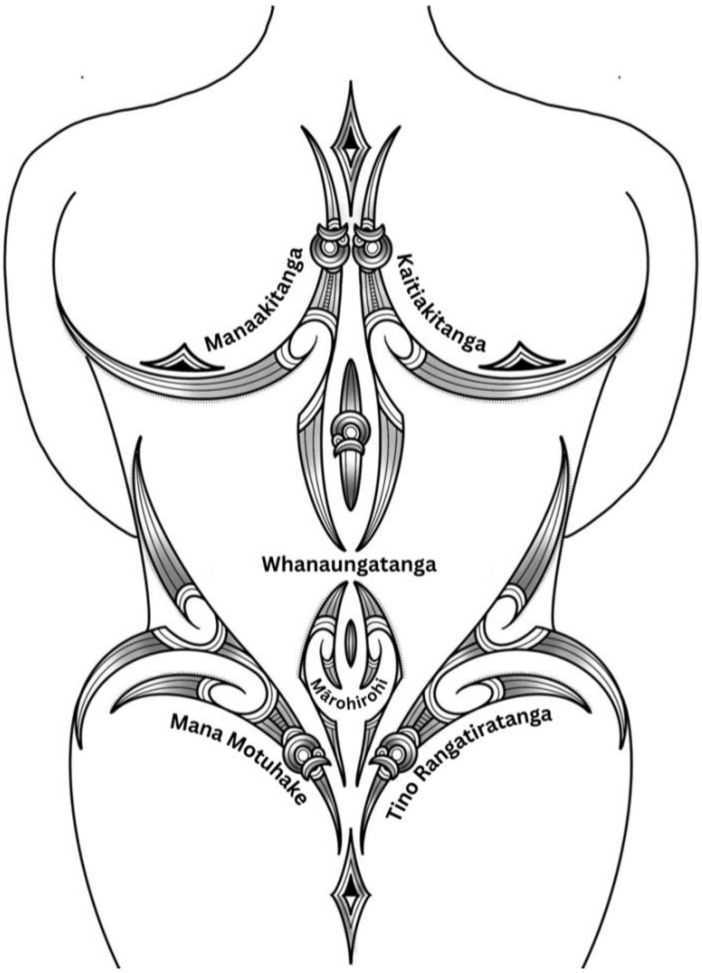

Figure 1: Te Ira Wahine framework designed by Te Okiwa Morgan

Above is the physical representation of my Te Ira Wahine framework. Te Ira Wahine consists of six mātāpono: Manaakitanga, Kaitiakitanga, Whanaungatanga, Mārohirohi, Mana Motuhake and Tino Rangatiratanga[96] that collectively are applied to this research as my methodology. This framework showcases the innate values and belief systems that I was brought up with. It highlights the values that run through the bloodline of wāhine Māori and encompass our connections to each other and to our tupuna.

These mātāpono are represented in the torso of a wāhine to represent the mana, strength, and power of wāhine while highlighting the notions of pregnancy, birthing, giving-life, child-rearing and overall femininity. This traditional Māori design has a very intrinsic and special

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[96] The words in this list have either been defined previously or are to be defined on this page. Also, when referring to the mātāpono of this framework the values will be **capitalised** to show they are the name/pronoun of each component, however, when speaking generally about values they will be lowercase

meaning and was made specifically for this project. In this piece you will see four manu[97] which acknowledge my whakapapa to my hapū of Ngāti Manu and the importance of whakapapa in this narrative. Manu also represent strength, guidance, and protection which are very relevant to the role of wāhine.

In the upper half of the design are two manu coming together, the top left represents the Manaakitanga mātāpono and the top right represents the Kaitiakitanga mātāpono. Manaakitanga is the caring, respectful, nurturing, and hospitable characteristics of wāhine. These values are seen in the maternal nature of māmā and their empathy and compassion towards others. Kaitiakitanga symbolises the trusting and guiding nature of wāhine. This value is about protection of your whānau and preservation of the environment, as well as the protection of mātauranga Māori and tikanga.

The lower half of the design features two more manu facing downward and represent the mātāpono Mana Motuhake and Tino Rangatiratanga. Mana Motuhake and Tino Rangatiratanga are different concepts but are also one in the same. Mana Motuhake is the autonomy, control, and determination of oneself and one’s destiny, while Tino Rangatiratanga refers to control, power, and sovereignty over land, affairs, and people (i.e. the physical). Both values symbolise the attributes of independence, control, self-determination, and authority that are within us as wāhine Māori. The placement of these two manu on the hips and pointing towards the whare tangata and vagina represent the power, control, and strength wāhine have particularly during childbirth and pregnancy.

The design in the centre is a mangopare or hammerhead shark figure and represents Mārohirohi. Like the nature of hammerhead sharks, Mārohirohi is the principle of strength, bravery, and resiliency. In times of hardship and during labour, this perseverance is exercised. Mārohirohi also represents the whare tangata which includes the pito and reproductive organs.

Whanaungatanga is represented by all four manu and the six koru[98] within the design. Whanaungatanga signifies the connection and reciprocal relationship wāhine have to all things including whenua, whānau, pēpi, and atua. The relationship and placement of all four manu and the koru represent interconnectedness, relational values, and embodies new growth and learnings.

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[97] Bird(s)

[98] Coil but often referred to as the inner section that sprouts from a native fern tree

The two oval spheres are kākano or seeds. The top kākano is located between the Manaakitanga and Kaitiakitanga manu to represent the concept of parenting and the sharing of sacred mātauranga. The two diamonds placed at the top and bottom of the torso represent whakapapa and the bloodline. The placement of these diamonds signifies the passing down of knowledge and values from a tupuna to a tamaiti[99] or mokopuna – which is the key concept of Te Ira Wahine, the passing down of values.

Part 3 - Application of Te Ira Wahine Framework

My Te Ira Wahine framework embodies the strength of our atua wāhine and our taonga tuku iho. This framework is my kaupapa Māori, meaning it is based on my worldview and guides my research process. However, it can also be adopted and adapted by other kairangahau[100] to fit their values, that is the beauty of kaupapa Māori methodologies. In this section, I describe the application of Te Ira Wahine, in partnership with L. T. Smith's (2015) key ethical principles for research and kaupapa Māori methodology considerations.

Manaakitanga

(care, compassion, nurture, maternal, empathy, hospitality)

In research, Manaakitanga intersects with the kaupapa Māori principle of 'Tikanga' and the ethical principles of 'Aroha ki te tangata', 'Kia tūpato', 'Kanohi kitea', and 'Manaaki ki te tāngata' (L. T. Smith, 2012).

Applied to this research, Manaakitanga was relevant at any stage where I was engaging with people. This included recruitment, data collection, analysis, dissemination, and presentation of findings. Manaakitanga was applied overall by having a caring, respectful, and attentive attitude when talking, engaging with, and listening to my participants. Inviting pāpā[101] to be a part of this study is also an expression of Manaakitanga, because in relation to 'Mana Wāhine: Mana Tāne' it is important to have balance (L. T. Smith, 2015). All engagements were conducted kanohi-ki-te-kanohi[102] to ensure genuine respectful interactions, which also included my punctuality in meeting with the participants at a time and location that suited them and following their pace. During the data collection stage, Manaakitanga and 'Kia māhaki' (L. T. Smith, 2012) meant acknowledging the participants as the experts.

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[99] Singular child (tamariki is many children)

[100] Researcher(s)

[101] Father(s)

[102] Face to face

Manaakitanga is understanding that the kōrero[103] shared was based on trust and that data/kōrero/mātauranga is a taonga that should be treated with care, respect, and confidentiality. Koha[104] was also given to participants to thank them for their contribution to the kaupapa.

Kaitiakitanga

(guidance, protection, nurture, preservation, trust)

In research, Kaitiakitanga encompasses the kaupapa Māori principles of 'Whakapapa', 'Tikanga', 'Rangatiratanga', 'Te Reo Māori' and several of the ethical principles of research (L. T. Smith, 2015).

In this study, the principle of Kaitiakitanga was particularly relevant in terms of protecting the mana and wairua of the participants and all others involved (Aroha ki te tangata). Kaitiakitanga also includes confidentiality, privacy, and data protection protocols to ensure all participants' information is protected and safe. Participants were encouraged to bring whānau, partners, and friends as support to create a safe and comfortable environment. Care was taken to uplift and protect the mana of everyone involved in this project by having a mana-enhancing attitude and approach during verbal and physical communications (Kaua e takahia te mana o te tāngata, Kia tūpato).

Kaitiakitanga in engagements was also about having a heightened awareness of the participants lives; the extra stresses that come with being a young person, a parent, running a household, and studying in a society where there's stigma around their identity (Tītiro, whakarongo … kōrero) (L. T. Smith, 2012, 2015). Using Te Reo Māori, including karakia, and taking kai[105] and koha were important methods used to uphold the principles of 'Tikanga' and 'Te Reo Māori.'

'Whakapapa' was important during participant engagements, by sharing and understanding each other's whakapapa and using mihi to acknowledge the whānau of the participants. Regarding 'Rangatiratanga', participants had the power to talk about the topics they thought were important. They also had the choice not to answer questions if they so wished, and ultimately, they held the mana in all conversations and creative processes (Kia māhaki) (L. T. Smith, 2012, 2015). In the literature review, Kaitiakitanga was also important in the

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[103] Words, to speak or tell

[104] Gift, offering, or contribution – usually give in reciprocation of anothers contribution

[105] Food(s)

preservation of other scholars' ideas, the protection of mātauranga Māori, and giving all literature an equal chance.

Whanaungatanga

(connection, reciprocity, relationships)

In research, Whanaungatanga overlaps with the kaupapa Māori principle of Whakapapa and the ethical principle of 'Kanohi kitea.' In this project, Whanaungatanga was exercised in many ways. This includes the custom of introducing oneself to (and continuously building the relationship with) new people and finding common connection with them before getting into the work at hand (Kānohi kitea). Whanaungatanga and Whakapapa also means being conscious and aware that I am a representation of my tupuna and whānau (L. T. Smith, 2012, 2015).

Whanaungatanga in application helped to establish trusting relationships, in which participants felt comfortable sharing their experiences and opinions. This highlights the argument that in qualitative research, the quality of the findings is directly related to the calibre of the researcher. Like many others, Anderson (2010) highlights that the overall research quality is heavily dependent on the individual skills of the researcher and thus can also have consequences on the information received and the retention of participants.

In the literature review, Whanaungatanga was used to find 'relationships' between sources, between scholars, and to understand patterns and connections. One example of this was reference mining. During the analysis phase, the concept of Whanaungatanga was applied to finding patterns and connections in and between participant kōrero and identifying themes.

Mārohirohi

(strength, resilience, bravery, perseverance)

In research, Mārohirohi overlaps with the kaupapa Māori principles of 'Rangatiratanga', 'Mana Wāhine: Mana Tāne', 'Tikanga' and the ethical principles of 'Kia tūpato', 'Kaua e takahi te mana o te tāngata', and 'Aroha ki te tangata' (L. T. Smith, 2012, 2015).

In this project, taking a strengths-based approach – meaning using alternatives to perhaps traditional methods to refrain from allowing deficit narratives and negative labelling is Mārohirohi (Maton et al., 2004). Approaching and treating the research participants as the experts (Rangatiratanga, Mana Wāhine: Mana Tāne, 'Kaua e takahi te mana o te tangata') and my tuākana,[106] provided space for the participants to exercise and express their Mārohirohi.

As a student researcher, I also experienced and developed Mārohirohi. Initially, I was nervous; about being new to research, not being a mother myself, and being accepted and trusted by the participants. However, in taking their lead (Rangatiratanga) and approaching this project in the spirit of Te Ira Wahine, everything fell into place and went well. Although, as a Māori researcher, extra Mārohirohi was needed to keep a level head and to remain professional when listening to the participants' experiences of mistreatment. Mārohirohi was also relevant during the literature review, by taking a particular interest in literature that focuses on the strengths of young parents and Māori (Tikanga, 'Aroha ki te tangata').

Mana Motuhake and Tino Rangatiratanga

(autonomy, control, self-determination, sovereignty, power)

In research, Mana Motuhake and Tino Rangatiratanga encompass the kaupapa Māori principles of 'Whakapapa', 'Tikanga', 'Te Reo Māori', 'Rangatiratanga', and 'Mana Wāhine: Mana Tāne.' The ethical principle of 'Kanohi kitea' was also applicable here (L. T. Smith, 2012, 2015).

In this study, Mana Motuhake and Tino Rangatiratanga resides with the research participants. The study was named 'Karanga Atu, Karanga Mai' because the study was initiated by the participants, this was their declaration of Mana Motuhake as they wanted to share their experiences, and we followed suit (Rangatiratanga). For example, while there was a timeframe for the research, the participants set the pace for data collection and analysis (see Chapter 5). Conducting semi-structured interviews was a key component in allowing participants to guide the direction of the narrative and they had autonomy to share the experiences they wanted to highlight. Like Manaakitanga and Whanaungatanga integrating karakia, Te Reo Māori, kai, and koha were an assertation of Māori Mana Motuhake and Tino Rangatiratanga ('Kanohi kitea').

Mana Motuhake and Tino Rangatiratanga not only applied to the research process but also the research narrative (i.e. thesis). Beginning with my personal connection to this topic (birth story/whakapapa), a detailed Context that included the pūrākau and history of Te Ao Māori

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[106] Elder of the same generation – usually older sister/brother

and ngā atua Māori (Whakapapa, Tikanga), and the constant use of Te Reo Māori throughout the thesis upheld many of these principles.

Lastly, the decision to employ a kaupapa Māori research approach, and to construct my Te Ira Wahine framework – integrating pūrākau, is a declaration of Mana Motuhake and Tino Rangatiratanga (Rangatiratanga).

Summary

In summary, the purpose of this chapter is to present the methodological framework that has been applied to this study. Te Ira Wahine is a mātauranga Māori, values-based kaupapa Māori methodology that draws on my upbringing and the core attributes my tupuna wāhine have passed down to me. Inspired by Linda Tuhiwai Smith's (2015) kaupapa Māori principles and ethical principles for research (L. T. Smith, 2012), my framework has been applied to different parts of this study. In the course of this project, I also discovered how unique kaupapa Māori research is, in the sense that it can be a reflection of the values of individual researcher.

In the next chapter, I present my literature review including and observations the current research topic.

CHAPTER 4 LITERATURE REVIEW

Following G. H. Clarke's (2020) argument that one's methodological framework should inform every aspect of one's research, including the literature review, this chapter follows the methodology chapter.

Introduction

This chapter offers my review of the literature in relation to young mothers' experiences of pregnancy, birth, and into motherhood. In Part 1, I begin with an overview of the maternity sector, explaining how birthing in Aotearoa-New Zealand has changed over time and what maternity supported in currently offered to expectant parents. In Part 2, I then provide my empirical literature search and results, and observations about participants, methods/methodology, and researcher analyses. Lastly, I outline my key takeaways from the wider research context.

Applying Te Ira Wahine Framework

As described in Chapter 3, the mātāpono in my Te Ira Wahine framework overlap and intersect with one another. In application here, this meant Mārohirohi focused my attention on literature that enhanced the mana of Māori and pays homage to the various endeavours Māori have made throughout history. Manaakitanga encouraged me to be equally open and considerate to all knowledge, perspectives and views. Whanaungatanga guided me to conduct reference mining and connect sources to better identify patterns and gaps in the literature. Kaitiakitanga guided me to protect and encourage the views of Māori, mātauranga Māori, kaupapa Māori research. Tino Rangatiratanga and Mana Motuhake in application meant, asserting myself in this chapter and allowing this framework to guide me in choosing the search criteria, selecting relevant texts, and unpacking the prominent themes in the experiences of young parents.

Part 1 - An Overview of Maternity Care

Drawing on a selection of historical literature, this section provides a context for the empirical literature review. Here, I build on the Context (Chapter 2) by offering a short history of the medicalisation of birth, a summary of important codes of conduct for health professionals, a description of services currently available to mothers, and some recent maternity statistics. This section aims to provide the reader with an understanding of how the maternity sector has developed and changed over time and the effects this has had on the people of Aotearoa-New Zealand.

Regarding the statistics in this section, my intention is not to cast a negative light on young parents but ‘simply’ state some numerical facts so the reader can better understand the Aotearoa-New Zealand maternity landscape, including the impact of a western system of health for Māori.

The Medicalisation of Birth

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 (Tupara, 2011). This proverb expresses the importance of women and their roles as mothers and keepers of life. As explained in Chapter 2 for Māori, pregnancy, childbirth, and parenthood was/is a special and celebrated time and signifies the continuation of whakapapa and growing of families, hapū, and iwi.

Māori had many birthing and childrearing traditions that often worked in parallel to the natural environment. For a labouring mother, different types of tea from native plants were used as rongoā to help with pain and contractions. Blends of native plant oils were mixed to heal birth wounds and cleanse babies' skin. After birth, different ceremonies were conducted to honour the emergence of new life, including when burying the whenua (placenta) and pito (section of umbilical cord closest to bellybutton), when naming the child, and when conducting the tohi rite. Babies often slept and were carried in different types of baskets woven from harakeke,[107] and moss such as angiangi[108] were used as nappies. Mothers breastfed for many years, however, when it was time to wean babies, mothers often applied the bitter sap of the kawakawa plant[109] to their breasts (Naomi Simmonds, 2019; Pere, 1994; Pihama & Lee-Morgan, 2022; Walker, 2022). During early colonisation, many of these traditions were still practiced.

In the early 1900s, healthcare was streamlined/systemised in Aotearoa-New Zealand, which effected Māori immensely. There was a continued introduction of new diseases, Māori were pushed into urban areas, housing conditions were poor and less sterile, and led to many unnecessary deaths (Bartholomew & Ringer, 2020; Tupara, 2011). To address the rising death

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[107] Native flax plant

[108] Native Moss to Aotearoa-New Zealand - It's known to be antibacterial, antiviral & antifungal

[109] Native leafy plant often used in rongoā - has heart-shaped leaves

rates among Māori and non-Māori, the Public Health Department and Health Board of New Zealand were established, which included the introduction of 'native health officers' who treated Māori in rural areas and advocated for their needs in political health decisions. Lay-midwives[110] provided pre-natal and birth support, whilst also staying to care for wāhine in their home in the days that followed. Rongoā and traditional birthing practices were still prominent (Tupara, 2011).

However, the *Midwives Act 1904* standardised maternity training in state hospitals[111] and established legalities and restrictions around the conduct of midwifery practice. In these institutions, midwives were trained in western birthing and midwifery care, which put a halt to lay-midwives assisting births in the community and ultimately pushed women to birth in hospitals (Bryder, 2017; Tikao, 2013).

This medicalisation of birth, along with the passing of the *Tohunga Suppression Act 1907*, meant that Māori birthing traditions were suppressed. This particular Act banned traditional rongoā Māori along with any 'tampering' or 'supernatural' practice of Māori medicine. In 1911, the Native health nurses service was established to systemise their roles, however, nurses still were able to support the health of Māori and non-Māori within the community. In 1918, the influenza pandemic hit and again stunted the population growth of Māori whānau.[112] The death rate for Māori was eight times higher than non-Māori, and in 1935, a tuberculosis outbreak killed ten times more Māori than Pākehā (Lange, 2011b).

Healthcare in Aotearoa-New Zealand was systemised incrementally. The guidelines around nursing and midwifery practice meant western medicine was favoured to meet the health needs of Māori, particularly in maternity care. However, Māori grew sceptical of this system, and those who did access care experienced several barriers: some hospitals refused to admit Māori; some doctors refused to see/treat Māori patients; Māori women refused to be examined by male doctors (almost all doctors were male at this time); and hospitals did not value cultural practices or values (Cook, 2011). In his book, *Under One Roof: A History of Waikato Hospital,* Armstrong (2009) explains that because Māori owned their land, they did not contribute to 'paying (tax)' for healthcare services:

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[110] Midwife not formally trained – they often learnt from their own experiences and experiences in assisting qualified midwives

[111] 'St Helen's hospitals' were what Pākehā called the original state hospitals

[112] The first major 'stunt' being the flu pandemic of 1819, see Chapter 2.

> Māori population presented a financial challenge to the board because Māori land was not rateable, and therefore did not generate any funds. One prominent member of the board claimed that Waikato's ratepayers should not have to carry the 'burden' of providing hospital services for Māori. (p. 50)

Despite the medicalisation of birth, most Māori women continued to birth in the community and Māori birthing traditions were still practiced, up until the 1920s. However, over time, poor living conditions, less access to rongoā, and little help from lay midwives and nurses in the community pushed even more Māori to birth in hospitals. In 1937, it was recorded that only 17% of Māori women birthed in a hospital. In 1939, medical treatment in hospitals became free and attracted more Māori. By 1947, approximately 50% of Māori māmā birthed their babies in hospital, and in 1959 this rose to 90% (Lange, 2018).

Birthing in hospitals was not positive for women generally, and Māori specifically. Hospital rules were strict, and women were treated poorly. On arrival, to ensure the most hygienic and sterile environment for labour/birth, women were stripped of their clothes, washed, given enemas,[113] and their pubic hair shaved (Pollock, 2011). They were made to give birth lying on their backs with their feet in stirrups, and placenta were disposed of immediately (Stojanovic, 2002). Fathers and whānau were not allowed to attend births, only doctors (who were predominantly men) were present to deliver the baby, and nurses assisted (Bryder, 2015). Mothers often laboured in small dark rooms, and women giving birth were often highly medicated (sometimes without their permission), and medical intervention was common (e.g., caesarean sections) Clarke (2012). In her thesis, '*Leaving your dignity at the door'* Stojanovic (2002) provides evocative and detailed accounts of mothers who birthed, and nurses who worked, in hospitals in Wellington between 1950-1970.

Under a Pākehā regime, Māori traditions were dismissed. The *Adoption Act 1955* made it possible to adopt a child and all parties could stay anonymous. This Act affected Māori communities because it meant that the traditional practice of whāngai became illegal. If Māori babies were adopted out, their pepeha and whakapapa were not recorded and parents' identities could never be revealed, even in the child's adult life. The absence of this information was difficult for Māori as whakapapa is a very important part of identity (Ahuriri-Driscoll et al., 2023; Brickell, 2017; West, 2012).

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[113] An enema involves inserting liquid directly into the rectum to help to cleanse/flood out the bowels so that during childbirth there was less chance of 'mess'

In the 1900s, there was also a significant rise in teen and unwed pregnancy among Pākehā. Brickell (2017) states that between 1936 and 1949 "...60% of all pregnancies were conceived outside of marriage" (p. 253). Having a child outside of wedlock was frowned upon and parents of young pregnant women would send their daughters away to 'workhouses.' Here, young mothers worked, unpaid, often up until birth, and then their babies would be adopted out/given away (Doyle, 2022; Else, 2018).

The institutionalisation of health created significant barriers for Māori and made accessing healthcare difficult. Māori were pushed into urban areas, they had limited access to their own ways of healing, and new social and health challenges arose. Western medicine became the only way to treat the sick and more hospitals were built to accommodate the growing population (Lange, 2018). Western systems of education, governance, and health were discriminatory and racial segregation was evident. Segregation in Aotearoa-New Zealand was still prominent up into the 1960s. In some communities, Māori were not allowed in bars, cinemas, public toilets and barbers were segregated or refused to let Māori in. In Pukekohe there was an 'unwritten rule' not to rent to Māori, so whānau were forced to live, birth, and raise their children in sheds, shacks, and tents with no amenities. These conditions led to disease and contributed to the death of many children and infants (Bartholomew & Ringer, 2020).

Legislation and Codes of Conduct

Internationally, there are several laws and statues that keep consumers safe and service providers accountable to non-discriminatory practice in different service areas including health. The *Human Rights Act 1993* [HRA] states that it is unlawful to discriminate against any group or person on the basis of personal characteristics, and aims to give all people equal opportunities and prevent unfair treatment. *The United Nations Declaration of Rights for Indigenous Peoples [UNDRIP]*, although not legally binding, is a comprehensive international document that recognises Indigenous peoples and their many rights including sovereignty and freedom from discrimination/racism (*United Nations Declaration on the Rights of Indigenous Peoples*, 2007).

In Aotearoa-New Zealand, the *New Zealand Bill of Rights Act 1990 [NZBOR]* declares a set of fundamental rights and freedoms that protect the general public against discrimination. *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [HADSCR]* protects all health consumers and holds health services and practitioners accountable to a set of rights. This document declares that healthcare in this country should be respectful, non-discriminatory, and maintain certain standards. It gives the Aotearoa-New Zealand public the right to dignity and independence in healthcare choices, a right to effective communication, to make an informed choice, the right to be accompanied by support people, and the right to complain. The *HADSCR* applies to all clinical, non-clinical, independent, primary, and secondary healthcare staff. This includes all patient and non-patient facing roles in health. The principles in this code encapsulate the key elements of prior health codes of conduct, and ethical guidelines for different healthcare practitioners in Aotearoa-New Zealand.

Doctors

The *Medical Practitioners Act, 1867* was the first official statute that created specific medical practitioners' standards of practice. After several amendments and additions to this Act, it is now known as the *Health Practitioners Competence Assurance Act, 2003, w*hich all healthcare practitioners now must follow. This Act is designed to protect the health and safety of the public by providing mechanisms to ensure the lifelong competence of practitioners. It also established the New Zealand Medical Council, who is responsible for setting and reinforcing standards of clinical competence, cultural competence (including competencies to facilitate effective and respectful interaction with Māori), and ethical conduct for doctors (Sainsbury, 2015). In order to protect health consumers and guide doctors in the care they provide (including pregnancy, birth and post-natal care), the Medical Council also created the *Good Medical Practice Standards for Doctors (2021)*. The Council also have responsibility to uphold Right 4 of the *HADSCR*, which states that patients have "The right to have services provided that comply with legal, professional, ethical and other relevant standards" (Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Section 4).

Nurses and Midwives

The relationship between nursing and midwifery has been 'on and off' throughout history. As explained above, early nurses and 'native health nurses' were untrained and provided medical support within the community. However, this changed in the 1880s when nursing training became a requirement, which formalised and systemised practicing as a nurse. Later, the *Nurses Registration Act 1901* required nurses to complete a three-year apprenticeship in hospitals and a final exam before official registration.

Early ‘lay midwives’ were also untrained and often stayed with mothers before and after birth in their homes. However, like the *Nurses Registration Act 1901*, the *Midwives Act 1904* (as outlined above) formalised and systemised midwifery training (Kirkman, 2011).

Later, the *Nurses and Midwives Registration Act 1925* created maternity nurses who assisted doctors in the delivery of babies in hospital, and registered midwives, who worked autonomously to deliver and provide in-community care. However, this changed in 1957 when midwives were required to become a registered nurse before completing midwifery training, and from 1971 they could not deliver a baby without a doctor present (Kirkman, 2011).

Later, the *Nurses Amendment Act 1990* permitted midwives to practice autonomously again, and educational institutions could offer direct-entry midwifery training (e.g. midwifery degrees). Nursing training was also moved from hospitals to educational institutions.

Along with the New Zealand Medical Council, the *Health Practitioners Competence Assurance Act 2003* established the Nursing Council of New Zealand and Midwifery Council of New Zealand to reinforce the safety of all healthcare consumers and to create ethical standards of practice. The Nursing Council then created a *Code of Conduct for Nurses (2012);* a set of eight principles describing the behaviours and professional conduct for registered nurses. The Code also states, “…because nurses must have the trust of the public to undertake their professional role, they must also have a high standard of behaviour in their personal lives” (Nursing Council of New Zealand - Te Kaunihera Tapuhi o Aotearoa, 2012, p. 2). The Midwifery Council also established a *Model for Practice*, which includes a set of four *Competencies* and a *Code of Ethics* that outline a set of principles, standards, and conduct of practice for the continuity of care of mothers during pre-, birth, and post-natal periods. These standards of care are key features of the *Midwives Handbook for Practice (2015)* which states that Midwives are required to “…conduct themselves personally and professionally in a way that maintains public trust and confidence in the midwifery profession” (p. 4).

Maternity Care in Aotearoa-New Zealand

In relation to the research questions, it is important to understand what maternity services are currently provided in Aotearoa-New Zealand. The *Primary Services Notice 2021* acknowledges that women, their partner, and their whānau deserve to have every opportunity to have a fulfilling outcome in pregnancy and childbirth. It also recognises that pregnancy and childbirth are normal stages of life (Ministry of Health - Manatū Hauora, 2021).

At the time of writing this thesis, primary maternity care is funded by Manatū Hauora - Ministry of Health. Hospital specialist care, primary community care, and lead maternity carers [LMC] are free; however, expectant mothers may be required to pay for some scans and other elective services (LMC's are predominantly midwives but can also be Obstetrician-Gynaecologists). Unlike the 1970s, maternity care is now predominantly led by LMCs rather than General Practitioners [GPs], although GPs still provide support for general health needs, including pregnancy symptoms.

Finding an LMC

Every mother has autonomy to have an LMC of her choice, women can look for one independently or seek help from their GP. Finding a midwife in Aotearoa-New Zealand can be difficult at times. However, created by the New Zealand College of Midwives, the 'FindMyMidwife' website is a popular interactive tool that supports pregnant women to find a midwife nearby (New Zealand College of Midwives, n.d.). LMCs are responsible for assessing the needs of the expectant mother and planning the birth-care of her and her baby's up to six weeks after baby is born. Midwives are usually self-employed/independent, employed by a community midwifery provider, or employed at a secondary or tertiary hospital (Ministry of Health - Manatu Hauora, 2021). In 2021, 93.3% of women who gave birth chose care from a community-based LMC (Dixon et al., 2011; Te Whatu Ora - Health New Zealand, 2023a).

Pre-natal

During pregnancy there are a range of checks, tests, scans, immunisations, and other clinical and non-clinical options an expectant mother can choose from. The clinical options are routinely offered as a pre-natal pathway to track the health of mother and baby during pregnancy. However, it is ultimately up to the expectant mother and their LMC to put together a maternity plan that meets the needs and wants of her and her whānau. Where appropriate, the LMC will refer women to the necessary providers. There is also a range of other pre-natal support options such as antenatal classes, breast-feeding/lactation support, and social services that provide help to whānau preparing for the arrival of a baby ("Community Midwives and Midwifery Services," 2024).

An increasingly popular option for expectant mothers and whānau are kaupapa Māori antenatal classes. Run throughout Aotearoa-New Zealand including Northland, Waikato, and Taranaki Hapū Wānanga are open to all expectant mothers, Māori and non-Māori. These wānanga educate parents about pregnancy and birth, integrating a holistic kaupapa Māori approach, and provide information about Māori birthing traditions. Hapū Wānanga were created in response to low attendance to traditional childbirth education classes by Māori, and their continued poor maternal and infant health. Barrett et al. (2022) and Barrett (2022) examined Hapū Wānanga ki Tainui (located in the Waikato region) over three years. The participants included 1,152 māmā and their whānau, who shared this initiative was valuable and exceeded their expectations overall.

Birth

Women in Aotearoa-New Zealand have the option to birth at home,[114] in primary,[115] secondary,[116] or tertiary facilities.[117] However, this is subject to the availability of birthing rooms, whether their chosen midwife has access to these facilities, and the woman's health status. When extra support or intervention is needed during birth and/or in post-natal care, other healthcare staff may assist the LMC. This might include a secondary midwife (from the community or hospital), nurses, an anaesthetist, an Obstetrician-Gynaecologist [OB-GYN], or other doctors. If needed, there are also specialist units called Special Care Baby Units [SCBU] and Newborn Intensive Care Units [NICU] that care for newborn babies who need extra support.

Post-natal

In post-natal care, LMCs are required to support women until their baby is six weeks old. A Well Child Tamariki Ora provider/nurse then usually takes over from the LMC to provide further education and routine check-ups for mother and child. The Well Child Tamariki Ora service can include anything from health, growth, and development checks for babies, to immunisation, early childhood education, and oral health and GP registration support. This programme is fully funded and services can continue up until children are five years old or

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[114] Home birth refers to a birth that took place in a person's home and not in a maternity facility

[115] Primary facility refers to a maternity unit that provides care for people expected to experience a normal birth with care of a midwife – this refers to a community based. Primary facilities do not provide epidural analgesia or operative birth services (Te Whatu Ora - Health New Zealand, 2024c)

[116] Secondary facility refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births – birth at a secondary facility may include; obstetrician, anaesthetist, paediatrician, radiological, laboratory and neonatal services (Te Whatu Ora - Health New Zealand, 2024c)

[117] Tertiary facility refers to a hospital that can provide care for people with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. (Te Whatu Ora - Health New Zealand, 2024c)

until families choose to leave the service (Te Whatu Ora - Health New Zealand, 2024a). Kahu Taurima is a newly funded national initiative established by Te Whatu Ora and Te Aka Whai Ora and works with whānau and communities to integrate culturally tailored services and programs to support whānau of young children in their first 2,000 days of life. The aim of this initiative is to remove barriers to care, coordinate primary and secondary services, and provide wrap-around support for babies and whānau (Te Whatu Ora - Health New Zealand, 2024b).

There are also services designed specifically to support the needs of young parents. Whānau Āwhina - Plunket offers a range of in-person seminars, walking clubs, and support groups. These services are also a place where young parents can meet other young parents. Charitable organisations also offer financial and social services with a focus on supporting young parents. Teen Parent Centres (Units)[118] [TPU] provide secondary education to parents wanting to obtain their NCEA qualifications, and support with transport, kai, and childcare. TPUs provide young parents with a safe space to learn, a community of other young parents, future career and education pathways and wrap-around support for other aspects of everyday life (Association of Teen Parent Educators of New Zealand, 2024).

Birth Statistics

In this section, I rely on the most recent and up to date national maternity data for Aotearoa-New Zealand, the *New Zealanders' Experiences and Perceptions of the Maternity and Perinatal System Report 2022,* which is conducted and published triennially.

National

The national maternity data shows birth rates in Aotearoa-New Zealand have increased steadily over the past ten years. In 2022, nationally, there were a total of 57,711 live births (Te Whatu Ora - Health New Zealand, 2024c). Most women who gave birth in that year received care from a community-based LMC (95%), and almost three-quarters of these women registered with a LMC in their first trimester of pregnancy (73%) (Te Whatu Ora - Health New Zealand, 2024c). The majority of women gave birth at a tertiary (46%) or a secondary (42%) maternity facility, whilst only 8% gave birth in a primary facility/birthing unit, and 4% at home.

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[118] Unit at times can have negative connotations to being sick or unwell, so centre is a better name to describe Teen Parent Centres

In 2022, Aotearoa-New Zealand also recorded its highest rate for caesarean section (30.2%). There was a continued upward trend in induced labour,[119] epidural analgesia,[120] and episiotomy[121] rates. 7.7% of babies were born preterm (before 37 weeks' gestation), and babies of preterm births and lower birthweight (less than 2500g) were common amongst women under-20 years and over-40 years of age. Pre-term births and lower birthweight are also common among Māori women, Pacific women, Indian women, and women residing in areas of high deprivation (Te Whatu Ora - Health New Zealand, 2023a). Aotearoa-New Zealand continues to have one of the highest rates for maternal suicide in the world, seven times the rate of the United Kingdom (Perinatal and Maternal Mortality Review Committee, 2012).

Māori

In 2022, Māori represented 26.5% of national births. More than half of Māori (58.2%) registered with an LMC in their first trimester and 22.2% in their second. It was not recorded whether these LMCs were community or facility based. Almost half of Māori gave birth at a secondary facility (49.7%), 33.7% gave birth at a tertiary facility, 11.6% at a primary facility, and 5.1% at home. It was also recorded that Māori had higher risks of poor outcomes during pregnancy that year, however, significantly lower rates of intervention by induction, epidural, and episiotomy (Dawson et al., 2019; Te Whatu Ora - Health New Zealand, 2023a, 2024c). Māori mothers are twice as likely to die during pregnancy, and 3.35 times more likely to die from maternal suicide than any other ethnicity (Hohepa, 2024; Russell, 2024).

In their literature review of barriers to equitable maternal health in Aotearoa-New Zealand, Dawson et al. (2019) and Edmonds et al. (2022) identified that Māori women in particular have poorer access to LMCs, young Māori mothers are more likely to experience systemic barriers when finding a midwife, and the inequity experienced by Māori mothers in healthcare is complex.

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[119] Induction of labour is the process of starting labour artificially, rather than waiting for labour to start naturally. An induction will only be offered if there is a good medical reason (Te Whatu Ora - Health New Zealand, 2024c)

[120] A type of medical intervention during labour, epidural is used only in a main maternity hospital as they require insertion by an anaesthetist. A small plastic tube is inserted into the lower back under local anaesthetic (Te Whatu Ora - Health New Zealand, 2024c)

[121] A medical intervention during labour, an episiotomy is a surgical incision (cut) into the perineum (the skin between your vagina and anus) and can be a life-saving procedure if your baby is in distress or their shoulder is stuck (Te Whatu Ora - Health New Zealand, 2024c)

Young Mothers

Pregnancy in younger women in Aotearoa-New Zealand is declining but remains high compared to other countries, particularly amongst Māori and Pacific young people (Oranga Tamariki - Ministry for Children, 2019). In 2022, the birthrate of women 20 years of age or younger was 3.1% of national births (Te Whatu Ora - Health New Zealand, 2024c). Around half (46%) of mothers under 20 years of age registered with an LMC in their first trimester. It is not recorded whether these LMCs were community-based or facility-based. Most young mothers birthed in a secondary (49.3%) or tertiary (39.4%) facility, while 9.7% birthed in a primary facility, and 1.5% at home. It is well documented that having a child young comes with certain risks; there is a higher chance of complications during pregnancy, risk of lower birth weights, premature births, and a higher incidence of still birth. However, sources also show that plenty of young women have healthy pregnancies and births (Te Whatu Ora - Health New Zealand, 2023a, 2023b; Te Whatu Ora Waikato - Health New Zealand, 2023).

Waikato

In 2020, Waikato reported *the* highest number of Māori births nationally, and since then has continued to stay within the top four regions for Māori births. In 2022, births in the Waikato region equated to 9.5% of National births and 35% of women who birthed in the Waikato were Māori, with 21% of these mothers aged under 25 years old. All births that year were also likely to be multigravida (a third, fourth or more child) (Ministry of Health - Manatu Hauora, 2023, p. 202; Te Whatu Ora - Health New Zealand, 2023a; Te Whatu Ora Waikato - Health New Zealand, 2023).

Part 2 - Empirical Literature Search and Results

In Part 2, I provide the results from my empirical literature search. Giving an overview of the literature, I present the key Aotearoa-New Zealand studies conducted in this area and have included two international studies to show the broader interests of researchers. I also offer some observations about participants ethnicity, age, gender, location and experiences in the literature. To conclude this section, I share further observations about the analyses of researchers, and the key learnings I have taken away from this literature review.

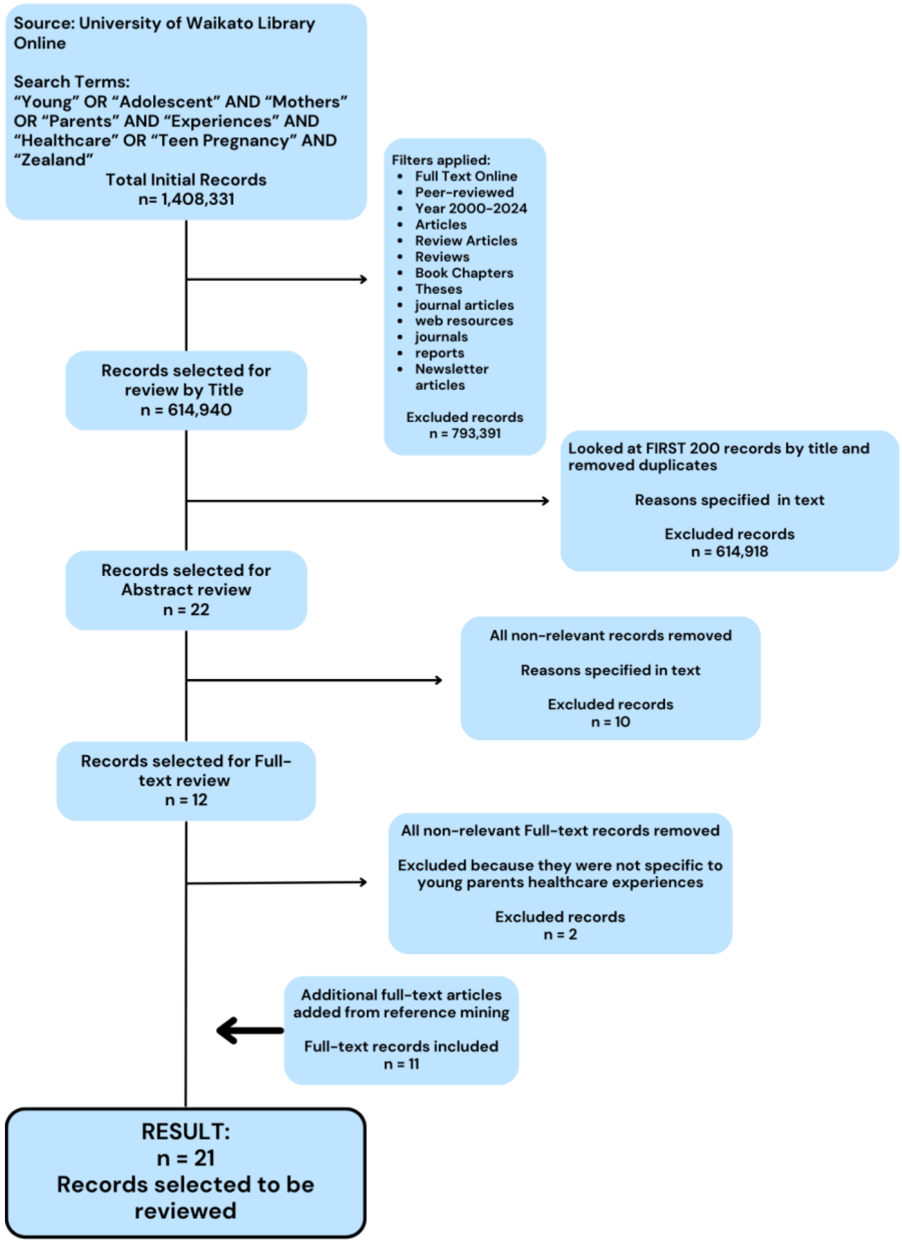

Figure 2: Literature Search

Search and Screening Process

Throughout this research project, a total of three in-depth literature searches were conducted; at the beginning of the study, after the participants had been interviewed, and before submitting this thesis. For the first literature review, the following search terms were used to identify relevant articles and sources using the University of Waikato library database: "Parents" AND "Mothers" AND "Young" AND "Healthcare" AND "Health care" AND "Young parents" AND "Young mother" AND "Health" AND "Experiences" AND "Zealand."

After completing this search, I noticed other words and terms were used more frequently by other scholars. Therefore, in the second and third literature searches, the following terms were used instead: “Young” OR “Adolescent” AND “Mothers” OR “Parents” AND “Experiences” AND “Healthcare” OR “Teen Pregnancy” AND “Zealand.” Figure 2 illustrates the process used to conduct the second literature review. The third literature search produced almost identical record results.

The new search produced **1,408,331** hits. Applying the filters listed in Figure 2, this reduced the number to **614,940**. Only reviewing the first 200 record *titles* and removing any duplicates. The literature search produced, **22** sources that were relevant to my topic. The excluded titles (**n=178**) were deemed not relevant because they focused on the following:

- Conducted overseas; prominent locations included America, Canada, England, and with other Indigenous cultures such as Latin, Mexican, African parents
- Parenting methods/styles, parenting attitudes, parenting by grandparents, the role of a parent in child development, caring for young children, caring for young children with health issues and chronic conditions
- Health of mothers 30 years and over, mothers with health issues, parents with health issues

After reviewing the *abstracts* of the **22** selected sources, a further **10** sources were excluded, leaving a total of **12** sources to be full text reviewed. The sources excluded focused on:

- Kaupapa Māori approaches to parenting young children
- Young peoples’ opinions of parenting styles (who were not parents)
- Parents with young children
- Social and health needs of parents 30 years and over

After a closer reading of these **12** sources, **two** more were excluded. I also mined the references of these **10** sources and found a further **11** relevant texts, resulting in a grand total of **21** relevant literature published between 2000 and 2024.

It is important to note that nine of the total sources are derived from the E Hine study (see below).

Initial Observations

International Literature/Research

As illustrated in Figure 2, there is a dearth of Aotearoa-New Zealand research that focuses specifically on the experience's that young parents/mothers are having in maternity care. This gap supports the relevance of the current study. However, there are a large number of international studies that examine young/teen parents experiences of parenting and interactions with welfare and health systems. The majority of these studies were conducted in America and focus on minoritised groups (e.g. Latino, African American, and Mexican). There are also a large number of studies conducted in Canada and England with young mothers/parents. Also noted in this search is the overall interest in parenting young children, parents with young children, looking after young children with health issues, and the role parents have in young children's development.

This wide-spread interest in the experiences of young mothers demonstrates the importance of these topics. Given the much smaller number of Aotearoa-New Zealand studies in this area, and to gain a broader understanding of the experiences of young mothers, I included two of these international studies in my review. A qualitative study conducted in Scotland (Robb et al., 2013) is included because they asked seven young mothers about their encounters with health professionals and service providers during pregnancy/birth. An article written by SmithBattle et al. (2013) was also included because it synthesises the findings of 22 qualitative studies that examine teen mothers' experiences with breastfeeding and the factors that impacted on their breastfeeding journey.

Another observation made was the extensive use of the phrase 'teen parents' particularly in America. This phrase seems to be closely associated with the negative discourse and theories about teen parents. However, it appears I am not the only researcher to make this observation, as there seems to be a shift away from the phrase 'teen parents' to the less stigmatising phrase, 'young parents.'

Aotearoa-New Zealand Literature/Research

My literature search indicates that in Aotearoa-New Zealand between 2000 and 2024 there have been two major studies that focus on the experiences of young mothers in health/maternity care. These studies are profiled below and are a key feature in the following review.

'E Hine'

To date, *E Hine: Reducing barriers to care for pregnant Māori women under 20 years and their infants [E Hine]* appears to be the most extensive qualitative research project to focus on the needs and experiences of young Māori mothers. *E Hine* is a 'by Māori, for Māori' longitudinal study led by the Women's Health and Research Centre [WHRC] at Otago University, Wellington.[122] This study was conducted from 2012 to 2013 and examined the experiences of 44 young Māori mothers through pregnancy and into motherhood in two locations (Hawkes Bay and Wellington). Employing semi-structured interviews, participants (14-21 years old) were interviewed several times over the two-year period. Half of the māmā shared retrospective experiences while the other half shared prospective experiences up until their children were two years old. The research team conducted a total of 160 interviews and employed a thematic analysis method.

Using the E Hine data, WHRC researchers sampled different data sets to examine and analyse particular experiences. Lawton et al. (2016) published a paper about access to contraception (44/44 interview data), Stevenson (2016) focused on lived realities and birthing experiences (16/44 interview data), Makowharemahihi et al. (2014) examined young mothers experiences of initiating maternity care (44/44 interview data), Cram et al. (2021) analysed young mothers experiences with welfare benefits (28/44 interview data), and Dhunna et al. (2021) explored intimate partner violence (6/44 interview data). Adcock (2016) produced a master's thesis entitled *E Hine, ngā whaea: Teen mothering in the gaze*, and also published her analysis/findings in an article (Adcock et al., 2018).

Lawton et al. (2013) also published a paper about the focus groups and co-design process to develop of this project, and Adcock et al. (2016) interviewed six government agencies to discuss support for teen parents.

All nine texts of the 'E Hine' study have been included in this literature review as they draw on important topics highlighting their real-life experiences. This research has laid the foundation for further research in this area.

'Teen Pregnancy: Cause for Concern'

The second major study of relevance to this topic appears to be the largest study conducted thus far and is often referenced by scholars/academics. The Christchurch Health and Development

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[122] The Women's Health and Research Centre [WHRC] is now known as Te Tātai Hauora o Hine, National Centre for Women's Health Research Aotearoa at Victoria University of Wellington, Te Herenga Waka

Study [CHDS] was a longitudinal study conducted by the Christchurch School of Medicine from 1977 to 1998. The CHDS interviewed the parents of 1,265 infants (630 females) born in the Christchurch region and tracked the health, education, and life progress of these children until they were 21-years old (Woodward et al., 2001).[123] To determine the prevalence of teenage pregnancy and parenthood in Aotearoa-New Zealand, Woodward et al. (2001) sampled and analysed data from 533 of the females in this study and found:

> By age 21 years, 26% (n = 136) of the sample had been pregnant and 14% (n = 74) had become parents. Most pregnancies occurred between ages 17-21 years. [to explain further] the remaining pregnancies were terminated (32%), miscarried (12%), or the child was placed for adoption (2%). these results are consistent with national birth and abortion data. (Woodward et al., 2001, p. 301)

This article is often referenced when highlighting the deficit, negative, and risk-based perspective regarding young pregnancy/parents. The authors identify a number of risk factors for early pregnancy including: being Māori, living in a lower-socioeconomic area, parented by a single mother, poor school achievement, “early adolescent conduct problems” and complicated family backgrounds (Woodward et al., 2001, p. 302).

Methodology and Method

The majority of scholars employed a ‘by Māori, for Māori’ kaupapa Māori research approach, while others included frameworks based in psychology and other theoretical frameworks. Nine studies were qualitative, employing semi-structured, kanohi ki te kanohi interviews, and eight studies conducted thematic analyses, while three studies (Elkington, 2016; Marsh, 2019; Ware, 2019) used a narrative/pūrākau analysis approach. These methods are common in Indigenous research and are based on Māori ethical principles and tikanga (L. T. Smith, 2012). Ware (2019) explains “…a Māori narrative approach revealed a more complex and nuanced understanding of the interrelatedness and influence of societal expectations, indigeneity, Māori culture and whānau” (p. 80).

In relation to co-design as a method, Bealing (2019) asked her participants for feedback on her ’Positively Parenting’ App. Co-design is an important method in research with young parents because resources, services and programmes that are created to support them need to be responsive to their needs and inclusive of their experiences and opinions (Elkington, 2016;

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[123] This cohort was studied at different stages of their lives - at birth, four months old, one-year old, annual intervals to sixteen years, at eighteen years, and again at 21 years (Woodward et al., 2001)

Haerereoa, 2015; Ware, 2019). As outlined in Chapter 5, I have employed my own kaupapa Māori methodological framework to create a tangible output using co-design in the current study.

Participants

Focusing on demographics, I made the following observations about ethnicity, age, location, gender, and the reported healthcare experiences of participants in the previous literature.

Ethnicity

Except for one study that focuses specifically on the experiences of young Pākehā mothers (Banks, 2008; see below) all other studies focused specifically on Māori (Adcock, 2016; Adcock et al., 2016; Dhunna et al., 2021; Elkington, 2016; Haerereoa, 2015; Lawton et al., 2013, 2016; Makowharemahihi et al., 2014; Marsh, 2019; Stevenson et al., 2016) or included Māori (Bealing, 2019; Rawiri, 2007; Southorn, 2016; Ware, 2019). Woodward et al. (2001) did not identify the ethnicity of their 533 wāhine cohort.

The prevalence of research featuring Māori parents signals a clear interest in the experiences of young *Māori* parents. According to the E Hine research team, this interest is related to evidence that shows young Māori mothers and their babies are at higher risk of poor health and maternity outcomes. The majority of the literature/research has also been conducted by Māori researchers, which affirms and builds a library of ‘by Māori, for Māori’ literature as opposed to Māori being the ‘subjects’ of research (L. T. Smith, 2012).

Only one study conducted from my review did not include Māori. In her thesis, Banks (2008) conducted a Hamilton-based qualitative study that explored the experiences of 12 Pākehā mothers who gave birth at ages 15-18 years old. At the time of data collection, the participants’ ages ranged from 16-44 years old. This study was of particular interest as these mothers commented on the experience of being stigmatised based on western cultural and religious constructs and ideas about women and marriage. Banks (2008) referred to this as the “interruption” or “challenge” of the prescribed trajectory of a woman's life (p. 69).

Age

The age criteria for research participants involved in young or teen parent studies ranges between 13 and 25-years-old. This variance points to different views about who is and is not considered to be a ‘young’ parent/mother. Some scholars shared their age bracket selection was based on the government's definition of ‘school age.’ Other scholars adopted not only

Aotearoa-New Zealand's ‘legal age’ (18-years), but also the legal age of consent (16-years). Whist others were not strict, and allowed anyone who wanted to participate, to do so (Adcock, 2016; Makowharemahihi et al., 2014; Marsh, 2019; Rawiri, 2007; Southorn, 2016). International studies also tend to use the same age bracket. Robb et al. (2013) recruited seven mothers in Scottland aged 13-19 and one that was 23 years of age. While in SmithBattle et al. (2020), they reviewed 22 different studies that included participants under 20 years of age.

Moreover, in analysing the literature, I identified that most studies were conducted after 2010, and I now explore three main reasons why researchers may have focused on young parents at this time. First, the fertility rate of young women in Aotearoa-New Zealand spiked in 2010, with 26% of women who gave birth that year being under 25 years old, and Māori represented more than double the birth rate of non-Māori. Additionally, the Māori population overall (in 2010) was very young (35% aged under 15 years) and regional and national records showed Māori were extremely overrepresented in negative statistics and at higher risk of poor maternal and child health outcomes (e.g. poor mental health, increased mortality rates, higher risk during pregnancy, low birth weights, premature, and still birth) (Ministry of Health - Manatū Hauora, 2010; Perinatal and Maternal Mortality Review Committee, 2012). Lastly, researchers identified that the voices and experiences of young parents/mothers were not included in resource and service development. In her master's research about young Māori mothers and bed-sharing, Haereroa (2015) identified that although Māori Sudden Unexpected Death in Infancy [SUDI] rates are significantly higher than non-Māori, little or no qualitative research privileges or includes young Māori voices. Other scholars have also identified this lack of inclusion (Adcock, 2016; Elkington, 2016; Ware, 2019).

Location

Research focusing on the healthcare experiences of young mothers/parents in Aotearoa-New Zealand has largely been conducted in the North Island. The *E Hine* study was conducted in the Hawkes Bay and Wellington, which were “…chosen for their social, geographical, and tribal relevance” (Lawton et al., 2013, p. 53). Another study was conducted in the Manawatū region (Ware, 2019). Whilst Marsh (2019) and Bealing (2019) recruited participants from different locations across the North Island. Two studies were conducted in the South Island, in Christchurch (Woodward et al., 2001) and Canterbury (Southorn, 2016). Rawiri (2007) did not identify the location of his study.

There were also three masters' studies conducted in Hamilton. Banks (2008) interviewed four Pākehā mothers attending the Fraser High School Teen Parent Unit (TPU) - now known as

He Puaawai. Haereroa (2015) conducted her research with 10 Māori mothers and Elkington (2016) interviewed a group of eight Māori fathers, also in Hamilton.

Gender

Another observation is the lack of research exploring the experiences of expectant or new young fathers. Some researchers have noted this lack of young fathers' perspectives, and attempted to recruit fathers, but there was a lack of response (Adcock, 2016; Rawiri, 2007; Southorn, 2016), while others noted the complexities of young parent relationships (Banks, 2008; Ware, 2019). This was also noted internationally as many studies focus on young mothers (Robb et al., 2013; SmithBattle, 2013).

In relation to gender roles, Marsh (2019) emphasised that in early colonial accounts males played a crucial role in raising children especially young men, and therefore it is important their voices are heard. Elkington (2016) conducted the only study that specifically focused on young fathers. The findings highlighted that these young Māori fathers had a strong desire to be involved in raising their children, had big life and career aspirations, and that whānau relationships supported their resilience and motivation to fulfil their responsibilities as fathers. Elkington (2016) also asked for the young men's perspectives on different parenting resources. Unfortunately, this article does not speak any further about whether these resources were created. This was of particular interest to me as the co-design of materials is one of the aims of my research.

The lack of research conducted with young fathers highlights more effort needs to be taken to include and support young fathers to share their perspectives. Although mothers' experiences may be prioritised due to the physicality of carrying and giving birth to a child, acknowledging fathers emphasises the importance of their role and supports a whānau-centric approach. Thus, the participant criterion for my research is inclusive to young māmā and pāpā (see Chapter 5).

Experiences

In this review, there are only five studies that refer specifically to healthcare practitioners (Adcock, 2016; Makowharemahihi et al., 2014; Rawiri, 2007; Stevenson et al., 2016; Ware, 2019). Overall, participant feedback about doctors, nurses, midwives, and other healthcare practitioners (e.g. receptionists) were mixed.

In the positive experiences, participants said that healthcare staff were supportive, seemed to care, were empathetic, listened, and often went above and beyond to organise extra services such as antenatal registration or transport. In the negative experiences of participants with doctors, nurses and midwives, the majority of studies found participants concerns were not taken seriously, staff made assumptions, and were dismissed/not listened to, and staff were unsupportive. Participants also talked about a lack of or breakdown in communication and being ignored at different stages in their maternity journey.

I have also identified the following themes. Five studies emphasised that negative experiences in healthcare is a barrier and leads to mistrust of healthcare practitioners and services overall (Adcock, 2016; Bealing, 2019; Cram et al., 2021; Makowharemahihi et al., 2014; Rawiri, 2007; Stevenson et al., 2016; Ware, 2019). Four studies talked about the importance of whānau support and how being separated from their baby, whānau, and partner caused distress (Adcock, 2016; Elkington, 2016; Marsh, 2019; Stevenson et al., 2016). Whilst Haereroa (2015), Makowharemahihi et al. (2014), and Ware (2019), went into detail about the lack of resources for young Māori parents and how young parents' perspectives are often forgotten. The two international studies also found that being given the right information and support was important to young mothers in pregnancy and birth (SmithBattle et al., 2020; Robb et al., 2013).

In contrast, three studies identified the positive outlook and aspirations of parents who were becoming mothers or fathers, including wanting to do better and their continued desire to strive for their goals and aspirations (Banks, 2008; Elkington, 2016; Southorn, 2016).

Researchers and Research Approach

In the literature, when researchers analysed the experiences of their participants they identified the presence of stigma, judgement, and deficit perspectives about being a young parent or a young Māori parent. Researchers described a range of western and societal ideas about being a child, and what a child is and is not supposed to do. They also highlight western colonial ideas about Māori and explained various ideas related to the stigma of ‘unwed’ young mothers.

Stigma

A number of researchers explain that their participants are very aware of the stigma associated with being a young mother/father/parent. For clarity, stigma refers to “...any negative attitude, prejudice, or false belief associated with specific traits, circumstances, or health symptoms” while discrimination “...describes how you treat someone because of this stigma” (Biggers, 2023). For the young parents in Ware’s (2019) study, the stigma of being a young parent created "…a fear of discrimination and constant judgement [that] silences young Māori parents' feeling able to ask for help and demand the same rights, resources and respect as other parents" (p. 166). In discussing job security with young fathers, Elkington (2016) discovered that they often felt stigmatised by social welfare services and therefore avoided seeking welfare all together. In Marsh's (2019) thesis about intimate partner violence, one of her participants shared stories of being stigmatised and "…labelled and portrayed as a 'bad mother' by different people" (p. 146). A participant in Southorn's (2016) study also shared that a main factor for her was just "staying calm during pregnancy" and "block[ing] out" her surroundings because of the judgement she felt by people looking at her and pointing "the finger" (p. 36).

Whilst one of the main findings of Adcock (2016) and Stevenson (2016) was that young parents felt excluded in hospitals because of poor treatment by healthcare staff, which suggests stigmatisation. Participants in Banks's (2008) research with Pākehā mothers also shared experiences of stigma related being a young/teen mother.

Moreover, Ware (2019) refers to a "two-fold dual-stigma" or stereotyping where mothers are not only stigmatised because they are young, but because they are Māori as well (p.192). This concept is known as intersectionality, which highlights that there are interlocking systems of oppression based on different cultural constructs and ideas of social identity (Núñez et al., 2020). Dhunna et al. (2021) also refers to this concept, stating there are "...multiple intersecting tropes on teenage motherhood that ultimately give rise to pervasive social stigma" (p. 6196).

Deficit Narratives

Consequently, the stigma of being a young parent is closely associated with deficit perspectives that portrays them as "virtually less" (Adcock, 2016). Many scholars, particularly in western discourse, continue to condemn young parenthood as a "cause for concern" (Woodward et al., 2001), a "problem" Luker (1996), and a "disadvantage" (Breheny & Stephens, 2010). Young parents are seen as irresponsible," "unmotivated" and "incompetent" (SmithBattle, 2013). Adcock (2016) explains "...it is common for research in New Zealand to focus on 'risks' and 'dangers'. Hence, public (and public service) perceptions of [young] women are often negative" (p. 2). Adcock (2019; as cited in Edmonds et al., 2022) emphasises that young Māori parents are often seen as "abnormal and in need of regulation" (p. 325). These concepts are often closely followed by the argument that teen pregnancy leads to unemployment, long-term welfare dependency, and low educational achievement (Adcock, 2016; Breheny & Stephens, 2010; Pihama, 2011; Woodward et al., 2001).

However, despite these deficit views, attitudes, and discourse, young parents in several studies “resist” (Ware, 2019, p. 183) this stigma by continuing with their education, striving for their goals, and excelling in other areas of their life (Adcock, 2016; Banks, 2008; Adcock, 2019; as cited in Edmonds et al., 2022; Elkington, 2016). The young Māori parents in Ware’s (2019) research were excited to become new parents and wanted to re-engage with education and work harder to provide a positive future for themselves and their children. In the E Hine study, young mothers were proactive and engaged early in seeking contraception (Lawton et al., 2016), and with health services for maternity care (Makowharemahihi at al., 2014). Southorn (2016) also noted that young mothers had a “strong affinity for spending time with their children and did not seem to mind losing the relative freedom...” (p. 68).

These findings highlight that although young people are actively trying to overcome the deficit narrative, the prominence of negative perspectives and stigma associated with being a young (Māori) parent is still common.

Construction of Childhood

Scholars also acknowledge a connection between western views of childhood and the stigma of being a young parent (Adcock, 2016; Dhunna et al., 2021; Pihama, 2011; Ware, 2019). This concept is complex and multifaceted, and different authors refer to different concepts and constructs.

For example, Pihama (2011) states “The concern of ‘who is too young to have a baby’ is linked to the construction of age itself” (p. 8). To give a more in-depth explanation about what Pihama is referring to here I offer Lee’s (1982) explanation of the ‘Three Paradigms of Childhood.’ He explains that the concept of childhood evolved over time. Firstly, in pre-industrial society, the concept of a ‘child’ was non-existent - children were considered property “...not unlike pets or slaves” (p. 591). The second paradigm includes a shift where children were then seen as fragile and innocent - needing protection. The third shift occurred in the early twentieth century, when children moved to urban areas to work and live independent of their parents. Ari’es (1973; as cited in H. Wilson & Huntington, 2006) adds that this stage was a “...transition from dependence to independence which was responsible for constituting a new ‘age’ between childhood and adulthood” (p. 60). This independence gave ‘children’ the freedom and confidence to act how they wanted, which birthed the concepts of ‘adolescents, ‘juvenile delinquency’ and children were seen as defiant and problematic. There are other concepts and theories to unpack here, however, the key connection but all that needs to be noted is from juvenile delinquency came deficit narratives and negative perspectives of young people that are still societal norms today (Pihama, 2011).

Western Views of Māori

A final observation I would like to make is that in reading the different analyses, the western colonial perspectives of Māori and women are also arguably connected to the stigmatisation of young mothers.

This western colonial or ‘imperialist’ gaze derives from colonisation and creates an imbalance where Indigenous peoples and Māori women as ‘other’ (Mikaere, 2003; L. T. Smith, 1999). The majority of the research in this area was conducted with Māori participants, therefore, intersectionality (as explained above) also applies here, because it is difficult to differentiate whether young parents are stigmatised because of their age, gender, or ethnicity. However, scholars commented on the presence of western colonial views about young Māori parents.

Ware (2019) shares that a father in her study “feels that he is discriminated against for being physically identifiable as a Māori parent, that he is scrutinised more for his parenting and expected to fail” (p. 120). Participants in Adcock’s (2016) research also highlight the view others have on young Māori māmā:

> I see people looking at me like they think, like people ask me, ‘is it all Māori and Island girls that come to TPU?’ and I say ‘no, it’s not. There’s actually quite a few white girls that come here.’ And they just always assume that it’s Māori girls here. (p. 97)

Western Views of Women

Scholars in this area also highlight the western colonial perspectives of women. Rawiri (2007) points to the western colonial perspective of wedlock, explaining “…having a child out of wedlock is not easily accepted within the church and both [participants] recalled being treated negatively by other [church] members” (p. 116). This connects closely to Banks (2008) who interviewed Pākehā mothers about their experiences of young motherhood. A key finding from Banks’s (2008) research reveals is that being a young mother/having a child ‘early’ was problematic because it challenges Pākehā cultural constructs and the "traditional... prescribed life trajectory of Pākehā women" (Banks, 2008, p. 58). This concept is interesting as it highlights that being a young mother challenge the historical idea that women first need to be educated, then get married, buy a house, and *then* have children. What is also interesting is that this stigma is prevalent for young Māori and non-Māori mothers.

Summary

This chapter examines the different studies, scholars and concepts in this area, and provides a foundation of knowledge for the current study. For clarity, the purpose of a literature review is "…to determine what is known on the topic, how well this knowledge is established and where future research might best be directed" (University of Melbourne, 2023, p. 2).

In summary, I offer my key learnings from my review of the literature.

After mapping the wider research context, I feel I have a better understanding about the area of research for the current study; I have a broader understanding of how the maternity sector has changed over time, and what it now provides to expectant mothers, as well as the codes of conduct in place to keep health consumers safe. I have learnt from the current statistics that young Māori have high birth rates in Waikato, and therefore, it is likely there will be a high number of Māori in the cohort of the current study. Based on my search it appears that few studies have been conducted with young mothers in Aotearoa-New Zealand and even less in the Waikato region. The current study aims to include both Māori and non-Māori participants, however, because the majority of studies in this area included Māori, I expect that a lot of our participants will be Māori.

After analysing the age brackets other scholars have used and why, I have learnt that our age criterion fits within the general age bracket of 13-25 years but will be slightly different because of the standardised ages of young parents attending Aotearoa-New Zealand TPUs. In relation to gender, I have learnt few studies have included fathers and had trouble recruiting them, therefore, the current study aims to include and support fathers to participate.

The literature also indicates that there have been a mix of both negative and positive experiences; young parents experience a lot of stigma about being young (Māori) parents, but also report health staff are helpful at times. Therefore, I expect there could also be mixed experiences in the current study. I have also noticed the need for strengths-based research that supports young people and their ability to be great parents, rather than focuses on deficit narratives. This literature review has taught me that there are different societal and social constructs and ideas that lead young parents to being stigmatised (western ideas of children, Māori and women) and I am interested to know whether these concepts are still present in the current study.

Overall, the E Hine study was of particular interest to me, as it is an exemplary study that is strengths focused and advocates for young mothers. The E Hine study demonstrates the benefits of a kaupapa Māori approach, and I believe my research will add to the findings of this study by taking a deeper look into the clinical experiences of these young parents.

Furthermore, I also have a better understanding of the effective methods I can use to conduct my research. The fact that a number of scholars utilised different kaupapa Māori frameworks gives me confidence in utilising my Te Ira Wahine framework. Using wānanga and semi-structured interviews kanohi-ki-te-kanohi seems to have been useful for previous scholars and therefore will be employed here (see next Chapter).

In analysing the literature, I believe the current study is necessary. There needs to be more research that adds to the evidence in this area. No studies focused specifically on the role of health professionals or created tangible co-designed resources, and few of this nature have been conducted in the Waikato.

Therefore, in the next chapter I present the qualitative methods and process employed to conduct this study.

CHAPTER 5 METHODS

Introduction

This chapter describes and explains the various methods employed to conduct the current research. I begin by providing a brief synthesis of the current study, outlining the ethical guidelines, and recruit process and criteria. I then offer a demographic overview of the 22 young parents who participated in this study. To conclude, I present my research design, and the various methods employed to collect the participants kōrero and disseminate the findings.

As a reminder, Karanga Atu, Karanga Mai [KAKM] emerged out of The Collaboration Study conducted by Te Whatu Ora Waikato - Māori Health Research Team (see Chapter 1). The KAKM project was a qualitative study that explored the healthcare experiences of young mothers attending He Puaawai Teen Parent Centre in Hamilton. The aim was to listen, learn, and use the findings to co-design educational and informational materials for healthcare practitioners to better understand the young mothers they serve. The purpose of this research was to influence change in how healthcare services are provided to young mothers and their whānau. For clarity, while fathers were involved in this study I tend to refer to ‘young mothers’ and māmā because only one of these fathers spoke (twice) during the research.

Research Process

Steering Group

The Steering Group for this study consisted of prominent figures within the wāhine hapū and health sector space including: Dr Nina Scott (Director of Rangahau Hauora Māori, Mātauranga Māori - Te Aka Whai Ora), Prof. Ross Lawrenson (Professor of Population Health – University of Waikato and Population Advisor Strategy and Funding – Te Whatu Ora Waikato), Dr Amy Jones (Research Programme Manager, Te Whatu Ora Waikato), Miss Tina Baty (Wāhine Hapū Research Officer - Te Whatu Ora Waikato), and Miss Gillian Cotter (Principal - He Puaawai, Teen Parent Centre). The lead investigator was my supervisor Dr Gloria Hinemoa Clarke (Lecturer of Māori Health - University of Waikato), however, when I decided to conduct this research for my master's qualification, she stepped in to the principal investigator role, and I became the associate investigator - responsible for all administrative tasks, all interviews, wānanga, transcription, and I directed the analyses. Throughout the KAKM study, the research team met bi-monthly to discuss the project and its progress.

Research Questions

The three main research questions for this study were:

1. When caring for young māmā and their tamariki what are doctors, nurses, midwives, and other healthcare practitioners doing well?
2. When caring for young māmā and their tamariki what are doctors, nurses, midwives, and other healthcare practitioners not doing well?
3. What are the messages and lessons you want to get across to improve how health professionals treat and service young māmā and whānau?

Participation Criteria

A brief criterion was set for interested participants:[124]

- a present or past He Puaawai Teen Parent Centre student
- pregnant and/or have given birth in the last two years
- of secondary school age (13-21)

Ethics

Full informed consent was given by all participants before the study commenced and release forms were completed after member checking of all transcripts (see Appendix F). As outlined in the Information and Consent Form (see Appendix A) participants were able to withdraw from the study at any time. If they agreed, any information collected prior to withdrawing was included in the study. If they did not agree, interviews were removed. The consent form also made it clear that data collected during the wānanga could not be disentangled and therefore withdrawn. Consent was also obtained for the use of participants' photographs and for the release of co-designed resources (see Appendix I).

The Collaboration Study conducted by the Te Whatu Ora Waikato - Māori Health Research Team (see Chapter 1) was granted ethics approval by Northern B Health and Disability Ethics Committee in August 2021 [Ethics number 21/NTB/148]. To accommodate the addition of the current study (KAKM), an amendment was made and was approved on January 10, 2023 [Ethics review reference 2022/AM/10635] (see Appendix D)

A further ethics amendment was approved on April 11, 2023, to allow the participation of under 16-year-old students/parents [Ethics review reference 2023/AM/10635] (see Appendix

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[124] It is important to note no interested participants fell outside of this critera

E). Typically, under 16-year-olds are considered minors and therefore require parental consent to participate in research. However, because many of these young parents are independently living and raising their children, Gillian explains that they are the "pou-tokomanawa[125] of their own whanau" (see Appendix G). I also believed that because of their age, they could have potentially experienced more discrimination than other young parents and therefore it would be wrong not include their voices. To include under 16-year-old participants, another consent form was created (see Appendix B) and recruitment began only after all amendments were approved by the Ethics Committee.

Recruitment

This study began in November of 2022 and concluded in December of 2023. At the time of recruitment, there were 20 students enrolled at He Puaawai, and over the study period enrolments fluctuated. The recruitment process was guided by He Puaawai principal, Gillian Cotter, whose involvement was critical as the students trusted. Flyers were put up around the school inviting students to participate, and Gillian made communication with alumni via email.

Eligible and interested participants were given information sheets and consent forms (Appendix A & Appendix B). All participants were encouraged to talk to their support networks about the study and their feelings about joining the project. They were given time to read this information and to ask Gillian and/or the research team questions before consenting.

In the spirit of Manaakitanga and Kaitiakitanga (see Chapter 3), whānau members who wished to support or participate were also provided with information sheets and consent forms (see Appendix H). We also planned to work alongside the school kaumatua, however he was not available. In the spirit of Kaitiakitanga and Tino Rangatiratanga (see Chapter 3), the participants preferred that all interactions take place at He Puaawai.

With their consent form, participants were also given a brief set of demographic questions (see Appendix C) to gather basic background information such as contact details, age, tribal affiliation, living situation, distance they travel from school, and their number of children. This was to understand each participant as a whole person and gauge the external factors contributing to their lives.

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[125] Pou-tokomanawa is the middle ridge pole in a whare tupuna or wharenui of a marae. This centre pole holds up the entire house and is crucial to the stability of the house. Metaphorically when someone is a pou-tokomanawa they are the support 'pole' for their whānau, they hold up their whānau and support them in everyday life

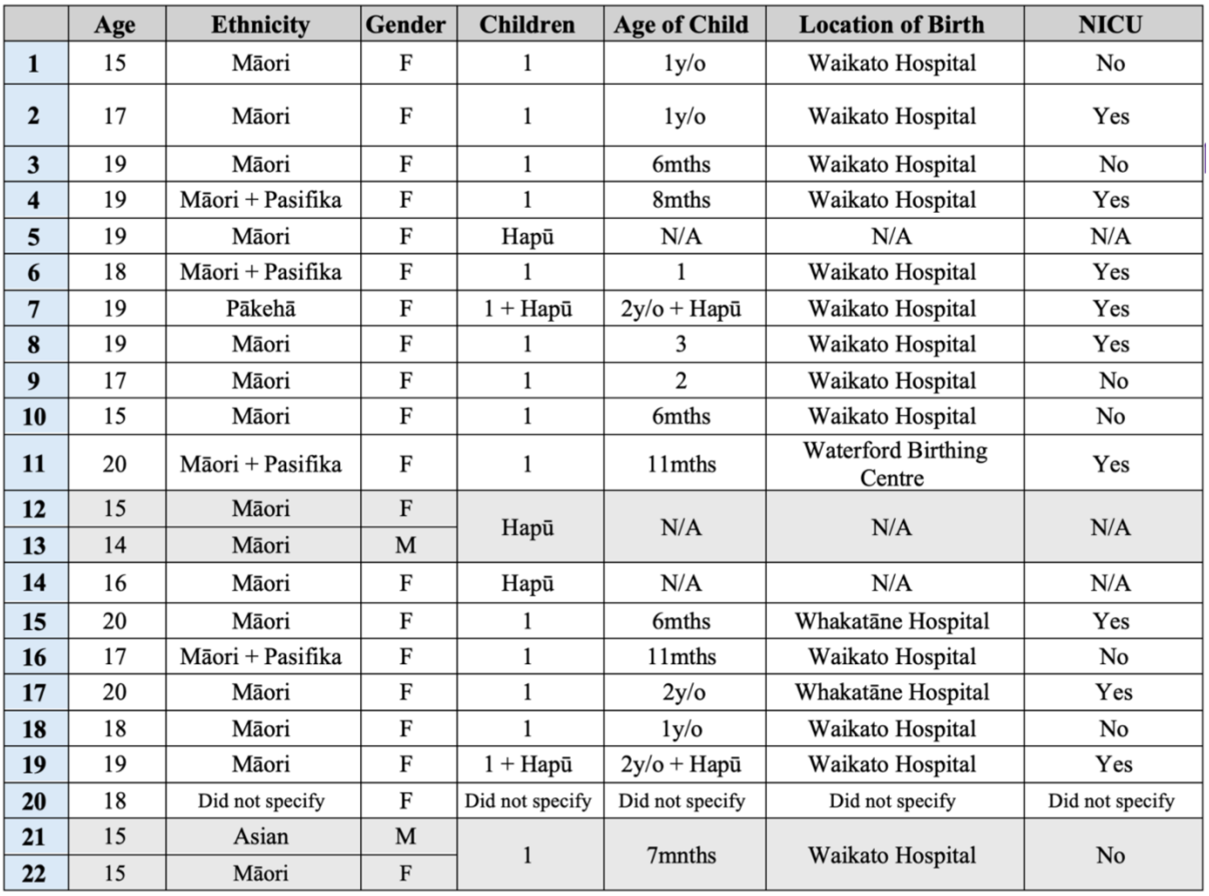
Data Management

The safety of the participants and the confidentially of their kōrero was of the upmost importance and treated as taonga. My Te Ira Wāhine framework (see Chapter 3) was implemented to ensure all information was treated with respect, privacy, protection, and care. Participants were given the option to use their real names, or they chose/were given a pseudonym. All information that identified third parties was replaced with common nouns such as 'nana' or 'the midwife.' All data collected from this study is kept on a password-protected device and original documents in a secured cabinet in my supervisor's office. All audio recorded data was transcribed using headphones and in private. The raw data is only available to members of the research team up until it is destroyed and all information collected remains strictly confidential in accordance with the *Privacy Act, 2020*. Five years after the completion of this study, the Lead Investigator will securely delete, and shred/dispose of all data stored physically and digitally. All the above is the application of Kaitiakitanga, Manaakitanga, and Mana Motuhake.

Participants

As illustrated in Table 1, a total of 22 parents volunteered to participate this study: 20 females and two males. Participant ages ranged from 14-20 years old, and 19 identified as Māori and/or Pasifika (82.6%). At the time of data collection, the majority of the participants had one child, no participants had two children, one couple and two mothers were pregnant with their first child, and two mothers were pregnant with their second child. Thirteen māmā gave birth at Waikato Hospital in Hamilton (65%), one gave birth at Waterford Birthing Centre (Hamilton), and two gave birth at Whakatāne Hospital. Eight of the pēpi born in Hamilton were admitted to a Neonatal Intensive Care Unit [NICU] after birth.

Table 1: Search Participants (at time of data collection)

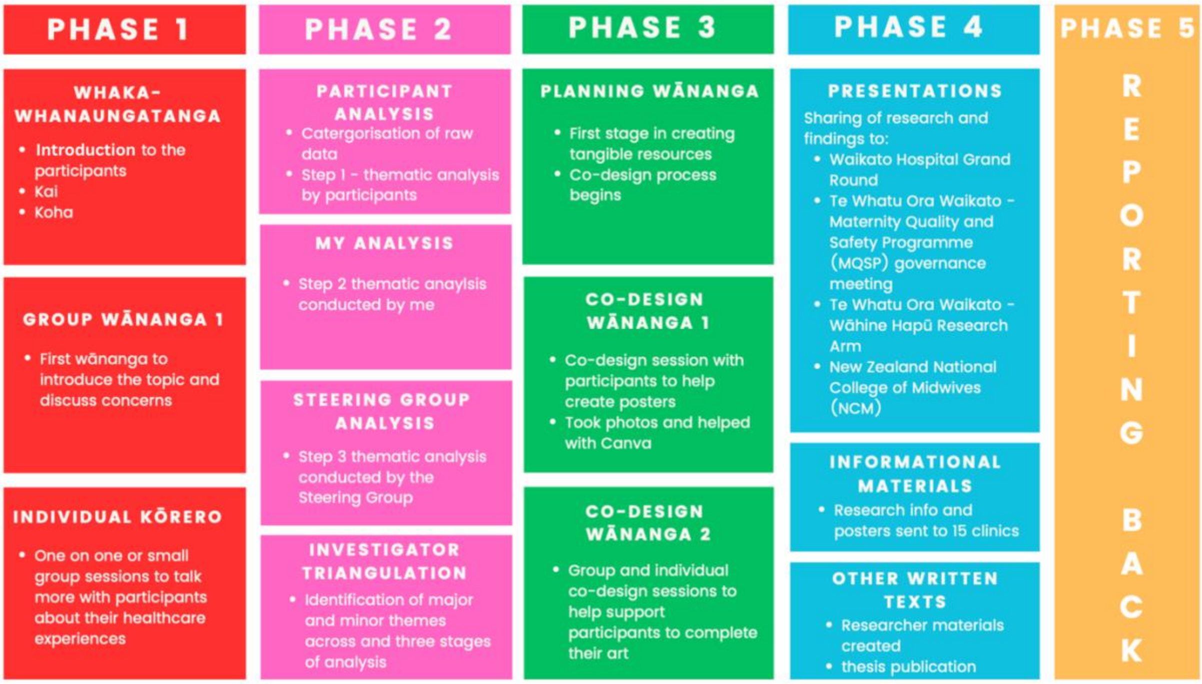


	Age	Ethnicity	Gender	Children	Age of Child	Location of Birth	NICU
1	15	Māori	F	1	1y/o	Waikato Hospital	No
2	17	Māori	F	1	1y/o	Waikato Hospital	Yes
3	19	Māori	F	1	6mths	Waikato Hospital	No
4	19	Māori + Pasifika	F	1	8mths	Waikato Hospital	Yes
5	19	Māori	F	Hapū	N/A	N/A	N/A
6	18	Māori + Pasifika	F	1	1	Waikato Hospital	Yes
7	19	Pākehā	F	1 + Hapū	2y/o + Hapū	Waikato Hospital	Yes
8	19	Māori	F	1	3	Waikato Hospital	Yes
9	17	Māori	F	1	2	Waikato Hospital	No
10	15	Māori	F	1	6mths	Waikato Hospital	No
11	20	Māori + Pasifika	F	1	11mths	Waterford Birthing Centre	Yes
12	15	Māori	F	Hapū	N/A	N/A	N/A
13	14	Māori	M				
14	16	Māori	F	Hapū	N/A	N/A	N/A
15	20	Māori	F	1	6mths	Whakatāne Hospital	Yes
16	17	Māori + Pasifika	F	1	11mths	Waikato Hospital	No
17	20	Māori	F	1	2y/o	Whakatāne Hospital	Yes
18	18	Māori	F	1	1y/o	Waikato Hospital	No
19	19	Māori	F	1 + Hapū	2y/o + Hapū	Waikato Hospital	Yes
20	18	Did not specify	F	Did not specify	Did not specify	Did not specify	Did not specify
21	15	Asian	M	1	7mnths	Waikato Hospital	No
22	15	Māori	F				

Methods

As illustrated in Figure 3, this study consisted of five key phases, and included three different qualitative methods: wānanga, kōrero, and an investigator-triangulation thematic analysis. In the following sections, I explain the process and methods employed at every step of this project.

This study was unique in the way that participants could choose which phases to participate in. During Phase 1: data collection, 17 participants attended the first group wānanga (including one pāpā) and seven māmā engaged in an individual kōrero. During Phase 2, 11 participants took part in the participant group analysis (including 1 pāpā). Whilst in Phase 3, 10 participants took part in the co-design process and produced eight posters



PHASE 1

WHAKA-WHANAUNGATANGA

- Introduction to the participants
- Kai
- Koha

GROUP WĀNANGA 1

- First wānanga to introduce the topic and discuss concerns

INDIVIDUAL KŌRERO

- One on one or small group sessions to talk more with participants about their healthcare experiences

PHASE 2

PARTICIPANT ANALYSIS

- Catergorisation of raw data
- Step 1 - thematic analysis by participants

MY ANALYSIS

- Step 2 thematic anaylsis conducted by me

STEERING GROUP ANALYSIS

- Step 3 thematic analysis conducted by the Steering Group

INVESTIGATOR TRIANGULATION

- Identification of major and minor themes across and three stages of analysis

PHASE 3

PLANNING WĀNANGA

- First stage in creating tangible resources
- Co-design process begins

CO-DESIGN WĀNANGA 1

- Co-design session with participants to help create posters
- Took photos and helped with Canva

CO-DESIGN WĀNANGA 2

- Group and individual co-design sessions to help support participants to complete their art

PHASE 4

PRESENTATIONS

Sharing of research and findings to:

- Waikato Hospital Grand Round
- Te Whatu Ora Waikato - Maternity Quality and Safety Programme (MQSP) governance meeting
- Te Whatu Ora Waikato - Wāhine Hapū Research Arm
- New Zealand National College of Midwives (NCM)

INFORMATIONAL MATERIALS

- Research info and posters sent to 15 clinics

OTHER WRITTEN TEXTS

- Researcher materials created
- thesis publication

PHASE 5

REPORTING BACK

Figure 3: Research Design

<u>Phase 1 – Data Collection</u>

<u>Whanaungatanga, Karakia, and Koha</u>

I was introduced to the students of He Puaawai in late 2022. In our first meet and greet, the focus was whanaungatanga – building relationships. On this day, we shared kai and everybody introduced themselves, and we talked about our connections to this kaupapa (Manaakitanga, Whanaungatanga). Whanaungatanga is a common practice/concept in Māori tradition which enables us to connect with others on a deeper level and creates strong foundations for a trusting relationship.

On majority of interactions with participants we arrived at the same time as them (in the morning) and this helped us get to know the students. We had time for small talk with both staff and students, we met their babies, and joined the He Puaawai whānau morning karakia and announcements. The morning karakia set the tone for the students work for the day and our sessions. This also meant that it wasn't necessary for us to say another karakia before our wānanga.

The regular koha was to bring kai for lunchtime and provide snacks for each engagement (Manaakitanga, Whanaungatanga). Providing/sharing kai is a common practice in Māori tradition and in kaupapa Māori research.

Group Wānanga 1

The first wānanga was held March 15, 2023, and was video and audio recorded. The objective of this wānanga was to discuss the concerns participants had raised during the parent study[126] (see Chapter 1) (Kaitiakitanga, Whanaungatanga). To begin, my supervisor helped to explain the research confidentiality, the purpose of the video/audio recording equipment, and answered any questions from the participants. Those who chose to participate, then signed a consent form. To help learn everyone's names and with transcribing, we all created personalised name plates as a fun introductory activity. We then discussed the three research questions. Everyone was able to share as little or as much as they wished to, and ultimately the participants had the mana to direct the conversation where they wanted. Gillian stayed and participated in the group wānanga; this was to support me as the researcher but also to support the māmā as their kaitiaki.[127] This wānanga was transcribed verbatim using the audio recording and video was used to help identify who was speaking.

Wānanga as a Method

Wānanga are group discussions, where a safe space is created for everyone present talk and share their thoughts, feelings, and experiences. Smith et al. (2019) explain:

> Wānanga provide a culturally determined space for the wise transmission of knowledge and disrupt and decolonize traditional western methods by positioning the collective production of knowledge as central, including knowledge translation, rather than just relying on research outputs and a repositioning of researcher/researched relationships. (p. 5)

The benefits of wānanga include the safe space for participants come together and kōrero, whilst providing participants the opportunity to exercise authority over their data and how information will be shared (Reweti, 2023). Limitations of wānanga can sometimes include longer engagement times and participants being reluctant to speak in larger group settings. Smith et al. (2019) also explain that at times there can be a challenge in ensuring all participants are ‘present’ and engaged in wānanga.

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[126] The Collaboration Study: determinants of health for Māori mothers and adults with chronic diseases

[127] Guardian or protector

Individual Kōrero

Six māmā volunteered to participate in individual kōrero; three were conducted one-on-one, and the last was conducted in a small group of three (Mana Motuhake, Tino Rangatiratanga). The objective of the individual kōrero was to listen to the interviewees experiences in-depth and understand their perspectives when it came to the healthcare practitioners who service them (Manaakitanga, Kaitiakitanga, Whanaungatanga). This was also helpful for those who were reluctant to speak in group settings. I began by reiterating the guidelines around confidentiality and we began with karakia. To help the interviewees feel comfortable in talking to me and in sharing their stories, I shared a bit more about myself and my connection to the research topic. Some of the participants brought notes with them; ideas they wanted to share specifically in this forum. Using a narrative approach, these māmā shared their experiences with healthcare practitioners they engaged with from 'finding out' they were pregnant through to their more recent interactions. When needed, prompts were given based on the three main research questions. Each kōrero was also closed with a karakia whakakapi.[128]

All individual kōrero was voice recorded and transcribed verbatim. Transcripts were then returned to each participant for member checking, before analysis. Participants indicated on the consent forms whether they would like their name changed and had the option to choose a pseudonym.

'Interviews' as Method

For the purposes of this study, I adopted the terms 'individual kōrero' instead of interview. The term interview has connotations of investigation, which infers an imbalance of power in interactions, when in fact the researcher should be learning from the participant. Using the term individual kōrero for me implies that the participant holds the mana that guides the kōrero. This allows participants to express their tino rangatiratanga and mana motuhake, as they shape the narrative and control the conversation.

Rewi (2014) expands on the use of traditional research terminology such as 'informant' and emphasises that terms such as this imply that participants are strictly supplying information without necessarily participating beyond that. She further explains that staying away from these terms creates a safer space for participants and researchers to work together.

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[128] A closing karakia or prayer – usually to complement the opening karakia for the day/activity/meeting/gathering

Phase 2 – Analysis

As illustrated in Figure 3 this study featured a three-part thematic analysis: a participant group analysis, an individual researcher analysis, and a Steering Group analysis. So, I could not influence their thinking or process, the participants conducted their thematic analysis first. I then did my own analysis of the same raw data before the Steering Group because I did not want them to influence my thinking or process. The Steering Group was the last cohort to conduct an analysis because they have great experience in this field and would offer a clinical and cultural perspective. The analyses were conducted by writing directly onto a whiteboard (Participants and Steering Group) and onto paper (Steering Group and I).

A thematic analysis of the parents' stories was deemed the appropriate analytic tool because of the intensely rich and the amount of kōrero shared. Thematic analysis is common in kaupapa Māori research and is a common method for identifying themes in qualitative data (Terry et al., 2017). This approach worked for this study because there was a large number of participants who had many experiences; thus, we were able to capture the key points from every participant's story.

Limitations of thematic analysis can include researchers becoming overwhelmed with the volume of potential themes and may miss outlier topics (Terry et al., 2017). Moreover, novice researchers may be unsure about how to accurately conduct thematic analysis due to its fluidity and flexibility, which can lead to inconsistency when developing themes (Nowell, 2017).

Participant Analysis

Prior to the participant group analysis, I combined all the raw data into categories based on the three research questions:

1. When caring for young māmā and their tamariki what are doctors, nurses, midwives, and other healthcare practitioners doing well?
2. When caring for young māmā and their tamariki what are doctors, nurses, midwives, and other healthcare practitioners not doing well?
3. What are the messages and lessons you want to get across to improve how health professionals treat and service young māmā and whānau?

This is a provisional coding method (Saldaña, 2009).

In these categories, all quotes were grouped by origin (i.e. wānanga or individual kōrero). Comments that did not fit the scope of the study or relate to the research questions were removed. Each quote included a participant code. Because some participants contributed to both the group wānanga and the individual kōrero they had a higher input of ideas and kōrero than others. However, interesting or stand-out kōrero was added to a sub-section and included for analysis.

This selection of kōrero was then given to the participants to read, analyse, and write notes. On the day of the group analysis, they were invited to share their notes and thoughts, talked with their peers about the themes they identified, and I recorded the key terms and phrases on a whiteboard. Together, we then grouped the common and related terms/phrases into categories/themes based on healthcare providers: doctors, nurses, midwives, and others (Mana Motuhake, Tino Rangatiratanga). After the (22) main themes were identified (see Appendix J), participants were asked to raise their hand if that theme applied to their experience. The majority of participants raised their hands for majority of the themes. This was a second cycle of provisional coding (Saldaña, 2009).

My Analysis

Two weeks after the participants' group analysis, I conducted my own using the same raw data. To the best of my ability, I tried not to be influenced by the themes the students had identified and attempted to remain unbiased, regardless of my personal experience and those shared with me by these young parents. Te Ira Wahine was not explicitly applied because I wanted as much as possible for this exercise to be 'inductive', meaning I wanted the themes to emerge from the data rather than having preconceived ideas that guided this process (Saldaña, 2009). However, I also acknowledge that nothing we do is totally objective, and the themes one sees may be different to the themes the next person sees. In the end, I identified 46 themes and/or ideas (see Appendix K).

At this stage, my individual approach to thematic analysis featured one cycle of coding that employed a combination of provisional, In-vivo, descriptive, and magnitude (frequency) coding methods (Saldaña, 2009). For more clarity about coding, see Table 2 below for examples of different coding methods I used during this phase, and how they were applied to the kōrero from participants.

Table 2: Coding Examples

Sample quote	Coding methods
“I think that’s one thing that I don’t like about doctors.... is that they always think they know better than you, even when it comes to your baby, they always think they know better than you” - Vana	Doctor/Not doing well (Provisional coding, Q1) “They always think they know better than you” (In-vivo) Ego, elitist (Descriptive)

My first cycle produced a number of the same themes as the participants. My second cycle of coding occurred after the Steering Group analysis.

Steering Group Analysis

Lastly, the raw data scripts were given to all the members of the Steering Group and then discussed at a special analysis hui. This hui followed the same process as conducted with the participants and produced a larger set of themes, while also discussing some tentative solutions (see Appendix L). Post-hui, the members of the Steering Group gave me their annotated transcripts and their methods included In-vivo, descriptive, and holistic coding (Saldaña, 2009).

Investigator Triangulation

After the Steering Group analysis, I conducted a triangulated analysis by comparing the themes produced by the three different ‘investigators’ (participants, myself, and the Steering Group). Following Bhandari (2022), “Triangulation is a research methods strategy that uses multiple data sources, researchers, theories, or research methods to ensure that the data, analysis, and conclusions of a research study are as comprehensive and accurate as possible” (para. 1).

The purpose and benefit of investigator triangulation is to mitigate common limitations (as outlined above), such as bias and an overwhelming number of key themes. This is regarded as a second cycle of analysis. In this cycle I identified the themes that were similar across all three analyses. These themes became the major themes, and those that were not, were categorised as ‘minor’ themes. A minor theme could also be a theme that was of significance to a particular cohort but was not mentioned in volume.

Phase 3 – Co-design

The co-design process was employed to create educational and informational materials. Participants took the lead to design the resources they wanted to and chose to use posters featuring images and slogans (Mana Motuhake, Tino Rangatiratanga). The co-design process involved three wānanga. The primary goal for the co-design process was to produce a tangible output that would be shared with end-users (e.g. doctors, nurses, midwives). In the spirit of mana motuhake and tino rangatiratanga, we wanted the māmā to lead the design process. Co-Design is collaborating with others to produce a resource whilst prioritising relationship building, and decentralising power and hierarchy (Wardak et al., 2024).

The strengths of a co-design process are that participants voices are heard, and they are involved in every step, which builds capacity and empowers participants. However, co-design can also have its challenges. Co-design is often time and resource intensive, meaning more time and resources need to be allocated to reach the desired outcomes (Steen et al., 2011). There is also the question about whether it is really co-design if the research team design the research questions as this influences the thinking of participants before they are involved in the process (Singh et al., 2023). However, in employing a kaupapa Māori research approach and my Te Ira Wahine framework, we recognised the limitations around co-design and planned in advance to allow generous time and resources in this project.

Planning Wānanga

During the planning wānanga, the key themes were presented and put on a whiteboard. We talked about what resources they would like to make, what they would choose, (video, picture or in written form), and what themes they would focus on. Although it was suggested, they did not want to do videos, educational storyboards, or pamphlets. Instead, all the participants in the phase of the project chose to create posters. A brief presentation was given about the importance of identifying your message and target audience, and how best to communicate that message to that audience.

Co-design Wānanga 1 and 2

The co-design of materials was conducted over two main wānanga and various drop-in sessions. These wānanga focused on creating and completing the participants' posters/designs. During these wānanga the students/māmā worked together in small groups, as individuals, and with me to finish their creations. My involvement as the researcher included guiding participants with planning, taking photos, and navigating the creation software (Canva). In addition to the co-design wānanga, I conducted drop-in sessions to support the participants to complete their posters. When their creations were completed, the participants approved their works, gave me a brief description about their works, and gave consent for them to be disseminated.

Phase 4 - Dissemination

I feel at times there can be a disconnect in translating research to implemented systems change, unless there are strong efforts and plans in place to disseminate findings and reach people who can make change. Therefore, the purpose of Phase 4 was to reach the healthcare practitioners who do and will service young mothers/parents. Educating healthcare practitioners on the experiences of young mothers when accessing healthcare and sharing the young parents' messages was conducted in three ways: presentations, distribution of co-designed materials, and other written texts.

Presentations

Supported by members of the Steering Group, I presented the research findings and co-designed materials to different clinical and non-clinical healthcare staff and governance groups at various seminars and meetings (Whanaungatanga, Mārohirohi, Mana Motuhake).

At the time of writing this thesis, the findings have been presented to the following audiences:

- Waikato Hospital Grand Round (in-person)
- Te Whatu Ora Waikato - Maternity Quality and Safety Programme (MQSP) governance meeting
- Te Whatu Ora Waikato - Wāhine Hapū Research Arm
- New Zealand National College of Midwives (NCM)
- Waikato Hospital Grand Round: ‘Whānau Voice’ seminar (online)

Participants were/and will continue to be invited to present or attend each presentations/meeting/seminar. Avia (participant) was able to attend the second Grand Round ‘Whānau Voice’ seminar and spoke about her experiences and shared her key messages for healthcare practitioners.

Informational Materials

The participants were asked if there were any specific clinics, practices, or people they would like their works distributed to. However, while many of them mentioned particular people and clinics, when asked again, they asked me to choose the locations for them. Three different posters were sent to 15 randomly selected health clinics and general practices within Waikato. A cover letter outlining my research and the purpose of sending the materials produced by our participants, accompanied the posters (see Appendix M). The purpose of this distribution was to raise awareness about the experiences that young mothers are having and to inform healthcare practitioners about the study and the findings (Manaakitanga, Kaitiakitanga; see Chapter 6 for the feedback received).

Other Written Texts

During the dissemination phase, I also designed two posters (see Figure 9 and 10) and an informational pamphlet (Appendix N). Once I had designed my posters, I took them to show the participants, and they agreed that this aligned with the messaged they want to share (Whanaungatanga). The pamphlet was informational and included the research process and findings. After submitting this thesis, I also intend to write/submit at least one journal article.

Phase 5 - Reporting Back

After disseminating the findings, I reported back to the participants in a short presentation (Manaakitanga, Kaitiakitanga, Whanaungatanga). Each māmā was presented with a folder of materials, including a short summary of the study and dissemination work so far, any activities they had completed, glossy printed copies of their posters, and individual koha. This was conducted over lunch, and we thanked them for their passion towards this kaupapa and for opportunity to support them in having their voices heard.

Sharing research findings and reporting back to these māmā was very important. It was a way in which we could give back and reinforce the importance of their role, provide information that may be useful to them, and improve their trust in research and researchers (Hintz & Dean, 2020). Purvis et al. (2017) also explain that although participants consent to participate, they still 'own' the information. Therefore, it is a 'rite of passage' that participants have continued access to their input and are informed of the progression of the findings/their information.

Summary

In summary, I have three key learnings to take away from this chapter. One, I like qualitative research because it allowed me to step into our participants world and see their perspectives and views. Two, I enjoyed the co-design process, as it ensured that the participants were directly involved in shaping and sharing their messages. Lastly, during this process I learnt a key aspect of kaupapa Māori research, which is that often the community dictates your timeline, not the researchers. This was a valuable lesson because this concept not only gives participants the mana to guide the research process, but it is fits around their busy lives.

In the next chapter, I present the findings that emerged out of this triangulated approach to thematic analysis.

CHAPTER 6 FINDINGS

I have used some titles that are based on In-vivo coding (see Chapter 5) to capture the main theme in those sections. Throughout the wānanga and individual kōrero, I observed there were many different themes illustrated, in the experiences of these young māmā, their lives are complex, and there is a lot to unpack in their stories. All themes intersect and intertwine but for the purposes of this thesis they are structured as follows.

Introduction

This chapter presents and explores the findings and observations from the three wānanga and seven individual kōrero with the 22 participants. The aim of this study was to learn more about young parents' healthcare experiences in an effort to improve the way in which healthcare practitioners service and treat young mothers. Thus, the main research questions set out to investigate what healthcare practitioners are doing well, what they are not doing well, and the key messages young mothers have for health staff.

In Part 1, I describe the positive and negative experiences that directly relate to doctors, nurses, and midwives and present the key findings and the co-designed materials. In Part 2, I conclude by offering my analysis as the researcher.

Part 1 – Key Findings

Positive and Negative Clinical Experiences

In relation to the research questions, we originally chose doctors, nurses, and midwives as the health workforce to centre the conversation around. However, in looking at the findings it has been identified that participants engaged with several *different* types of doctors, midwives and nurses (e.g. OB-GYNs, paediatricians, NICU nurses, school nurses, nurses in hospital, community midwives, hospital midwives, and birth-centre midwives) which expanded our kōrero more. It is also noticeable that the different healthcare staff are present in different stages of participants' overall pregnancy and birth experiences.

Doctors

In relation to doctors, the general feedback was largely negative. The participants often spoke about doctors in a general sense and when referring to them, indicated they were mostly male. However, they also talked specifically about OB-GYNs, General Practice doctors, and Accident and Emergency medical staff [A&E]. Given that nine of our participants babies spent time in the Waikato Hospital NICU, it is interesting that Paediatricians were not mentioned.

When engagements were negative, participants expressed that older doctors had little time for them, made assumptions, did not listen to their concerns, and made them feel like they were not a priority.

> *"The older doctors and nurses need to stop assuming that because we're young and if something happens to our babies or to us it's violence and drugs or something like that, they need to open their eyes and just do your job."* - ***Robyn***
>
> *"...it's hard to trust them if they're not gonna treat you well, we're gonna have this bad mindset on... doctors and stuff when we don't want that and we don't want to teach that to our kids!"* - ***Avia***[129]
>
> *"I think that doctors are faced with a lot but they have their priorities the wrong way around."* - ***Vana***
>
> *"[We need] doctors that take their time."* - ***Rehua***
>
> *"I think that's one thing that I don't like about doctors, is that they always think they know better than you, even when it comes to your baby..."* - ***Vana***

In contrast, the participants agreed that younger doctors were more likely to listen and were more attentive and understanding. Avia[130] provided a detailed example, when an older Pākehā nurse made an unsolicited judgmental comment during a visit to the hospital:

> *"[I said to the young doctor] 'we don't actually want this lady here, we don't want her 5 cents, she's just being nosy, and we don't want her opinion.' I told the male doctor what the lady had said, and he was like, 'yeah, that's not acceptable, I'm very sorry, you know I've got notes on her name. I'll report that. I'm so sorry that that happened to you'. It was awesome. Yeah, he was great."*

---

[129] Avia participated in both the group wānanga and individual kōrero, her individual kōrero was 2 hours in length and she articulated her ideas and experiences very well (not those others did not). Avia was an example of a young māmā who had negative clinical experiences at every stage in her pregnancy. These collective points are shown in the number of quotes and ideas she has contributed to this chapter.

[130] Please note there are two different participants: Avia and Aavia – this is not a spelling error

Nurses

In relation to nurses, participants shared varied feedback; some had positive experiences while others had negative experiences. However, in comparison to doctors, they agreed that nurses had more time for them and were usually more caring.

When experiences were positive, our participants said nurses had more patience and were more understanding.

> *"...They[nurses] have more patience, and they understand us and mothers more than the doctors. My experience with nurses was pretty cool. They were actually way nicer than the doctors that I took my son to go see."* - ***Matariki***

> *"I don't know, it was quite quiet and chill with me like they could actually sit down and talk with me."* - ***Te Rā***

One māmā shared a story about how they helped her with breastfeeding.

> *"The nurses like after you give birth to baby are really good with teaching you how to breastfeed and to latch or like they'll help with changing the nappies and letting you have a rest... once I had baby, they were like, 'so what do you want to do? Do you want to try feeding this way or this way, what do you want to do? Do you want to eat, do you want to go for a walk? We can give baby this shot, we can give you this shot."* - ***Avia***

A common theme was that the younger student nurses were "better" than the older nurses.

> *"Those studying nurses have more care and attention because it's still fresh.... Whereas the older people are just like 'oh, this is my all day, every day', you know, like and they just have no respect, no care, just rude."* - ***Avia***

When the māmā shared negative experiences, the majority referred to nurses working in the hospital or NICU. Specifically, the māmā who had children admitted to NICU said that nurses often did not ask or inform them about the treatment they were giving their babies.

> *"She had heaps of little holes in her feet and so I asked [the NICU nurses] why my baby had all of these and then asked why they were not telling me about it or asking for my permission. Like this is my child and you have to tell me before you do anything to her… then they tried to put a urine bag on her and it got stuck on her and they ripped it off and it was making her sore and red because they put it on wrong… so I made a formal complaint."* - ***Robyn***

> *"... I went there [NICU] one time and he[baby] had a plaster on his back and they didn't write down what they did or anything like why would he have a plaster on his back? -* ***Puanga***

> *"Same thing happened to me too, not the plaster on the back but they kept doing stuff without telling me. So, I made a complaint to the hospital, and I was like 'do you think just because I'm young you don't have to tell me what you do to my baby or get my consent?' then they were like 'oh we're just trying to help'. And I was like 'yeah, but if you're tryna help then you should tell me what you're doing." -* ***Robyn***

> *"When my baby went into NICU, cause I was breastfeeding and that, but I would pump him some milk and put it into the fridge. But then I'd got to sleep and I woke up and they'd given him [someone else's milk without telling me]." -* ***Matariki***

Many participants also explained that unlike Avia's positive experiences, nurses had pressured them to breastfeed when they did not want to or were feeling sore or uncomfortable after birth. When Jazz shared her experience, she expressed feelings of shock and disgust when she woke up to find a nurse hand-expressing milk out of her breast.

> *"I woke up and they [the nurse] were legit like squeezing [my breast] with a syringe tryna get some out, cause my daughter went to NICU... and I just wanted her to be on formula like I just didn't feel like breastfeeding and yeah, I just woke up and they were tryna get some out, like what... I was so tired and I woke up and they [the nurse] was legit on my tit tryna get some out." -* ***Jazz***

In the group wānanga, nods of agreement and supportive words demonstrated that this type of behaviour was a common experience among these young women. When asked if this had happened to anyone else, comments included:

> *"Yeah, well" -* ***Puanga***

> *"I just got woken up to do it myself" -* ***Pol***

> *"Yeah, and I felt like he was suffocating." -* ***Vana***

Waitī shared her experience:

> *"...at like 2 o'clock in the morning we went to the birthing centre and in there, you know when baby like cluster feeds on like the second night... I had like really sore boobs, I couldn't breastfeed and [they] were like putting me down for not breastfeeding cause I would ask them for formula and then every time they would*

> *come in and bring me formula, they would try put him on my tit again and I'd be like 'no, no I can't it's sore, it's sore, it's sore.' And they were like 'you really should, it's good for baby' and then, I was literally like crying to mum saying... I felt like I was poisoning him with like giving him the formula because that's what they made it feel like. And I was like 'I really can't breastfeed because he's not latching properly' and I was like 'it's really painful' and then we went back home like the next day and my mum was doing him a bottle up and then I started breastfeeding him again cause even my midwife was making me feel bad for not breastfeeding."*

It was not clear whether this behaviour were the actions of older or younger nurses or both.

What makes our participants current healthcare experience unique is that they have access to both an in-house nurse practitioner, and a Plunket nurse that visits He Puaawai if they or their pēpi need first-hand clinical support. When asked generally about what nurses were doing well, participants predominantly associated positive experiences with their school nurses rather than nurses in any other setting. The māmā described the bond they were able to develop with the school nurse over time and spoke of the constant care, time, and respect she has for them.

> *"I'd say our nurse is probably the best!"* - ***Pol***
>
> *"And she's always like checking in on our babies."* - ***Puanga***
>
> *"...she's not doing it just because it's her job."* - ***Paki***
>
> *"And if she needs to tell us or ask us something then she pulls us aside to kinda like do that, she's more hands-on"* - ***Pol***
>
> *"We have a Plunket nurse that comes here and she's amazing."* - ***Jazz***

Aside from this service, I noted that none of the participants mentioned any other Plunket nurses, which demonstrates the great standard of care māmā and pēpi are provided at He Puaawai.

Midwives

In relation to midwives, participants engaged with both primary and secondary maternity care services. However, they often struggled to find a midwife but once they found one their experiences were predominantly positive.

Six participants in the group wānanga shared that they had difficulty in finding a midwife, and with midwives swapping or leaving half-way through their pregnancies.

> *"I found out I was pregnant at 7 weeks... but I actually didn't get a midwife until I was 14 weeks pregnant and then you get the whole 'why didn't you find a midwife your so behind, you didn't get this scan done, you didn't get this test and I'm like 'I really tried'...but then I had to lose her because of the mandates and I got another awesome one but that's a whole 7 weeks of tests, like I missed out on getting the down-syndrome tests, I didn't even know that was a thing, so I went my whole pregnancy freaking out like 'what if my kid has down-syndrome and I missed it."- **Avia***
>
> *"I didn't actually find me a midwife until after like 20 weeks pregnancy maybe like 24 and it was like every time I pretty much seen someone concerning baby they were like 'oh have you found you a midwife yet'? And I had to say like 'no I have been waiting for a call back from hospital midwives, community midwives and they need to get back to me.' So, maybe 2, maybe 3 whole months I was constantly on the phone every single day if not every second day and honestly got no help until one of my aunties [helped me find a midwife] after 21 weeks pregnant." - **Tanya***

In trying to find a midwife, some participants also experienced discrimination, ageism, and unsolicited judgement. Avia shared her experience with a tentative midwife she had just met:

> *"I wanna talk about the stereotypes with our age! Because it was really hard for me to find a midwife! I found out I was hapu at seven weeks, so, pretty early and I would call them [different midwives] on the phone and I would try going in and every time I would go in and have appointments with a midwife, they would think my nana would be pregnant and when they found out it was me, they'd say:*
>
> ***Midwife**: Oh, when are you due?*
>
> ***Avia** Oh, I think I'm seven weeks*
>
> ***Midwife**: Oh sorry, I'm full that month*
>
> ***Avia**: Oh, well I let you know before I came, that's why I came, that's why I had the appointment*
>
> ***Midwife**: Oh, sorry I think I'm full that month*
>
> ***Avia:** ...I had that happen to me 3 times so, we tried me going in on my own with this one lady in [name of town] and the same thing happened, I let her know through the phone, I had the messages and everything, [I said] 'I'm this many weeks pregnant', I didn't tell her how old I was or that I was Māori and I get in there and she just looks at me and says 'Is this your first baby?' and I said 'Yes' and she goes 'When are you*

> *due?' and I said, I let you know in the message that I'm due at end of Feb/ start of March and she said 'Sorry, no I'm full' and I got really frustrated with her and I said 'You didn't even give me the opportunity' and every time I would call on the phone they would say 'congratulations, oh this is going to be a great!' and then I would say 'I'm 17, I'm a young māmā and I'm due this month' and they would say 'Ohhh, I don't work with young mums' or 'I haven't worked with young mums'. I actually didn't get a midwife until I was 14 weeks pregnant. And then I got the whole 'why didn't you find a midwife you're so behind, you didn't get this scan done, you didn't get this test and I'm like 'I really tried' and lucky enough I found a whānau friend that was a midwife"*

Pol had a similar experience. When she went to meet with a midwife, the midwife assumed that her mother was pregnant and when Pol corrected her, *"...[she] looked at me funny and, she asked if I knew where the abortion clinic was..."*

Te Rā also shared her experience in finding a midwife:

> *"I was bluntly rejected by an older midwife when asking for help, she judged me because of how old I was and I had to go through the hospital to get a midwife, which was not what I wanted."*

Once these young women found a midwife willing to care for them, participants described the overwhelming amount of support, care and kindness they received.

> *"My support person was my midwife and she was amazing" -* ***Matariki***
>
> *"I loved that she[midwife] really stood up for what the mum wanted..." -* ***Avia***
>
> *"She[midwife] was lovely, she made me feel comfortable and just was really helpful and just overall prepared me for labour" -* ***Aavia***
>
> *"I reckon if it wasn't for my midwife making that call, [baby's name] wouldn't be here. It was that quick." -* ***Jazz***

Although Avia had a challenging start to her first birthing experience, she had a great experience with her midwife who advocated for her:

> *"I loved that she really stood up for what the mum wanted, especially at the hospital she hated the hospital as well.... I was in labour and I was waiting there for 40 minutes. The lady [receptionist] told me 'you gotta wait here to get a covid screening and then you can go out back'...I'm standing there in my final stages of labour, crying, about to take my pants off cause I needed to push. [the receptionist] just sat on*

> *her computer and ignored me for 40 minutes, 'I was like can you please just shove the [covid] thing up my nose, I'll do it myself.' My midwife was like 'hello we're not invisible we need to go back there' [and] ended up just grabbing me... she took me out back. The [receptionist] lady was then like 'oh my gosh you can't go back there, you're endangering others'. We went out back and then I had my baby 8 minutes later."*

<u>Other Healthcare Staff</u>

The poor behaviour of receptionists that caused barriers for many of the māmā was a topic of discussion. When Avia shared her labour/birth story (above), the other students' reactions (e.g. yeah! They do that) corroborated her story. During her individual kōrero, she then shared two more experiences she had with receptionists:

> *"One time I had to go to a hospital just for a scan because a lot of the radiology's were full. So we went to the hospital, we did my ultrasound... my nana wasn't allowed in the room, but she was in the waiting room while I had my scan... [while I was in my scan] my nana overheard the lady... [say] to one of the other receptionists, 'oh, another Māori pregnant, and she's young'. And then my nan was thinking 'is she talking about Avia?' And then I came out and I was like 'thank you, bye' and the lady was like 'oh, bye'... then I just turn around and nana leans over [the reception] and she goes 'you should be ashamed of yourself! and then I was just like, 'oh, I was like I always miss it', and then I scampered off with her.... she didn't even tell me about it until like my daughter was three months old. But I love that my nana, she always stands up for me. Yeah, that was very uncultured of her [the receptionist]. 'oh, another Māori young woman, pregnant'. 'Young māmā pregnant'."*

She also related an experience with a pathology receptionist who breached confidentiality:

> *"There's always this one lady and I went to her once and... she goes*
>
> ***Receptionist:*** *'...this blood test is just to check your HGC hormones, you know and your white blood cells for pregnancy'.*
>
> ***Avia:*** *'yeah, yeah', sitting there like 'yup'.*
>
> ***Receptionist:*** *'oh, so you're 17'*
>
> ***Avia:*** *'Yes'.*

> ***Receptionist:*** *'Oh, [Avia's last name], I know a [last name], she lives in [home town]'.*
>
> ***Avia:*** *'Yep, that's my auntie'.*
>
> ***Receptionist:*** *'Oh, does she know you're hapū?'*
>
> ***Avia:*** *'You know, I'm still in early days and I'd prefer it to stay that way'.*
>
> ***Receptionist:*** *'oh, it's confidential'*

Later that day, Avia received a text from her mum asking if she had told her aunty about her pregnancy.

Participants also talked about being ignored by paramedics, including their midwives. Other participants joined the conversation.

> ***Matariki***: *Yeah, cause I caught a ride from [small town] to [other small town] hospital and it's from like here [talks about short distance]. And I was like in mean pain and my contractions were like getting closer and closer and sorer and sorer and I was asking them if they were able to put their sirens on and get there faster, and they were just like 'no you're alright, you're okay it will fade away soon, it's just contractions' and then my midwife was also asking [ambulance driver]. Like 'please we need to get her into a hospital bed, that's the best place for her to be' and they just drove on the road like normal, no lights, no nothing waiting in the traffic behind all the cars. And I was crying I was sore and I just wanted to go to my mum.*
>
> ***Rehua:*** *it's like they want you in pain aye*
>
> ***Avia:*** *Do you think like if like what we were talking about like the way you presented yourself [dressed] and if you had a support person and stuff it would have been different?*
>
> ***Matariki***: *My support person was my midwife and she was amazing, she's like you Gill, shes like really cool and tryna explain in her nicest way ever tryna explain to them that 'we need to get there asap, she is gonna start pushing soon'.*
>
> ***Mia:*** *Do you think midwives get looked over often?*
>
> ***Matariki:*** *Looked over, honestly yeah. My midwife got looked over quite a lot but she was really amazing.*

No one provided positive stories about any 'other' healthcare staff.

Female Healthcare Staff

A focal point our participants discussed was also the positive engagements they had with female healthcare staff. Although there are significantly more female nurses and midwives than males' in the health sector participants noted that there was a significant difference in treatment and care from female health personnel than male. Wainui stated *"...every lady that I've been to has been so nice."* Their numerous comments above about midwives and nurses illustrated that participants felt more comfortable with female staff closer to their age rather than males.

Patient-Centred Care

One of the main topics my participants highlighted was the need for better patient-centred care during engagements with healthcare practitioners. Participants expressed that those they had positive engagements with often had great interpersonal skills, communication, they listened, they took their time and advocated for their needs where necessary. The four headings in this section are the participants own words (In-vivo coding), linked to their direct experiences of these four topics. As discussed above, it was difficult to separate the themes shown, as a lot of the topics discussed intertwine and overlap.

"I appreciate the communication"

Participants shared their experiences with uncommunicative clinical staff and non-effective communication throughout their pregnancy. Although, at times it was difficult for participants to understand where the breakdown in communication occurred, Tanya's statement illustrates this theme:

> *"I just think their communication is terrible, like the urgency to help any mum who's pregnant or even just looking for a midwife is really shocking..."* - ***Tanya***

Three participants discussed being ignored by healthcare staff or mistaken as being the support person rather than the pregnant māmā:

> ***Pol:*** *Like even if your [support]person says 'oh were you talking to them' - they still don't really talk to you.*
>
> ***Matariki:*** *They look straight past you.*
>
> ***Pol:*** *Yeah, yeah. Their focus...they keep their focus at that other person.*

> ***Avia:*** *Or they…when they talk to you about what they're gonna do, they don't really give you the option, like 'oh we're gonna take', no 'can I take' your blood or like they come and just do it. And if you ask questions like 'oh, how come you need blood again' they just like 'oh we just, we just need it', 'we need to do more tests' like they don't give you the option like [I feel like they think] 'she's just a kid, she's just a kid having a kid; she doesn't get a say.' That's how it is.*

In contrast, participants expressed that when they're communicated with effectively, they feel informed, treated like adults, and can make decisions about their care. Shanti described how communicative healthcare staff made her feel:

> *"I appreciate the...communication, for me that's really important. Like just telling me, I might already know, but it's always good to hear it a second time..." - Shanti*

"They should ***listen*** *more"*

Participants also expressed that they appreciated being heard and listened to. Again, some māmā had positive experiences, and others did not. Avia had complications during her first pregnancy. At 23 weeks' gestation she was told that she was going into labour and her baby may not survive, however, she was adamant that she was not:

> *"At that time that they told me I was going to give birth to my baby when I wasn't. It's like I was just genuinely trying to tell them [multiple times, I wasn't]…. I really thought I was going to lose my daughter and I really thought that she was going to die and they weren't listening to me! They ignored me multiple times."*

Again, when Avia didn't agree to come in and be induced at 38 weeks:

> *"…they just wouldn't listen. They were just like 'you know, it's really dangerous that you're going against our medical advice.' I said, well, I want to talk to my midwife because she's not here, I don't have a support person and this is my first time and I don't understand whether or not you're trying to help me, but I'm just trying to think of all options..." -* ***Avia***

Robyn also shared her experienced-based opinion:

> *"I think they should listen more and really take into consideration what people [we] are telling them when it comes to what is wrong with them and investigate it properly." -* ***Robyn***

Providing a positive example, Aavia shared her experience when asked what she liked about doctors:

> *"He[doctor] listened, he didn't tell me 'no', he just listened."*

"Too much in a rush"

Time was a common factor that the participants highlighted in relation to their healthcare engagements. Jazz stated that her concerns were overlooked because time was scarce, which some other participants also experienced. These comments highlight an awareness of time and resources and what a lack of this results in:

> *"[We need] doctors that take their time."* - ***Rehua***
>
> *"They're too much in a rush, like they'll see you but not see you."* - ***Jazz***
>
> *"It was ridiculous how long we had to wait before. There's just, just too busy. There are" too many people there. Not enough staff."* - ***Jazz***
>
> *"If it's convenient for them then they'll do it but if it's not then 'oh nah' they'll just dismiss it."* - ***Tanya***

These comments support the previous comments about nurses having more time for them than doctors.

"She really stood up for what the mum wanted"

When participants were asked what healthcare practitioners were doing well, they shared stories of midwives and doctors who stood up for them when other healthcare staff did not listen. In Avia's experience (outlined above), her midwife pushed passed the receptionist just in time to deliver her baby, and in another experience a young doctor, reported a rude nurse who made an unsolicited judgmental comment. Jazz shared her birth story, stating she had quite a few complications, but her midwife pulled her baby out just in time, despite her doctor's orders:

> *"...if it wasn't for my midwife making that call, [my baby] wouldn't be here."* - ***Jazz***.

Marginalisation

One of the main topics the māmā highlighted was marginalisation. Marginalisation is the act of making someone feel or treating someone as if they are less, insignificant, or not important. Many of our participants shared feelings of disempowerment, dismissal, dramatisation, and frustration which all stem from behaviour of healthcare practitioners. The following sections are the participants own words (In-vivo coding), and their direct experiences of these three topics. As discussed above, it was difficult to separate the themes shown, as a lot of the topics discussed intertwine and overlap.

“They think we’re stupid”

This theme is about feeling disempowered by healthcare practitioners. Disempowered meaning our participants being made to feel incapable, incompetent, and made to feel as though they cannot be good mothers and look after themselves and their children. During this study, the participants often expressed experiences and feelings of disempowerment that they attribute to poor treatment by healthcare practitioners. These māmā made numerous comments similar to the following:

> *“They think we’re stupid.”* - ***Rehua***
>
> *“...[they make me feel] invisible and like we’re not doing good enough.”* - ***Avia***
>
> *“They look straight past you.”* - ***Matariki***
>
> *“I should be treated the same”* - ***Shanti***

Participants often felt unsupported to make decisions for themselves and their children. Vana explained for instance that although healthcare practitioners were educated in providing clinical care, they neglected her mother-child bond and ignored her suggestions about why her baby might be ill.

> *“...they always think they know better than you, even when it comes to your baby, they always think they know better than you. But like, when we tell you a mum knows their child better than anyone, they do!”* - ***Vana***

“It’s nothing big, go home”

Related to disempowerment, many of our participants told stories of not being taken seriously. They were often dismissed literally by being told to go home, or their feelings were dismissed when in the presence of healthcare staff. They believed that this treatment underpinned the notion that ‘young people are dramatic’ and are unable to accurately articulate how they are feeling, and what is going on with their baby:

> *"I feel like they brush off a lot of situations 'like it's nothing big, go home'.... [but] they tell you 'take your babies in to get checked' and that was the result of taking the baby in to get checked, you got sent home and the same thing happens."* - ***Vana***

> *"I honestly think that they think as young people, we're just dramatic... a lot of times it's just 'you're just being dramatic', 'there's nothing actually wrong with you'..."* - ***Pol***

> *"I feel like they need to remember feelings and stuff and understand how we're feeling in that moment"* - ***Vana***

"That's not their child"

The comments below illustrate the frustration, resentment and worry mothers' feel when their maternal intuition, concerns, and innate connection to their child are ignored and overlooked.

> *"they're not pregnant, they don't know what's going on"* - ***Pol***

> *"It feels like 'that's not even my child'. Like I'm not even a whole mother to them."* - ***Matariki***

> *"...that's not their child."* - ***Matariki***

> *"Stop making us feel unsafe."* - ***Jazz***

> *"Just do your job, if that's what they love and they want to help people and save babies, then just do that and don't judge."* - ***Aavia***

The above comments illustrate these young mothers feelings of disempowerment, and how this treatment caused māmā to question their ability as parents.

Discrimination

Another prominent subject within this research were the discriminatory behaviours of healthcare practitioners towards our participants. Discrimination is the process of making unfair prejudices between people and acting on those, based on class, age, race, gender or any other identity markers (Biggers, 2023). Throughout this study, participants shared stories of being treated differently mainly because of their age, race, and gender. Interactions such as these highlight that healthcare practitioners are integrating their personal opinions and beliefs into the service they provide and placing judgement on young parents. These experiences overall had major effects on the lives of these young māmā and can be seen in the way they articulate themselves within this chapter.

Ageism

Majority of the participants attribute poor treatment by healthcare staff to being a 'young mother' or 'teen parent.' They shared comments to the tone of 'young means dumb' and 'oh a baby having a baby.' Participants acknowledged that were well aware of the stigma related to being young parents, before they became pregnant, and how young parents are perceived by not only healthcare practitioners but the wider public.

In this study, participants shared that experiences of discrimination collectively occurred at every stage of their pregnancies.

Included in the 'Midwife' section above, when Pol informed/corrected the midwife that she was pregnant and not her mother, the midwife *"...looked at [her] funny and, she asked if I knew where the abortion clinic was..."*

Avia felt she was discriminated against because of her age (also outlined in the 'Other Health Staff' section), in her 'altercation' with a receptionist. She stated *"...she was rude, and you could tell she was just discriminating because of my age."*

The following comments and experiences also intertwine with the notion 'they think we're stupid':

> *"...they don't give you the option like "she's just a kid, she's just a kid having a kid; she doesn't get a say." That's how it is."* - ***Matariki***
>
> *"Being young, they think I don't know what I'm doing and judging me trying to look after a newborn..."* - ***Aavia***
>
> *"The ageism, you know, it's not their business"* - ***Paki***
>
> *"They think we're not old enough to make our own decisions and we just don't understand what they're saying."* - ***Avia***
>
> *"Age is just a number, I should be treated the same."* - ***Shanti***
>
> *"We're all our own adults. Like we're all equal. Don't judge a book by its cover.... We're all human."* - ***Matariki***
>
> *"...These professionals and these people are like "oh, you're young" or ... 'I feel for this kid' kinda thing..."* - ***Avia***

Racism and Religion

While the majority of the 22 participants in this study were Māori and/or Pacific, only Avia spoke about racism. In her individual korero, she shared her experience when her grandmother accompanied her to an ultrasound appointment. Just after Avia was called and went through to have her ultrasound, from the waiting room, her nana overheard the receptionist say *"oh, just another Māori young woman pregnant' [in a rude and condescending voice]."*

Another minor theme that was mentioned by one participant was religion. When asked to share their final messages for healthcare practitioners, Vana stated:

> *"I think doctors, midwives and nurses they all need to keep their own personal religion and beliefs to themselves and put that aside because this is a professional matter."*

"Changing Codes"

A rather interesting topic that arose during the group wānanga was the need to look or talk a certain way when accessing healthcare. This was a strategy the participants had developed in order to avoid and minimise discrimination. Participants agreed with Gillian and called this "changing codes." During the group wānanga, the māmā expressed how they have identified this concept and learnt to 'change codes' in order to receive the care they needed. Often participants likened this concept to a 'job interview'.

The following conversation also highlights the themes of ageism and race.

> ***Robyn:*** *Yeah, well when I went to the X-Ray with Jazz, they were talking to Jazz instead of me and Jazz was like 'um, she's the mother' and I was like 'yeah, excuse me'.*
>
> ***Gillian***: *And why do you think that was?*
>
> ***Robyn:*** *Maybe because she's like taller?*
>
> ***Gillian:*** *Do you maybe think it was because she was Pākehā?*
>
> ***Pol***: *Oooo, omg that could it too Gill actually, that's a good onee!*
>
> ***Robyn***: *Do I not look like a Pākehā?*
>
> ***Pol***: *No, you don't!*
>
> ***Avia:*** *No way girl.*

Pol: *Nooo, why did I not think of that, aye?*

All: *[Big Laughter]*

Robyn: *Nah, I reckon I could pass as full-blood Pākehā.*

Waitī: *Yeah, like look at our skin difference.*

ALL: *[big laughter]*

Pol: *'Robyn', your face says it all, haha you're done, you're done.*

Gillian: *That's interesting though right, you guys are a similar age and Jazz is also a young parent.*

Robyn: *Yeah, and they kept talking to her even after like I said that, she told them that I was the mother. Like that's my daughter.*

Vana: *Wait, especially when I went to take my baby to hospital. Um I was with Paki and all the doctors and stuff were talking to Paki and not me and I was like the mum and I told them like 'I'm actually her mum, like she wouldn't know this, I would know this' and she's like 'oh okay' and asked me one question then continued to talk to Paki.*

Gillian: *Because Paki's older than you aye?*

Several Participants: *Yes [in agreeance]*

Gillian: *Sorry, Rehua what were you gonna say? You think it's about the image about how they go off how you look…*

Waitī: *Look, yeah*

Gillian: *How do you mean? Can you explain that to me?*

Pol: *Presentable, the presentation.*

Waitī: *Like what you wear? Like there's hori, then theres flash or tidy and dirty.*

Rehua: *Yeah.*

Several Participants: *[in agreeance]*

Pol: *Yanno, cause Jazzy comes with her hair tied up and…*

Vana: *Clean or dirty?*

Pol: *I don't know, she looks professional, I guess.*

Rehua: *They presume, presume that the cleanest person is the one that needs to be treated the most.*

Avia: *Does that happen to you? [asking Rehua]*

Rehua: *Yeah.*

Matariki: *That actually makes sense, I do be looking like this [references her own attire] and my support person do be looking like nice, and tidy and dress coats on.*

Gillian: *Rehua, can you repeat to 'Vana' what you said. That the person that looks the cleanest?*

Gillian: *Do they get treated different? Like they deserve the treatment.*

ALL: *Yes/yeah [all in agreeance]*

Avia: *It's as if they know what they're saying because they look smart.*

Gillian: *So, it's like a preconception or a stereotype like you said earlier a stereo-typer aye Anonymous 2? What do you think about that? Where does that come from?*

Anonymous 2: *I've been bought up in a family where I've been fortunate enough to have both my parents together, and the areas we live in are more fortunate than others and just the way that I dress compared to some of my friends that I went to high school with and that. We could both go out somewhere, but someone would treat me with more respect than my friends or like more than my cousins. And like, I feel it, it's mamae(sore) for me because that's my family you know, and yeah. Just that pulls on some strings for me. Cause we could both be the same colour but just cause I'm maybe like wearing I don't know… [gets slightly upset and shies away from conversation]*

Vana: *You probably won't even be wearing much but, for example, your eyebrows are really nice and that could just set it off and like your friend's eyebrows they look like Māori eyebrows, they're not like shaped, they're not like, they're just rough and um.*

Anonymous 2: *It could even be the way that I present myself, it could even be the certain words that I use, or if I'm like going for a job interview or something. The easiest way for me to put it for everyone to understand is that I'd talk like a Pākehā, I would use certain words because I have that knowledge and it's just sad that you have to.*

> ***Gillian:*** *It's like changing codes aye?*
>
> ***ALL:*** *Yes/yeah! [comments in agreeance]*

Final Messages - Co-design Posters

The following posters present some of the final messages drawn out of the overall research process. The messages themselves illustrate the feelings and experiences of the young māmā in this study and connect to a number of the themes reported in this chapter. The eye-catching designs and messages were purposively selected to attract attention, educate and give information about the reality these young māmā and their whānau experience.

Great Midwives

GREAT MIDWIVES...

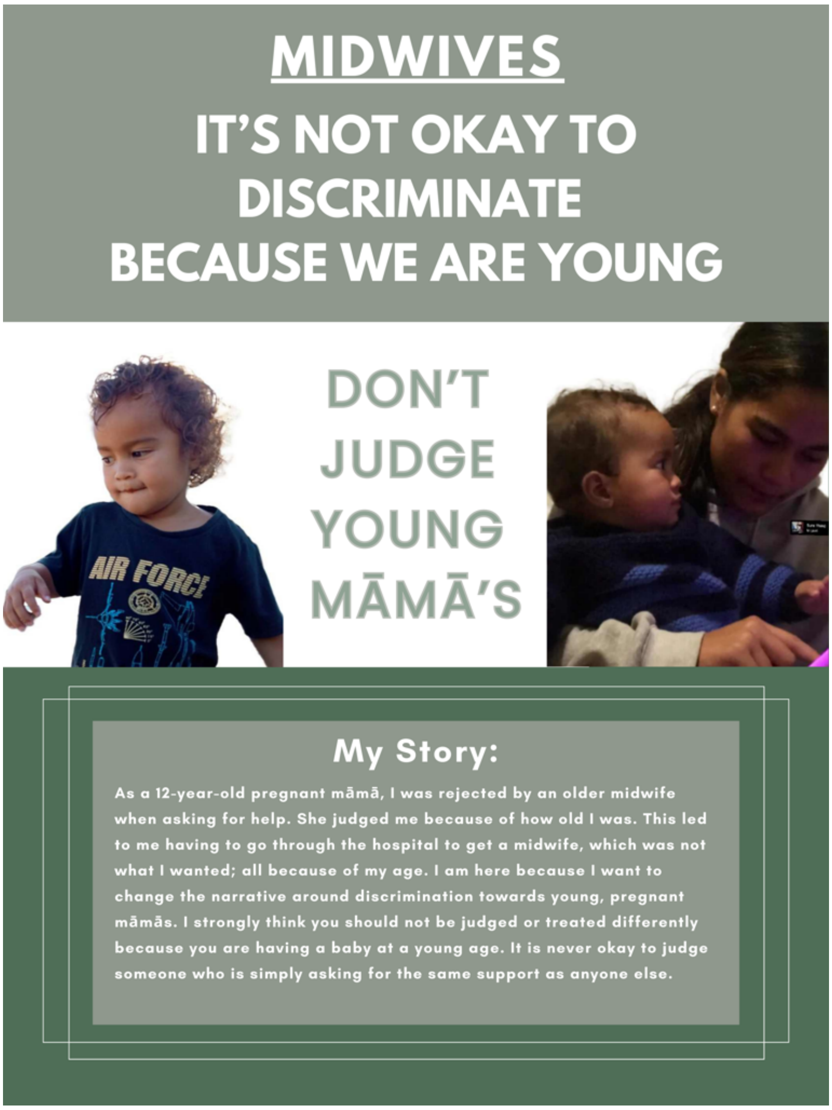
- Don't judge or Discriminate
- Are understanding
- They listen
- Are respectful
- They communicate

Made by young māmā's to create change

Figure 4: Great Midwives poster

This poster was co-created by Jazz, Robyn, Pol and Paki. Initially, they made a list of what their midwives didn't do well. However, we then discussed how midwives might receive this negative messaging and together we flipped the narrative to encourage midwives to be more respectful, understanding, communicative, and non-discriminative. The māmā stated they wanted midwives to identify their own potential prejudices and patient-centred approach to caring for young māmā in their interactions.

Don't Judge Young Māmā



MIDWIVES

IT'S NOT OKAY TO DISCRIMINATE BECAUSE WE ARE YOUNG

DON'T JUDGE YOUNG MĀMĀ'S

My Story:

As a 12-year-old pregnant māmā, I was rejected by an older midwife when asking for help. She judged me because of how old I was. This led to me having to go through the hospital to get a midwife, which was not what I wanted; all because of my age. I am here because I want to change the narrative around discrimination towards young, pregnant māmās. I strongly think you should not be judged or treated differently because you are having a baby at a young age. It is never okay to judge someone who is simply asking for the same support as anyone else.

Figure 5: Don't Judge Young Māmā poster

Figure 5 was created by Te Rā, who had a particularly difficult experience with finding a midwife and was discriminated against because she was a young pregnant māmā. She felt quite strongly about young mothers not being judged and although did not say much during the group wānanga, she wanted to share her experience through this avenue. She said, "I want to make more midwives aware that young māmā still need help, they shouldn't push them off to the side because they're too young." This māmā stated that she wants midwives to engage and support young māmā better, and if they are unable to support young mothers the right thing to do is find someone who can (Te Rā, personal communications, 23 October 2023). Due to Te Rā's experience, she wanted to write a letter of complaint to the Health and Disability Commission and asked for my support in doing so – which I gave, however, I left it in her hands to send when she wished to.

My Mum Matters, My Life Matters

Figure 6: My Mum Matters poster

Figure 7: My Life Matters poster

These posters were created by Hiwa-i-te-rangi. This māmā wanted to send a powerful message to all healthcare practitioners. She felt that a short and sharp but clear slogan would be easier to read and more impactful to staff walking past. In discussing her message, this māmā talked about her many negative experiences and she wanted healthcare practitioners to 'do better' when caring for young parents. She felt strongly about this message and felt it would make an impact and grab the attention of those walking by.

Our Lives are in Your Hands

Figure 8: Our Lives are in Your Hands poster

This poster was created by Jazz and Robyn. Together, they wanted to bring the reality of healthcare practitioners' roles to life, and have this message heard and felt. Their experiences in the hospital directly influenced this poster and is a plea to clinical healthcare staff to be more aware of the power they hold. Jazz and Robyn also shared messages about wanting healthcare practitioners to stop rushing, to listen and communicate, and hear/take their concerns seriously.

Do Better for Our Children

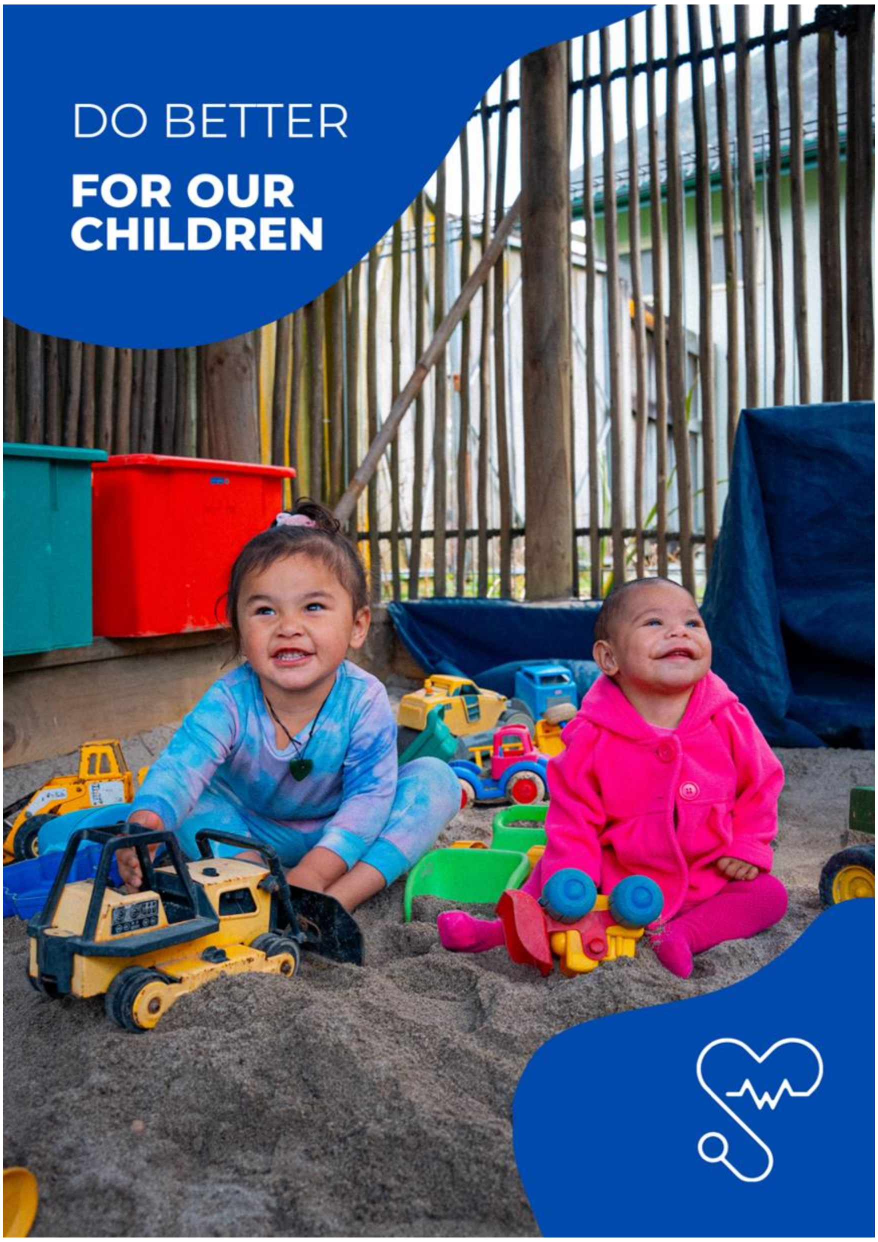


Figure 9: Do Better for our Children poster

This poster was also created by Jazz and Robyn who wanted to talk about the treatment of their children. These māmā shared that their motivation for participating in this research was their kids and their future children. They expressed not wanting their children to experience the same treatment in health that they did, and so they were happy to be a part of something that might change the health system for the better. This poster is a reminder to healthcare staff to think about the effects that their actions could potentially have for their children and future generations.

We Love Nurses Who Are…

Figure 10: We Love Nurses Who Are…poster

This poster was created by me and based on the findings of this study. I took the same approach as Jazz, Robyn, Pol and Paki's midwife poster attempted to switch the narrative, so nurses would be more inclined to listen. Although participants had predominantly negative experiences, I thought it was important to also highlight the positive experiences and findings of this research and encourage more of those actions. This poster emphasises that great nurses should advocate for young mothers, not discriminate and overall, they should support and uplift young mothers to ensure the best possible outcomes for mother and child.

Receptionists

RECEPTIONISTS

As the first point of contact, you are a vital part of our healthcare experience

☑ PLEASE	☒ DON'T
Greet us with a smile	Bring personal views to work
Listen to us	Judge us
Take us seriously	Make assumptions
Take care of us	Look past us
Treat us with respect	Ignore us

YOUNG MĀMĀ INFLUENCING CHANGE

SCAN FOR MORE INFO

Figure 11: Receptionists poster

This poster was also designed by me and based on the findings of this study. As explained earlier, receptionists were the 'other healthcare staff' that young mothers had predominantly negative experiences with. Participants experiences showed that receptionists caused a barrier to accessing healthcare and when asked about their messages for receptionists, participants gave several 'please' and 'don't' comments. The aim of this poster is to encourage better treatment of young mothers by receptionists and raise awareness for those who may not realise this is an issue and barrier. To ensure I was on the right track with the messaging of this poster, I asked Jazz, Pol and Paki if this was an accurate representation of their feelings/the findings of this study, and they agreed.

Responses

Mail-out

As explained in Chapter 5, I sent a letter to 15 different general doctors' practices and clinics around Hamilton (see Appendix M). I wasn't certain if I would get any feedback or even communication in return, but I did. Only one clinic replied and gave constructive criticism, they stated their management team had reviewed the materials and wanted to provide feedback. The email then went on to say that they "...love what [we're] doing and the rationale behind the research" however, the messaging on the posters had a negative tone and they felt a "more positive approach" with "positive focused messaging, would go a long way."

Questions from Presentations

As stated in Chapter 5, we have presented this research to a number of regional and national cohorts and meetings. Overall, we found that healthcare practitioners were willing to listen. Many of them support this kaupapa and acknowledged the importance of this research. We shared the posters with all those present and overall had a good response. During presentations we have answered questions about the research process and the findings and shared the key messages our participants had for healthcare staff. Our participant Avia was able to attend the 'Whānau Voice' Grand Round presentation and presented her experiences of pregnancy, birthing, and motherhood to over 120 different healthcare staff from around Aotearoa-New Zealand. This presentation had great feedback, and I was very proud of Avia and her strength and courage.

Throughout all the five presentations, there were few questions which indicated to me that the findings of this study were quite shocking and/or the audience was listening and taking in the information. There was one question in particular that has stood out for me from the presentation to the New Zealand National College of Midwives. This was from a midwife who asked about our findings, she said "how do young mothers know they are being treated differently to other mothers?" I replied that many of our participants had seen first-hand that other mothers were often prioritised, given more time, attention, and spoken to more nicely than them. At the time, this question suggested to me that healthcare providers weren't aware of their actions or what experiences service users were having. This emphasises the need for more education about the experiences of young parents within the health sector.

Feedback Survey

During the first and largest presentation, Waikato Hospital Grand Rounds (to date), I used a QR code to ask three questions. Seven individuals completed the Google Form.

When asked if the presentation/research would inform their practice moving forward four stated they 'strongly agree', two stated they 'agree' and one person answered 'neutral'. The second question asked, what are the key messages you took away with you from this presentation/study? The responses were:

- *Listen and respect with compassion*
- *Openness of the mama answers*
- *Importance of cultural safety, where the system is failing young māmā, central role of empathy/ tikanga/ whakawhanaungatanga*
- *There is a lack of humanistic approach, care and practice as well as a lack of cultural understanding and care*
- *Māmā can advocate for themselves if given a safe respectful space to do so*
- *That young mamas are having poor interactions with health professionals at Waikato Hospital*
- *Our whānau (Māmā)have a voice that is being recognized, finally*

The third question asked for other feedback or comments:

- *Please give examples of what was lacking or said by health professionals when subjects said "do your job" "don't judge"*
- *Loved your research, love your mahi! You should present it to the midwifery/ obstetrics department if possible :)*
- *It would be interesting to see if there are any comparisons or similarities between urban & rural experiences*
- *I'm an immigrant to this country. I have experienced bad healthcare. Now I work in healthcare and have a master's degree. While this info showed some interesting conversation points, I wish there was more to go on. I found the statements really vague. I need more concrete examples to learn from, for examples was the language too dumbed down? Too much jargon? What's your definition of basic standards of healthcare? Is everything time related- is it only a good standard of care if I spend "half a day" with the patient as given by example in your research? DO BETTER sounds incredibly judgemental and negative to an already exhausted workforce. I'm surprised that someone saying no I'm sorry I can't provide the service for you is taken in such a negative term and calling them ageist seems very harsh. I wouldn't be comfortable caring for a 14yo hapū mama in the community myself. Why is it that*

we couldn't highlight this as a learning point for midwives since someone has clearly highlighted a gap in their expertise rather than take a chance on the mum and Pepe's health. Since 9/15 babies ended up in NICU, perhaps that midwife was right to begin with. I think with the health system being what it is, we need to support when someone makes a decision like this instead of jumping down their throat to say they're wrong etc. I think the research is a good start but I wish there were more details to go on. The findings are too vague to create any learning goals from.

- *Ngā mihi e te whānau mo ōu mahi hei āwhina ki ngā Māmā [thank you for your work in support of māmā]*

Part 2 - Analysis - "Just Do Your Job!"

Throughout the research, our participants repeated the statement "just do your job!" This phrase describes their desire for healthcare practitioners to leave personal opinions at home and just provide the care they are tasked to give (with none of the extra unsolicited advice, judgement or discrimination):

> *"The best you can do is do your job, both care and support them because there's so many extra things that we don't need."* - ***Avia***
>
> *"Yeah, that's it, DO YOUR JOB…"* - ***Pol***
>
> *"Just do your job, if that's what they love and they want to help people and save babies, then just do that and don't judge."* - ***Aavia***

This message sums up the key themes as it describes exactly what participants are trying to articulate in one phrase. It shows the real and raw plea of these māmā to be treated well and without judgment. "Just do your job" means not giving unsolicited advice and just providing the care that is outlined in the role - giving only a professional opinion on clinical matters. In this section, I offer my analysis of the overall kōrero. The points that follow show that all themes in this chapter point to a lack of manaakitanga and basic etiquette, and also a lack of professional practice conduct, which has ultimately resulted in participants lives being impacted significantly.

Basic Conduct and Ethical Standards

In the course of this study, the māmā have basically described an overall lack of manaakitanga from healthcare providers. Manaakitanga as described in Chapter 3 refers to care, compassion, and respect and the findings have shown it is also about communication and listening. Manaakitanga is a value system that lays a foundation for all healthy relationships and in this case patient-provider relationships. In the experiences of these māmā basic human values such as compassion, empathy, and respect appear to be forgotten and young parents are not listened to, undermined, and made to feel small.

In listening to the participants experiences, māmā have shared instances where there are several violations of the *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [HADSCR]*, which apply to all clinical and non-clinical healthcare providers (e.g. receptionists) (Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, 1996).

The following rights are of particular relevance:

Right 1 – The Right to be treated with respect

Right 5 – The Right to effective communication

Right 6 - Right to be fully informed

Right 7- Right to make an informed choice and give informed consent. (para 1-7)

More specifically, the *Code of Conduct for Nurses (2012)*, the *Medical Council of New Zealand Good Medical Practice Standards (2021),* and the *New Zealand College of Midwives Handbook for Practice (2015)* all feature at least one point related to communicating effectively, respecting patients, and providing a safe patient-provider relationship. However, as demonstrated in this chapter, most of these māmā have not been treated with respect, communicated with effectively, and were mostly uninformed about the care they or their babies received.

Avia was not listened to when telling healthcare practitioners that she was not in labour and would not give birth at 23 weeks' gestation. At her first appointment with a midwife, when her age became apparent, Pol was asked if she knew where the abortion clinic was. Robyn's baby was pricked several times in NICU without her knowledge or consent, and Jazz woke up to a nurse hand expressing milk from her breast without her permission. The basic requirements of asking for permission, having care and respect have been neglected. These collective experiences suggest that healthcare staff are not reflecting on their own practice and behaviour, not keeping themselves and peers accountable, and there is a lack of accountability by healthcare services to ensure their staff are fulfilling their duties as healthcare providers. In relation to the existing literature, it is concerning that this study contributes to other findings and indicates a continued lack of basic human etiquette and care for patients over several years in various locations.

Professional and Non-Discriminatory Practice

Not only has there been an overall lack of manaakitanga shown by healthcare practitioners in this research but there is also the presence of unprofessionalism and discrimination. The experiences of these māmā highlight that there are different factors at play including prejudice, stigmatisation, marginalisation, ageism, and racism. For clarification, my interpretation is that: prejudice is an *opinion* about an individual or group that is not based on actual experience or reason; stigmatisation is *describing* someone as worthy of disgrace or disapproval, which in this case could be related to marital status, thoughts about 'what a child is' and being a parent, young; marginalisation is the *treatment* of a person as insignificant or 'other' while discrimination is the unjust or different *treatment* of someone based on (but not limited to) their ethnicity, age, or sex (Biggers, 2023). Whilst ageism and racism are types of discrimination and can sometime intersect (e.g. intersectionality (Núñez et al., 2020), and dual stereotyping (Ware, 2019). These concepts are all examples of unprofessional behaviour that according to the Medical Council of New Zealand (2020), are not permitted in patient-provider relationships.

In patient-provider relationships, acting on prejudices and offering opinions based on personal beliefs highlights an imbalance of power. This research reports that, power has been used to minimise and undermine the roles of māmā as parents, and as wāhine. Vana states: *"I think that's one thing that I don't like... is that they [healthcare practitioners] always think they know better than you, even when it comes to your baby."* The experiences of the māmā in this study shine a light on several rights, codes, principals, and standards that all affirm discrimination in any sense is not okay.

For example, *The United Nations Human Rights Act, 1993 [HRA]* declares it unlawful to discriminate on the grounds of sex (including pregnancy and childbirth), marital status, religious belief, ethical belief, colour, race, ethnicity, disability, and age. *The United Nations Declaration of Rights for Indigenous Peoples [UNDRIP]* and *New Zealand Bill of Rights Act 1990* also declare that as the Aotearoa-New Zealand public and as Indigenous peoples we all have the right to be free from any kind of discrimination (*United Nations Declaration on the Rights of Indigenous Peoples*, 2007).

When referring to health, *the HADSCR, the Code of Conduct for Nurses (2012), Competencies for the Midwives' Scope of Practice (2004), and Medical Council of New Zealand Good Medical Practice Standards for Doctors (2021)* declare that health practitioners and providers are required to uphold a level of professionalism and not discriminate in practice. However, at every stage of the participants' pregnancies - from finding a midwife, pre-natal care, birth, and post-natal care, a number of healthcare staff have applied personal beliefs and opinions to the care they provide.

In looking for a midwife Pol, Avia and Te Rā were met with judgement and assumptions that suggest these midwives breached the *Competencies for Entry to the Register of Midwives (2004)*:

> Competency 4.8 - recognises their own values and beliefs and does not impose them on others
>
> Competency 4.9 - is aware of the impact of gender, race and social policies and politics on women, midwives and the maternity services. (para. 4).

Many māmā shared experiences of prejudice and discrimination, including Jazz and Robyn, who shared storied of the nurses in NICU who did not uphold their *Code of Conduct for Nurses (2012)*:

> 1.6 - Practise in a way that respects difference and does not discriminate against those in your care of the basis of ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age (p. 9)
>
> 1.7 - Do not prejudice the care you give (p. 9)
>
> 1.8 - Do not impose your political, religious or cultural beliefs on health consumers and intervene if you see other health team members doing this (p. 9)
>
> Principle 2 - Respect the cultural needs and values of the health consumer (p. 3).

The dismissiveness and unsupportive nature in Avia, Robyn and Vana's experience emphasises the need for doctors who follow the standards of professional behaviour outlined by the *Medical Council of New Zealand - Te Kaunihera Rata o Aotearoa (2020)*:

> Behaviour that may be considered unprofessional, includes, but is not limited to, behaviour such as bullying…. discrimination, racism, insensitivity or rudeness towards others; putting your own interests ahead of your patient's…. and overly critical comments or behaviour; or refusal to work collaboratively with others or to follow best practice…. While there may be a number of reasons for unprofessional behaviour — whether personal, professional, or situational, as a doctor, **you must demonstrate professional behaviour at all times** [emphasis added]. (para 3)

In summary, the findings of this research clearly demonstrate that the role these healthcare practitioners have as kaitiaki for young parents is being disregarded. As described in Chapter 3, Kaitiakitanga is about providing support, protection, and guidance. In this sense, healthcare staff are required to put aside their personal beliefs when supporting and caring for patients. The following quotes illustrate the participants aspirations for equal treatment and their want to not be treated like a child or discriminated against because they are young:

> *"Age is just a number, I should be treated the same."* - ***Shanti***

> *"We're all our own adults. Like we're all equal. Don't judge a book by its cover.... We're all human."* - ***Matariki***

> *"It's hard in this society for those that are in the healthcare profession to not stereotype people."* - ***Puanga***

> *"I think doctors, midwives and nurses they all need to keep their own personal religion and beliefs to themselves and put that aside because this is a professional matter."* - ***Vana***

> *"Stop assuming and just help us and our babies"* - ***Aavia***

Even though 'teen pregnancy' in Aotearoa-New Zealand is not new, in sharing their healthcare experiences, these māmā have revealed that ageism, racism, stigmatisation, and marginalisation are 'alive and well.' The codes of conduct and practice standards for health staff explain they are required to uphold a level of professionalism in their roles, which in application means putting aside their personal beliefs, giving their *professional not personal* opinion. However, the evidence in this chapter of unprofessional and discriminatory practice highlights that more accountability, and resources need to be directed towards educating healthcare practitioners on how to better support and service young parents in the health/maternity sector. It emphasises that young parents need to be supported and encouraged in all areas of life rather than looked down on and judged.

Avia articulates a great final message stating:

> *"I didn't plan to be a young māmā. I don't regret being a young māmā, but you shouldn't criticize and judge me for or because I am a young māmā. I'm still a person. I still have feelings. I still deserved medical treatment and attention and care without your negative feedback."*

The Impact and Effects

The consequences of negative experiences with healthcare practitioners are present throughout our participants narratives and is consequently having an impact on their lives. Māmā in this study talk about how healthcare practitioner behaviour has affected them, their identity as māmā, and their lives generally. They share experiences and extreme feelings of disempowerment, diminishment, lack of self-confidence and systemic mistrust that they attribute to their negative experiences throughout their pregnancy, birth, and into motherhood. They have come to normalise not receiving good care and some participants shared this leading to post-natal depression.

Young parents already deal with a lot in day-to-day life. From finding out they are pregnant, preparing for and raising a new baby, they manage their household, education, and external affairs for their families.[131] Thus, they don't need the personal thoughts, unsolicited comments and deficit ideas of anyone else making their lives more complicated. As I experienced with my friend (see Chapter 1) a lot of young girls look forward to becoming mothers, however, negative experiences and discriminatory behaviour of healthcare staff can affect this milestone significantly. For example, being forced to breastfeed and being pressured to meet the standards of other mothers emphasises the need for a more supportive maternity sector for young māmā.

These feelings of disempowerment and marginalisation directly relates to the diminishment of our participants mana as women and as mothers, which can have long-term physical, spiritual, and emotional effects. The dismissal of participants situations and dramatisation of

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[131] See Appendix G where Gillian outlines the complexities of these young mothers' lives

their feelings feeds the societal stigma that young people are not in touch with their feelings and gaslights māmā into thinking they are incorrect and that their instincts are wrong.

The participants' posters show the trauma they carry and are a plea for a more supportive maternity sector. The negative and strong expressions in the posters and comments illustrate how terrible our participants experiences were. Whilst creating their posters, these māmā were upset but used their experiences as fuel to contribute their all to this study so that future young māmā hopefully won't have to go through the same experiences that they did.

As a result of negative healthcare experiences, participants also talked about boycotting certain GP and midwifery practices. The concept of word-of-mouth came up often, meaning when family or friends asked about healthcare services, they strongly recommended not using particular services where negative experiences had occurred. This reflects the mistrust and long-term effects that can be a result of marginalising, and unsupportive practitioners.

Another observation I made in analysing participants kōrero was the constant use or interjection of the word "actually" when talking about what practitioners were doing well. When talking about an appointment Te Rā had with her school nurse she stated "...they could *actually* sit down and talk with me." Matariki said "...she[nurse] *actually* has time to come here and spend like half the day with us to help us" and Jazz shared "she[nurse] actually cares about the patient...she has a passion for it." The recurrence of the word 'actually' demonstrated to me that positive engagements are not common for these young māmā, and it is not often that healthcare staff care or take time for the needs and concerns of these wāhine.

Continuous negative experiences such as those above can lead to post-natal depression and a mistrust of healthcare staff, and the healthcare system as a whole. Avia recalled and articulated her experiences during our group wānanga she explains how the accumulation of negative stigma, trauma, and mistreatment throughout her hapūtanga, birth, and motherhood has had a lasting effect on her and her role as a māmā. She stated:

> ***Avia**: "...it just already plants that seed in your head that if people are looking at me and treating me like this, am I actually doing the right thing for my baby? Am I gonna be a good mum? Can I give my baby the best if these 'professionals' and these people are like 'oh, you're young' or like 'oh it's another Māori/Tongan young māmā' or like a 'I feel for this kid' kinda thing and it, it plants that seed. I think it really contributes to postnatal depression. And I suffered really hard with that, like thinking to myself every day like 'I'm not doing good' and I'm not doing good because all people*

> *throughout my pregnancy said so like 'you're young' and 'you're just a young solo mum.'*
>
> ***Mia**: "...if the [healthcare staff] around you were more supportive, would that have helped?*
>
> ***Avia**: "I think I would have loved my pregnancy a lot more, I always try and find the positives in everything and I have a good support system but it's just like that mental seed was already planted and I think, honestly it really contributed a lot to me having long postnatal depression. And because my daughter never goes without, she never has, she's always clean... everything she was warm but always at the end of the day [I think] 'maybe this wasn't a good idea to have a kid' 'maybe I should have whāngai'ed her', and I still get that now like I look at her and think 'maybe I didn't do good enough'. But I just do so well as I can."*

Although the experiences above highlight predominantly negative experiences, it is important for me to emphasise that the wāhine in this study were/are not victims. Throughout their entire pregnancy, birth, and parenting journey they showed extreme resilience, perseverance, courage, and strength as mothers and as women. The māmā in this study were so passionate about making change and providing their information to better the health system for future generations of young māmā. They continued to contribute to this study with open hearts and minds and gave as much as they could to this study despite their busy schedules. During this study I had a first-hand look into the lives of young māmā and the many different factors that they have to deal with, and I grew a huge respect for all of them. They are all mana wāhine in their own right and have inspired this thesis in many ways.

Summary

In this summary, I share the key points from the findings in this chapter to allow the participants experiences to be heard in a more concise manner. First, in positive experiences, healthcare practitioners took the time to talk with our participants, they were proactive, caring, communicative and listened well. When asking participants what health professionals were not doing well, they highlighted experiences of unsolicited judgement, discrimination, dismissiveness, and lack of care. Participants had several messages for healthcare practitioners that illustrated how they would like to be treated when accessing healthcare. The variability in experience emphasised the importance of good basic standards of etiquette. The purpose of this chapter was to provide the findings for this study and examined different codes of conduct and ethical practice standards of care in relation to these young mothers' experiences.

In the next chapter, I provide a broader discussion that ring together my analysis, the previous literature (Chapter 4), and findings of this study.

CHAPTER 7 DISCUSSION

Introduction

The primary aim of this study was to learn about the healthcare experiences of young parents' and co-design informational materials to improve the delivery of services for young parents. Our research questions asked 20 māmā and 2 pāpā from He Puaawai Teen Parent Centre in Hamilton, what healthcare practitioners *are* doing well, what they *are not* doing well, and what the key messages were that they had to share with healthcare staff. Employing wānanga, semi-structured interviews, and an investigator-triangulation analysis, the findings reveal that these young mothers are having both positive, but more so negative experiences with doctors, nurses, midwives, and receptionists. Participants reported they appreciate healthcare practitioners who give them time, listen, and communicate effectively. In contrast, participants also shared experiences of judgement and discrimination about being a young (Māori) mother/parent and felt disempowered and unsupported to fulfil their role as mothers. These experiences have led to mistrust and avoidance of the health system as a whole and at times contributed to post-natal depression.

In an attempt to answer the research questions, I find that the negative experiences (question 2) of participants reaffirm and reinforce the positive experiences (question 1) in their maternity/healthcare journey. In other words, the good behaviours are the opposite of the bad behaviours, but the good/bad behaviour is then elevated/emphasised in their final messages (question 3). For example, the participants who had good experiences said they were listened to, whereas the participants who had bad experiences said they were ignored. Therefore, when asked about messages they had for healthcare staff, participants said “they should listen more”, which reaffirms both positive and negative experiences/behaviour. In relation to answering the research questions, the following discussion synthesises the positive (question 1) and negatives experiences (question 2) with the participants messages (question 3) because they are one in the same.

In this chapter, I describe how my research/this study fits into the wider research context and how it supports, adds to, builds on previous studies in this area. I focus on the similarities and differences of the current research and other studies. To conclude, I provide my recommendations for further research as well as the limitations of the current study.

Similarities

This study fills a gap in the existing literature. To date, nationally, no other studies specifically focus on the role of healthcare staff in the experiences of young parents, in their aims or objectives. While no studies conducted in the Waikato focus specifically on the pregnancy, birth, and early parenthood experiences of young parents. Additionally, this research is significant because Waikato continues to report one of the highest birth rates in Aotearoa-New Zealand and in 2020 had *the* highest number of Māori births nationally (Te Whatu Ora Waikato - Health New Zealand, 2023).

However, although this study is unique, there are themes that intersect with the previous studies. A small number of studies speak generally about healthcare practitioners in their research findings and touch on the roles of health staff in maternity experiences of young parents; although, this was not the focus of their research. The key themes include a lack of manaakitanga (care, communication, empathy), stigma, deficit views, and discrimination.

Manaakitanga

The young parents in this study reported predominantly negative experiences and a smaller number of positive experiences, the ratio of which supports previous research. With regards to positive experiences, other studies mention that some doctors and nurses in hospitals made an effort to engage with young parents (Adcock, 2016), offered antenatal support and help finding a midwife (Makowharemahihi et al., 2014), and that one midwife was really helpful during birth (Stevenson et al., 2016). Adcock (2016) and Ware (2019) also found that Māori health providers in particular were rather supportive towards young parents.

With regards to negative experiences, I have identified a lack of manaakitanga. This observation supports the findings of previous studies that have reported inadequate support by healthcare services and staff (Adcock, 2016; Banks, 2008; Bealing, 2019; Lawton et al., 2016; Makowharemahihi et al., 2014; Marsh, 2019; Rawiri, 2007; Stevenson et al., 2016; Ware, 2019). Like my research, other studies describe an absence of physical support by healthcare staff. This included a lack of support in finding a midwife (Adcock, 2016; Makowharemahihi et al., 2014), failing to provide information (Makowharemahihi et al., 2014; Stevenson, 2016), and not being attentive to patients' needs (Ware, 2019). My research also supports literature that identifies a lack of emotional support or basic compassion by healthcare staff and services, including empathy, respect, understanding, and concern (Banks, 2008; Cram et al., 2021; Elkington, 2016; Lawton et al., 2016; Rawiri, 2007). Participants in other studies also expressed that healthcare staff and services had little time for them and that their concerns and feelings were often dismissed (Adcock et al., 2018; Banks, 2008; Makowharemahihi et al., 2014; Ware, 2019). My participants described identical experiences. Vana illustrates this stating, *"I feel like they brush off a lot of situations 'like it's nothing big, go home'* (see Chapter 6).

Participants in my study also felt unsupported by other services including radiology, social welfare, and Plunket. Other studies also found that services and wider whānau were at times unsupportive (Bealing, 2019; Elkington, 2016; Rawiri, 2007; Southorn, 2016; Ware, 2019).

Another prominent theme reported in both my research and the literature was communication and the impact this had on young parents. All studies mentioned inconsistent or fragmented communication, miscommunication (where they were told the wrong information), and/or being ignored (looked past, or not communicated with at all) (Adcock, 2016; Banks, 2008; Bealing, 2019; Brown et al., 2021; Dhunna et al., 2021; Elkington, 2016; Haerereoa, 2015; Lawton et al., 2013, 2016; Makowharemahihi et al., 2014; Marsh, 2019; Rawiri, 2007; Southorn, 2016; Stevenson et al., 2016; Ware, 2019; Ware et al., 2018). This is supported by my research as participants were often subject to communication breakdowns, being ignored, and made to feel *"invisible."* Māmā in my study said: *"they look right past you"* and *"... [they make me feel] invisible and like we're not doing good enough."*

Overall, these experiences reiterate the importance of health services and staff who are supportive, communicate, take concerns seriously, are empathetic, respectful, and proactive in supporting young parents in their pregnancy, birth, and parenting journey. The negative experiences young parents continue to have, confirm and reinforce the importance of healthcare staff who embody manaakitanga.

The findings of this study, supported by previous research conducted between 2001 and 2024, suggest health staff are not following or have forgotten about the ethics, standards of practice, and codes of conduct for their dedicated professions. *HADSCR 1996* and the *Health Practitioners Competence Assurance Act 2003* lay the foundation for the practice of all clinical and non-clinical health staff in Aotearoa-New Zealand, including receptionists. In relation to doctors, nurses, and midwives there are several specific practice standards, codes of conduct, competencies and ethical principles that outline the etiquette each health practitioner should uphold. The following are just three examples of the many for each profession:

In relation to the above experiences, the *Good Medical Practice Standards for Doctors (2021)* standards state that: competent doctors should always care and treat patients with respect (Point 3, p. 6); listen and respond to their concerns, give them the information they want/need, and respect their right to make decisions (Point 4, p. 6); and outlines that competent doctors respect patients dignity as individuals (Point 1, p. 12).

The *Code of Conduct for Nurses (2012)* outlines a set of eight principles underpinned by four key values: respect, partnership, integrity, and trust. In relation to the above experiences, the principles state nurses should: respect the dignity of health consumers (Principle 1, p. 7); work in partnership to protect their well-being (Principle 3, p. 15); maintain trust by providing safe and competent care (Principle 4, p. 19); and act with integrity to justify health consumers trust (Principle 7, p. 31).

While the *Competencies for Entry to the Register of Midwives (2004)* outlined in the Midwives Handbook for Practice features a set of four competencies supported by a scope of practice, ten standards of midwifery practice, and a philosophy and code of ethics. In relation to the above experiences, the Competencies explain that midwives should: respect and support the needs of wāhine in promoting their own health and well-being (Competency 1.7, p. 6); communicate effectively with the wāhine and her family as defined by the woman (Competency 1.9, page 6); provide up to date information and support wahine in making an informed decision (Competency 1.10, p. 6).

In connection with manaakitanga, healthcare practitioners are also considered kaitiaki who are responsible for looking after their patients. However, this is clearly not the case for the young parents in this and previous studies conducted between 2001 and 2024. Given these consistent findings, this also suggests a lack of reinforcement by management and healthcare services to audit and ensure practice standards/codes of conduct are being upheld. There are several auditing procedures however, the quality of these processes is not the focus of the current study.

Discrimination

In conjunction with a lack of manaakitanga shown by health practitioners, participants in the current study reported several experiences of discrimination and judgement that they attribute to their age, and in some cases their ethnicity. These findings add to previous research that also reported young parents were discriminated against in their interactions with healthcare staff, social welfare, and the public (Adcock, 2016; Adcock et al., 2018, 2021; Brown et al., 2021; Cram et al., 2021; Dawson et al., 2019; Edmonds et al., 2022; Graham & Masters-Awatere, 2020; Lawton et al., 2016; Makowharemahihi et al., 2014; Pihama, 2011; Rawiri, 2007; Stevenson et al., 2016; Waetford, 2008; Ware, 2019).

In my research, several participants shared direct experiences of ageism after sharing their age with health staff. For example, in seeking a midwife, Pol was directed to the abortion clinic; in her final stages of labour, Avia was ignored by a receptionist and left in a waiting room; Te Rā was *"bluntly rejected by a midwife"* she went to for help (see Chapter 6); and participants discussed switching codes for fear of discrimination. Participants understood they had been subjected to ageism, discrimination, marginalisation, and racism:

> *"She was rude, and you could tell she was just discriminating because of my age."* - ***Avia***
>
> *"She's just a kid, she's just a kid having a kid; she doesn't get a say." That's how it is."* - ***Matariki***
>
> *"We're all our own adults. Like we're all equal. Don't judge a book by its cover.... We're all human."* - ***Matariki***
>
> *"Oh, another Māori pregnant, and she's young" - in **Avia's** experience*

These experiences of blatant discrimination support previous studies in which participants reported health staff were discriminatory and had negative attitudes towards young parents (Adcock, 2016; Banks, 2008; Makowharemahihi et al., 2014; Southorn, 2016; Stevenson et al., 2016; Ware, 2019). This made young parents feel excluded in hospitals (Adcock, 2016), and in public spaces (Banks, 2008; Ware, 2019). Young Pākehā mothers also reported experiences of ageism, being "watched", getting "looks" and feeling excluded (e.g. at daycare) because they were young (Banks, 2008, p. 65-67). I find this interesting because Māori participants in my study and in other research reported similar experiences to Pākehā participants, therefore, this discrimination may be more strongly connected to age rather than ethnicity. Intersectionality is discussed below.

As noted above, in relation to manaakitanga, the discriminatory behaviour of health staff supports the argument that codes of conduct and standards of practice are not being upheld. Along with the *Human Rights Act 1993* and *New Zealand Bill of Rights* there are several principles that declare discrimination has no place in patient-provider relationships and that practitioners should not impose their personal beliefs on patients (see Code of Conduct for Nurses, 2012, p. 28; Good Medical Practice Standards for Doctors, p. 13; Midwives Handbook for Practice, p. 12).

It is important to note that these documents are very detailed and encapsulate what a great healthcare practitioner should be doing. Therefore, my position is that these codes and standards should be upheld and enforced, rather than rewritten or reshaped.

The Framing of Young Parents

Related to the issues of discrimination, my research also supports the previous literature - all of which either mention or examine the stigma, marginalisation, and deficit framing of young parents (Adcock, 2016; Banks, 2008; Bealing, 2019; Elkington, 2016; Lawton et al., 2016; Makowharemahihi et al., 2014; Marsh, 2019; Rawiri, 2007; Southorn, 2016; Stevenson et al., 2016; Ware, 2019). My study reveals that young parents often felt like a problem and some of their comments included: "*…they think we're stupid", "oh, a baby having a baby", and "young means dumb."*[132] Supporting these statements, previous literature also examines that young parents are frames as a "problem" (Luker, 1996) and a "cause for concern" (Woodward et al., 2001), and young parents themselves are seen as "incompetent" (SmithBattle, 2013) and "abnormal and in need of regulation" (Adcock, 2019; as cited in Edmonds et al., 2022, p. 325).

This deficit discourse and problematisation of young parents (arguably) feeds the narrative that young parenting is a social problem and suggests that young parents are incapable of being good parents. This marginalisation and unsupportive deficit narrative can have detrimental impacts on young parents, as captured by Avia:

> *"... it just already plants that seed in your head that if people are looking at me and treating me like this, am I actually doing the right thing for my baby? Am I gonna be a good mum? Can I give my baby the best if these 'professionals' and these people are like 'oh, you're young' or like 'oh it's another Māori/Tongan young māmā' or like a 'I feel for this kid' kinda thing and it, it plants that seed. I think it really contributes to postnatal depression. And I suffered really hard with that, like thinking to myself every day like 'I'm not doing good' and 'I'm not doing good because all these people throughout my pregnancy said so."*

But Why?

Why young parents are discriminated against and 'framed' as a problem is a prominent theme in the literature and scholars agree that the reasons are complex. In my review of the literature, a number of scholars refer to colonisation, however, their narratives were challenging to follow, too brief, or the links were unclear. Pihama (2011) offers one of the clearer arguments: she makes connections between the construction of childhood and the problematisation of 'teen pregnancy', highlights the stigma around being an unwed mother,

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[132] The last two quotes were not transcribed verbatim and were said during the analysis phase and written down in my personal notes

and examines the common framing of Māori as a 'risk-factor.' However, to grasp the complexities of these topics and their relationships, it would be helpful to have these ideas discussed separately and in more depth.

I agree that the reasons why young (Māori) parents are stigmatised and discriminated against are complex and have adopted intersectionality to help me understand the associated factors. As explained in Chapter 4, intersectionality identifies that there are interlocking systems of oppression based on different cultural constructs and ideas of social identity (Núñez et al., 2020). In this case, being a woman, a young parent, and Māori, challenges and provokes colonial views and western societal norms related to gender, age, and ethnicity. Supporting the concept of intersectionality in relation to the stigmatisation of young parents, other researchers have identified: "a two-fold stigma" (Ware, 2019, p. 192) and "multiple intersecting tropes.... which give rise to pervasive social stigma" (Dhunna et al., 2021, p. 6196).

Western views about women, children, and Indigenous people are rooted in the past, and based on European/western societal norms and social constructs. However, I argue that in today's society, these ideas are still prominent, and anything/anyone that challenges these historical western rules and expectations are seen as deviant or a problem. During the colonisation of Aotearoa-New Zealand, settlers introduced western ideas of what women and children should and should not do.

In relation to women, one dominant argument is that women are supposed to be married with a wealthy husband, with a nice house, and then birth and raise children. Therefore, when women do not follow this path, they are looked down on and expected to fail. In this study, Avia experienced this stigma when a nurse said to her "... you shouldn't be working, your husband should be." This argument is supported by Rawiri (2007) who also argues young mothers are subject to western ideas about marriage and are labelled a problem by society. In her analysis, Bank's (2008) referred to this concept as "a woman's prescribed life trajectory" as she identified her participants shared stories of "challenging Pākehā cultural constructs" because they were young unwed mother (p. 101).

In relation to children, another historic western societal norm is the idea that there is a 'correct' or proper age children must reach before they are allowed to do 'adult things'. For instance, in New Zealand law, it is illegal to have sex before 16-years-old, and to buy alcohol before 18-years-old. Therefore, when children do not abide by these rules they are seen and treated as defiant and troublesome and are subjected to formal (e.g. legal punishments) and informal sanctions (e.g. public/social ridicule, shame, sarcasm, exclusion). This suggests that young people are incapable of making their own decisions, giving consent, and looking after themselves. Some scholars also argue these social stereotypes of childhood incapacitate, stigmatise, and marginalise young parents and their abilities to be good parents (Adcock, 2016; Dhunna et al., 2021; Pihama, 2011; Ware, 2019). Drawing on the theories of Lee (1982) (see Chapter 4), Pihama (2011) argues through a series of societal shifts age was constructed which eventually led to children being framed and treated as a problem/defiant.

Along with the accounts of ageism by my participants, some also shared feelings of self-doubt following and disempowerment they attribute to societal norms or views on children.

Another layer of discrimination for young parents in Aotearoa-New Zealand is ethnicity. In relation to Māori, it is well documented that Pākehā assimilated and enforced their societal norms, which were often racist and discriminatory. With regards to the discrimination of young Māori parents, Adcock et al. (2018) points to the stereotype that Māori are "yuck" (p. 1); meaning dirty or unsanitary. Other scholars note more specifically that Māori women giving birth or menstruating are seen in early ethnographic accounts as dirty (Murphy, 2011; Simmonds, 2009; Te Awekotuku, 1991). This is highlighted in the medicalisation of birth (see Chapter 4) where women were extensively 'sterilised' before stepping into the birthing rooms (Pollock, 2011; Stojanovic, 2002). This is one of the many theories that highlights the continued race-based stigma and discrimination associated with being a (young) Māori mother.

The stigmatisation, discrimination, and deficit views of young parents show that the historical western views of women, children, and Māori are still very much present today. This is because being a young (Māori) parent challenges a number of these social norms. It's clear the social constructs and societal ideas about the way women should live, when children should do certain things, and 'cleanliness of Māori' are ongoing.

But is this too simplistic? While I agree that colonial views underpin our current social values and norms, but I also feel that it's more complicated than this. Perhaps, the identity markers of an individual (e.g. religion, cultural beliefs, class, spirituality, upbringing, trauma) also need to be considered, rather than pointing to *just* colonisation and societal norms.

To be clear, in no way am I attempting to justify discriminatory behaviour, and it may be that individuals are just ageist, racist, and/or misogynistic. What I am suggesting is that health professionals may not be self-aware, do not realise their privilege, and the harm they are potentially causing. Therefore, they allow their bias to affect their work and relationships with others. Being aware of influences, and checking one's privilege, is the first step in proactively changing the way one thinks and acts.

In conclusion, the answers are not straightforward. This is a complex topic and was not the focus of this study. Thus, I offer only one argument of many that needs to be explored further. Work conducted in education could be useful (Bishop & Berryman, 2006).

Differences

In addition to supporting the existing literature, this study also adds to and builds on previous studies. In this section, I identify four key differences in this study compared with other studies: the importance of specificity, patient-provider congruence, receptionists, and emotional barriers.

Specificity

In looking at the wider research context, previous studies have not asked specifically about doctors, nurses, midwives, and other health staff. Therefore, my research fills this gap as it provides a more detailed analysis of the role played by specific healthcare practitioners in the positive and negative experiences of young mothers from pregnancy and into motherhood. As the first of its kind, this study should be repeated to ensure the full complexity of young mothers' healthcare experiences are explored and addressed.

Patient-Provider Congruence

A key difference identified in this study was patient-provider congruence. For clarity, patient-provider congruence refers to the connection between patients and providers of (in this case) health based on demographic characteristics such as age, ethnicity, or gender (Moore et al., 2022). In other words, participants reported a better alignment and comfort with younger female healthcare practitioners, and at times younger male doctors. They shared comments like *"younger nurses are better"* and *"those studying nurses have more care and attention."* Patient-provider congruence is not mentioned in other studies or are not specific enough to identify this connection. This is an important concept that needs to be taken into consideration when thinking about the experiences of young parents.

Receptionists

Another aspect that makes my research unique is identification of other service providers and their role in the maternity journey of young mothers. When asked if there were any other healthcare staff participants wanted to talk about, receptionists were the main cohort that participants identified. As explained in Chapter 6, engagements with receptionists were often negative ("rude" and "opiniated") and became a barrier to care. This finding was particularly interesting as it suggests receptionist 'fly under the radar' because they are not considered clinical. This also suggests that receptionists need more training regarding the Rights of patients and responsibility of clinical and non-clinical staff as declared in the *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [HADSCR]*. Additionally, receptionists are considered 'the face' of healthcare services, therefore, the way in which they engage with patients is very important, especially in relation to young people who are more perceptive to first impressions. The important role of receptionists warrants further investigation.

Impacts

Another topic that adds to the existing literature, is that the findings reveal several emotional barriers caused by negative health experiences. Previous studies tend to focus and report on physical barriers (e.g. transport, money etc.), whereas the participants in this study expressed a range of emotions related to the negative experiences had during pregnancy, birth, and/or early motherhood (see Chapter 6), including resentment and anger. As a consequence, participants talked about mistrust, avoidance, and boycotting the clinics or practices where negative experiences occurred.

Recommendations

Based on this research and informed by my Te Ira Wahine framework, I offer three recommendations.

Accountability, Auditing, and Upskilling

Accountability needs to be taken at all levels of the health sector for discriminatory behaviour and stigmatisation of young parents. Codes of conduct and practice standards need to be upheld and enforced in the workplace. Therefore, I recommend more emphasis and effort be put into auditing staff behaviour and practice in health. There also needs to be more emphasis on cultural competency in working with young parents. To keep up with constant social change, priority should be directed towards more regular training for health staff to refresh their skills.

Attention also needs to be directed towards changing the deficit views and stigmatisation of young parents in general. I recommend that health promoters include young parents in discussions and campaigns to address the treatment of young parents by society. This might include sharing young parents' success stories.

Youth Representation

Young mothers (and fathers) make up a significant portion of health consumers but continue to have negative experiences in healthcare. Therefore, I recommend there be dedicated seats on health and hospital boards around Aotearoa-New Zealand. Youth representation on these boards will enable young parents to have their say and share their opinions on the services that they engage with. It is also important that young parents are not only given a seat at the table but are supported in this space to learn and represent their community. Young parents might also like to establish their own youth board similar to the Te Whatu Ora – Waitaha Canterbury, who have a Young Advisory Council that advocates for young people aged 12-24 years old (Te Whatu Ora - Waitaha Canterbury, 2024).

Whānau Centred Approach

One of my key takeaways from this study, is how complex the lives of young mothers are. Therefore, to support young mothers in their day-to-day and in their educational aspirations, it is important that their wider environment and external influences (e.g. housing, transport, partners, family) are also supported.

Therefore, I recommend a holistic whānau-centred approach be adopted by healthcare providers; one that recognises the importance of external factors that help young māmā with the stresses and complexities of their lives.[133] This recommendation is based on Māori models of health, such as the Meihana Model (Pitama et al., 2007) and Te Pā Harakeke (Pihama et al., 2014), which acknowledge the significance of the wider-environment and whānau in the overall well-being of a māmā and her pēpi. A whānau-centred approach also recognises that expectant fathers also need support and when fathers are better supported, they are better equipped to be fulfil their responsibilities and support the wāhine hapū and pēpi.

However, where a young parent is not connected to their whānau, this approach is still able to alleviate the pressure of their external environment and support them to better focus on the health of them and her pēpi.

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[133] For example, the parent project (Collaboration Study) used WHIRI (Whānau Hauora Integrated Response Initiative) to create and pilot a holistic hauora assessment tool to support the wider needs of wāhine hapū and whānau

Limitations

Several limitations should be considered in the interpretation of the findings of this study:

- While this study was open to mothers and fathers, we had trouble recruiting fathers. Over the course of this research, there were only two fathers enrolled at He Puaawai and like other studies, fathers took a supportive role to their partners (Ware, 2019). This study cannot therefore contribute to a wider or deeper understanding of young fathers' healthcare experiences.
- While we intended to include whānau, kaumātua and/or kuia as support for the research and the participants, our schedules did not align and therefore, whānau and kaumatua/kuia perspectives were unfortunately not a part of this study.
- The retention of participants throughout the research was a challenge. Only two māmā participated in all four phases of this study, which reflected the busy schedules of young mothers. This mean that some participants voices are louder and more frequent than others. However, this was also a positive because we were able to capture a wide range of experiences by many māmā.
- In the participant analysis phase, it could be critiqued that the māmā who created posters focused only on their own personal feelings and experiences rather than what the group had collectively identified as the key themes. The posters, therefore, potentially represent individual views - however, that is the nature of collaborative approaches. Thus, these posters also emphasise the most important messages that these particular māmā want to communicate to health professionals.
- Findings regarding receptionists were unexpected and therefore this topic was not explored fully, nor was a literature search done for this particular topic. Thus, I recommend this be a topic for future research.

Summary

After reviewing the previous literature and analysing the findings of the current study, the messages are clear. Young mothers accessing healthcare in Aotearoa-New Zealand continue to report predominantly negative experiences. Although there were positive experiences, the negative experiences suggest there is a significant lack of effort put into patient-provider engagements. My research contributes to the wider research context that suggests manaakitanga - or a lack thereof - discrimination, and negative/deficit framing of young parents are all common experiences. These experiences also suggest that codes of conduct and ethical practice standards for doctors, nurses, midwives (and other health staff), are not being upheld or reinforced. Additionally, I identify arguments that suggest the origin of discrimination, and add to the wider research context by suggesting there is more to consider.

To conclude, young parents over the last twenty years, and in several locations, including the Waikato continue to report similar negative experiences. Thus, in response to my observations and comments in this chapter, I offer three key recommendations that I believe would improve the health outcomes and experiences of young māmā in the Aotearoa-New Zealand maternity/healthcare sector.

In the final chapter, I take a step back and reflect on this study, I share my conclusions about this research topic, and offer my key takeaways for future researchers.

CHAPTER 8 CONCLUSION

This research aimed to respond to the call of young mothers at He Puaawai – Teen Parent Centre and to learn more about young parents' healthcare experiences in an effort to improve the way in which health practitioners service them. The three main research questions we set out to answer were:

1. When caring for young māmā and their tamariki what are doctors, nurses, midwives and other healthcare practitioners *doing well?*
2. When caring for young māmā and their tamariki what are doctors, nurses, midwives and other healthcare practitioners *not doing well?*
3. What are the messages and lessons you want to get across to improve how health professionals treat and service young māmā and whānau?

In analysing the findings of this research, it was revealed that these young mothers have had predominantly negative experiences with a small number of positive experiences in pregnancy, birth, and into motherhood. The participants of this study report that healthcare staff who care, have empathy, respect and compassion, who listen, and give time to young mothers are considered to be 'doing well' (question 1). In contrast, healthcare staff who do not do these things (above), and judge, discriminate, and marginalise young mothers are considered to be 'not doing well' (question 2). The young māmā in this study shared stories of unsolicited judgement, discrimination, dismissiveness, and a lack of support from health staff - which they attribute to their age. However, intersectionality suggests that this poor treatment could also be based on ethnicity and/or gender, due to the majority of the participants in this study being Māori māmā.

Some of the key messages (question 3) that these young mothers shared included: "just do your job", "I appreciate communication", "they should listen more", "age is just a number, I should be treated the same", "stop assuming and just help us and our babies."

In presenting the findings of this study and the co-design materials to healthcare staff around the Waikato, we have created more awareness regarding the healthcare experiences of young parents, and informed health staff about how young parents want to be treated when accessing health services. I am hopeful that we, the Steering Group and research team, have reached the staff who need to hear these messages the most. We will continue to share the findings of this research and conduct more research in the hope of improving health outcomes for young mothers in the Waikato.

In reflecting on the research process, a key observation I made in carrying out this research is the uniqueness of a kaupapa Māori research approach. In learning about kaupapa Māori and creating and employing my Te Ira Wahine framework, I learnt that kaupapa Māori can be different for every kairangahau, based on one's values and up-bringing. I feel that kaupapa Māori allowed for flexibility and a more collaborative, inclusive approach in this study. Meaning we were able to respond to the call of these young mothers, serve them and their needs, whilst acknowledging that they are the experts.

In deep diving into the literature, and in conjunction with my findings, I also have some strong words to share:

First, it appears nothing has changed. Over the last 20 years young mothers (and fathers) continue to report experiences of stigmatisation and discrimination because of their age. Many of them feel dismissed, unsupported, disempowered, and left feeling they can't be good parents because 'society says so.' Literature continues to report similar themes, which highlights the argument as to whether the supports and services in place are actually working, or not reaching those that need it most. However, I do acknowledge that there are good healthcare practitioners and services that are supportive and caring towards young parents and want to emphasise the importance of these healthcare staff in particular.

Second, historical western views about women, children, and Māori are still used to stigmatise young parents today. The idea that women have a 'prescribed life trajectory', the concept that one should be a certain age before having a baby, and idea that Māori are destined for poor health outcomes are archaic and out of touch with societal evolution. Furthermore, being a young mother is not new. So, rather than framing young parenting as deficit and contributing to the continuation of these historical ideologies it is time change our way of thinking.

Third, despite *all* of the above, the young mothers (and fathers) in this study showed extreme courage, resilience, and passion towards this kaupapa. The title of this thesis is representative of their strength. These māmā, born from greatness, exercised their inherent mana in the many challenging experiences they had in pregnancy, birth, and into motherhood. Their desire to share their experiences and their fight to create change for not only themselves but other young parents is inspiring.

In conclusion, the fire in my belly is still very much burning. I believe more accountability needs to be taken for the negative experiences young parents continue to have in healthcare at all levels. There needs to be a larger emphasis on implementing support systems that protect and empower young parents to be great parents. Support also needs to be directed to educating and informing health staff to better care for and service young parents. Young parents need healthcare practitioners who ‘just do their job!’ Which means leaving personal beliefs and opinions at home, and just providing the care that is outlined in their practice standards and codes of conduct.

I now understand that the experiences of my friend and I *are* common, but I still have hope - for us, and for all mothers - that one day we will get the happy ending we dreamt of as little girls.

REFERENCES

Adcock, A. (2016). *E hine, ngā whāea: Teen mothering in the gaze* [Masters Thesis, University of Otago]. https://doi.org/10.26686/wgtn.17019212.v1

Adcock, A., Cram, F., Edmonds, L., & Lawton, B. (2021). He tamariki kokoti tau: Families of Indigenous infants talk about their experiences of preterm birth and neonatal intensive care. *International Journal of Environmental Research and Public Health*, *18*(18), 9835. https://doi.org/10.3390/ijerph18189835

Adcock, A., Lawton, B., & Cram, F. (2016). E Hine: Talking about Māori teen pregnancy with government groups. *AlterNative: An International Journal of Indigenous Peoples*, *12*(4), 380–395. https://doi.org/10.20507/AlterNative.2016.12.4.4

Adcock, A., Lawton, B., & Cram, F. (2018). Experiences of the health care system for young Māori mothers: "You know how some people look at Māoris like, 'yuck'?" *Journal of Paediatrics and Child Health*, *54*(S1), 6–6. https://doi.org/10.1111/jpc.13882_8

Adoption Act (1955). https://www.legislation.govt.nz/act/public/1955/0093/latest/DLM292661.html

Ahuriri-Driscoll, A., Blake, D., Potter, H., McBreen, K., & Mikaere, A. (2023). A 'forgotten' whakapapa: Historical narratives of Māori and closed adoption. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *18*(2), 135–152. https://doi.org/10.1080/1177083X.2022.2105725

Anderson, C. (2010). Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education*, *74*(8), 141. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2987281/

Armstrong, J. (2009). *Under one roof: A history of Waikato Hospital*. Half Court Press.

Association of Teen Parent Educators of New Zealand. (2024). *Teen parent schools—NZ TPUs*. https://teenparentschools.org.nz/teen-parent-schools/

Banks, H. (2008). *Young mothers speak out: Young Pākehā women's experiences of motherhood.* [Masters Thesis, The University of Waikato]. https://hdl.handle.net/10289/2519

Bardsley, D. (2008, November 28). *Settling the land*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/rural-language/page-3

Barrett, N. M. (2022). *Kaupapa Māori antenatal wānanga: A solution to refocus New Zealand health service delivery for improved engagement and responsiveness with Māori māmā hapū and pēpi* [Doctoral Thesis - Embargoed]. University of Waikato.

Barrett, N. M., Burrows, L., Atatoa-Carr, P., & Smith, L. T. (2022). Hapū wānanga: A Kaupapa Māori childbirth education class for Māori and non-Māori māmā hapū and whānau. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, *11*(1), 51–67. https://doi.org/10.20507/MAIJournal.2022.11.1.5

Bartholomew, R. E., & Ringer, J. B. (2020). *No Māori allowed: New Zealand's forgotten history of racial segregation: How a generation of Māori children perished in the fields of Pukekohe*. Robert E. Bartholomew.

Bealing, J. (2019). *Teen pregnancy: Tailoring a pregnancy app to the needs of pregnant adolescents* [Masters Thesis, The University of Waikato]. https://hdl.handle.net/10289/12932

Bhandari, P. (2022, January 3). *Triangulation in research: Guide, types, examples*. Scribbr. https://www.scribbr.com/methodology/triangulation/

Biggers. (2023, July 25). *Types of stigma and how to stamp it out*. Healthline. https://www.healthline.com/health/what-is-stigma

Blake - Inspiring Environmental Leadership. (2024). Sir Mason Durie. *Blake NZ*. https://www.blakenz.org/person/sir-mason-durie/

Breheny, M., & Stephens, C. (2010). Ageing in a material world. *New Zealand Journal of Psychology (Online)*, *39*(2), 41. https://mro.massey.ac.nz/server/api/core/bitstreams/29343832-0c6d-448d-a321-93266276ca9c/content

Brickell, C. (2017). *Teenagers: The rise of youth culture in New Zealand*. Auckland University Press.

Brown, S., Toki, L., & Clark, T. (2021). *Māori māmā views and experiences of vaccinating their pēpi and tamariki: A qualitative kaupapa Māori study*. Te Hiringa Hauora/Health Promotion Agency. https://nzpri.aut.ac.nz/__data/assets/pdf_file/0019/613621/HPA_Report_2021.pdf

Bryder, L. (2015). Fathers and hospital childbirth in New Zealand. *Social History of Medicine*, *28*(4), 725–741. https://doi.org/10.1093/shm/hkv034

Bryder, L. (2017). "An area peculiarly our own": Women and childbirth in early to mid-twentieth-century New Zealand. *New Zealand Journal of History*, *51*(1), 92–112. https://www.nzjh.auckland.ac.nz/docs/2017/NZJH_51_1_05.pdf

Chilisa, B. (2019). *Indigenous research methodologies*. Sage.

Clarke, A. (2012). *Born to a changing world: Childbirth in nineteenth-century New Zealand*. Bridget Williams Books.

Clarke, G. H. (2020). *Whānau aspirations, extracurricular activity and positive youth development: The leisure activity patterns and narratives of successful young Māori men and how they might inform urban whānau raising tamatāne.* [Doctoral Thesis, The University of Waikato]. https://hdl.handle.net/10289/13695

Community midwives and midwifery services. (2024). *New Zealand College of Midwives*. https://www.midwife.org.nz/women/about-midwives/about-lead-maternity-carer-lmc-services/

Cook, M. (2011, November 5). *Women's health*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/mi/womens-health/print

Cook, M. (2013, September 5). *Māori smoking, alcohol and drugs – tūpeka, waipiro me te tarukino*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/maori-smoking-alcohol-and-drugs-tupeka-waipiro-me-te-tarukino/print

Cram, F., Adcock, A., O'Brien, M., & Lawton, B. (2021). E Hine: Young Māori mothers talk about welfare benefits. *Social Policy & Administration*, *55*(4), 543–558. https://doi.org/10.1111/spol.12641

Davison, I. (2024, July 25). *Govt accused of treating Māori as 'expendable' in emotional debate*. NZ Herald. https://www.nzherald.co.nz/nz/maori-health-authority-to-close-in-june-after-government-introduces-repeal-bill/PNARESQ4SNC3BGC3JQ4YZKBIVM/

Dawson, P., Jaye, C., Gauld, R., & Hay-Smith, J. (2019). Barriers to equitable maternal health in Aotearoa New Zealand: An integrative review. *International Journal for Equity in Health*, *18*(1), 168. https://doi.org/10.1186/s12939-019-1070-7

Derby, M. (2011, May 5). *Māori urban migration*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/maori-pakeha-relations/page-5

Derby, M. (2018, May 22). *Cultural go-betweens: Missionaries*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/cultural-go-betweens/page-3

Dhunna, S., Lawton, B., & Cram, F. (2021). An affront to her mana: Young Māori mothers' experiences of intimate partner violence. *Journal of Interpersonal Violence*, *36*(13–14), 6191–6226. https://doi.org/10.1177/0886260518815712

Dixon, L., Fletcher, L., Hendry, C., & Guilliland, K. (2011). *Midwifery and maternity partners organisation annual report*. Midwifery Council of New Zealand. https://www.midwife.org.nz/wp-content/uploads/2018/08/MMPO-Rpt-2011-Final-sml.pdf

Doyle, K. (2022, October). *Stolen babies: Unwed mothers forced to give up children demand government apology*. Stuff NZ. https://www.stuff.co.nz/national/130269236/stolen-babies-unwed-mothers-forced-to-give-up-children-demand-government-apology

Edmonds, L., Cram, F., Bennett, M., Lambert, C., Adcock, A., Stevenson, K., Geller, S., MacDonald, E. J., Bennett, T., Storey, F., Gibson-Helm, M., Ropitini, S., Taylor, B., Bell, V., Hoskin, C., & Lawton, B. (2022). Hapū Ora (pregnancy wellness): Māori research responses from conception, through pregnancy and 'the first 1000 days' – a call to action for us all. *Journal of the Royal Society of New Zealand*, *52*(4), 318–334. https://doi.org/10.1080/03036758.2022.2075401

Elkington, A. M. B. (2016). *The role of fatherhood in the everyday life of young Māori men* [Masters Thesis, University of Waikato]. https://hdl.handle.net/10289/10733

Ellison-Loschmann, L. (2003). Irihapeti Ramsden. *BMJ: British Medical Journal*, *327*(7412), 453. https://doi.org/10.1136/bmj.327.7412.453

Else, A. (2018, April 18). *Adoption*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatū Taonga. https://teara.govt.nz/en/adoption

Fast Track Approvals Bill (2024). https://www.legislation.govt.nz/bill/government/2024/0031/latest/LMS943195.html

Foreshore and Seabed Act (2004). https://www.legislation.govt.nz/act/public/2004/0093/latest/DLM319839.html

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health*, *44*(3), 193–200. https://doi.org/10.1111/1753-6405.12971

Haerereoa, N. M. (2015). *Young Māori mothers and bed-sharing with their pēpi/baby: A case study focusing on the relevance and influence of three varying health promotion resources* [Masters Thesis, University of Waikato]. https://hdl.handle.net/10289/10116

Hanham, D. E. (2003). *The impact of introduced diseases in the pre-Treaty period 1790-1840* [Masters Thesis, University of Canterbury]. http://hdl.handle.net/10092/6837

He Whakaputanga o Te Rangatiratanga o Nu Tireni (1835).

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (1996).

Health Practitioners Competence Assurance Act (2003). https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Hiam, L., Harrison, D., McKee, M., & Dorling, D. (2018). Why is life expectancy in England and Wales ‘stalling’? *Journal of Epidemiology and Community Health*, *72*(5), 404. https://doi.org/10.1136/jech-2017-210401

Higgins, R. (2011, May). *Tangihanga – death customs—Mythological origins*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/tangihanga-death-customs/page-2

Higgins, R., & Keane, B. (2013, September 5). *Ongoing work, 1980s to 2000s*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-reo-maori-the-maori-language/page-6

Hintz, E. A., & Dean, M. (2020). Best practices for returning research findings to participants: Methodological and ethical considerations for communication researchers. *Communication Methods and Measures*, *14*(1), 38–54. https://doi.org/10.1080/19312458.2019.1650165

Hohepa, T. (Director). (2024, May 8). *It takes a kāinga* [YouTube Video]. https://www.youtube.com/watch?v=8pAQrS4y9vY

Human Rights Act (1993). https://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html

Keane, B. (2023, January 11). *Ngā rōpū tautohetohe – Māori protest movements*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/nga-ropu-tautohetohe-maori-protest-movements/print

Keenan, D. (2024). *Full timeline*. New Zealand Wars: Ngā Pakanga Whenua o Mua. https://newzealandwars.co.nz/full-timeline/

KidsHealth NZ. (n.d.-a). *IV Line (Cannula)*. https://www.kidshealth.org.nz/iv-line-cannula

KidsHealth NZ. (n.d.-b). *Meconium Aspiration Syndrome (MAS) (for Parents)*. https://kidshealth.org/en/parents/meconium.html

Kirkman, A. (2011, May 5). *Health practitioners—Nurses and midwives*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/health-practitioners/page-3

Lane, R. (2015). Tariana Turia: Looking ahead to a tobacco-free New Zealand. *The Lancet*, *385*(9972), 937. https://doi.org/10.1016/S0140-6736(15)60518-9

Lange, R. (2011a). *Te hauora Māori i mua—Health devastated, 1769 to 1901*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-hauora-maori-i-mua-history-of-maori-health/page-2

Lange, R. (2011b, May 5). *Te hauora Māori i mua – history of Māori health—Health improves, 1900 to 1920*. Te Ara-The Encyclopedia of New Zealand; Ministry for

Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-hauora-maori-i-mua-history-of-maori-health/page-3

Lange, R. (2018, April 4). *Te hauora Māori i mua – history of Māori health—Slow progress, 1920 to 1945*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-hauora-maori-i-mua-history-of-maori-health/page-4

Lawton, B., Cram, F., Makowharemahihi, C., Ngata, T., Robson, B., Brown, S., & Campbell, W. (2013). Developing a kaupapa Māori research project to help reduce health disparities experienced by young Māori women and their babies. *AlterNative: An International Journal of Indigenous Peoples*, *9*(3), 246–261. https://doi.org/10.1177/117718011300900305

Lawton, B., Makowharemahihi, C., Cram, F., Robson, B., & Ngata, T. (2016). E Hine: Access to contraception for indigenous Māori teenage mothers. *Journal of Primary Health Care*, *8*(1), 52–59. https://doi.org/10.1071/HC15021

Leahy, H. (2015). *Crossing the floor: The story of Tariana Turia*. Huia Publishers.

Lee, J. A. (1982). Three paradigms of childhood. *The Canadian Review of Sociology*, *19*(4), 591–608. https://doi.org/10.1111/j.1755-618X.1982.tb00883.x

Lissienko, K. (2011, September 13). *Vitamin K for newborn babies to prevent serious bleeding*. KidsHealth NZ. https://www.kidshealth.org.nz/vitamin-k-newborn-babies-prevent-serious-bleeding

Luker, K. (1996). *Dubious conceptions: The politics of teenage pregnancy*. Harvard University Press.

Mahuika, R. (2008). Kaupapa Māori theory is critical and anti-colonial. *MAI Review*, *3*(4), 1–16. https://www.journal.mai.ac.nz/system/files/maireview/153-877-1-PB.pdf

Makowharemahihi, C., Lawton, B. A., Cram, F., Ngata, T., Brown, S., & Robson, B. (2014). Initiation of maternity care for young Maori women under 20 years of age. *The New Zealand Medical Journal*, *127*(1393), 52–61. https://pubmed.ncbi.nlm.nih.gov/24816956/

Manatū Taonga — Ministry for Culture and Heritage. (2020, September 23). *First known encounter between Māori and Europeans*. NZ History. https://nzhistory.govt.nz/page/first-contact-between-maori-and-europeans

Manatū Taonga — Ministry for Culture and Heritage. (2021a, March 16). *Native Land Court created*. NZ History. https://nzhistory.govt.nz/page/native-land-court-created

Manatū Taonga — Ministry for Culture and Heritage. (2021b, April 12). *Māori land loss, 1860-2000*. NZ History. https://nzhistory.govt.nz/media/interactive/maori-land-1860-2000

Manatū Taonga — Ministry for Culture and Heritage. (2021c, October 19). *Musket wars-Overview*. NZ History. https://nzhistory.govt.nz/war/musket-wars/overview

Manatū Taonga — Ministry for Culture and Heritage. (2021d, October 20). *The Wairau incident*. NZ History. https://nzhistory.govt.nz/war/wairau-incident

Manatū Taonga — Ministry for Culture and Heritage. (2021e, October 21). *Waikato War map*. NZ History. https://nzhistory.govt.nz/media/photo/waikato-war-map

Manatū Taonga — Ministry for Culture and Heritage. (2021f, October 27). *Whina Cooper leads land march to Parliament*. NZ History. https://nzhistory.govt.nz/whina-cooper-led-land-march-te-ropu-o-te-matakite-reaches-parliament

Manatū Taonga — Ministry for Culture and Heritage. (2021g, November 5). *Invasion of pacifist settlement at Parihaka*. NZ History. https://nzhistory.govt.nz/occupation-pacifist-settlement-at-parihaka

Manatū Taonga — Ministry for Culture and Heritage. (2022, January 13). *He Whakaputanga—Declaration of Independence*. NZ History. https://nzhistory.govt.nz/culture/declaration-of-independence-taming-the-frontier

Manatū Taonga — Ministry for Culture and Heritage. (2024a, May 8). *Treaty events 1850-99*. NZ History. https://nzhistory.govt.nz/politics/treaty/treaty-timeline/treaty-events-1850-99

Manatū Taonga — Ministry for Culture and Heritage. (2024b, June). *Te Rōpū Wāhine Māori Toko i te Ora Māori Women's Welfare League*. NZ History. https://nzhistory.govt.nz/women-together/maori-womens-welfare-league

Māori Community Act (1962). https://www.legislation.govt.nz/act/public/1962/0133/latest/DLM341045.html

Māori Representation Act (1867). http://www.nzlii.org/nz/legis/hist_act/mra186731v1867n47357/

Marsh, T. M. (2019). *Violation of te whare tangata—The maternal body: Young women's journeys through pregnancy and partner terrorism* [Masters Thesis, The University of Waikato]. https://hdl.handle.net/10289/12749

Maton, K. I., Dogden, D. W., Leadbeater, B. J., Sandler, I. N., Schellenbach, C. J., & Solarz, A. L. (2004). Strengths-based research and policy: An introduction. *American Psychological Association*. https://doi.org/10.1037/10660-001

Mead, H. M. (2016). *Tikanga Māori: Living by Māori values*. Huia Publishers. http://ebookcentral.proquest.com/lib/waikato/detail.action?docID=1359704

Medical Council of New Zealand - Te Kaunihera Rata o Aotearoa. (2020). *Unprofessional behaviour*. www.mconz.org.nz

Medical Council of New Zealand - Te Kaunihera Rata o Aotearoa. (2021). *Good Medical Practice Standards for Doctors*. https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf

Medical Practitioners Act (1867). http://www.nzlii.org/nz/legis/hist_act/mpa19681968n46242/

Merriam, S. B. (2002). Introduction to qualitative research. *Qualitative Research in Practice: Examples for Discussion and Analysis*, *1*(1), 1–17.

Midwives Act (1904). http://www.nzlii.org/nz/legis/hist_act/ma19044ev1904n31210/

Mikaere, A. (2003). *The balance destroyed: The consequences for Māori women of the colonisation of Tikanga Māori* [Doctoral dissertation]. University of Auckland.

Ministry of Health - Manatū Hauora. (2010). *Report on Maternity [Webtool/data set]*. http://www.health.govt.nz/system/files/documents/publications/report-on-maternity-2010_0.doc

Ministry of Health - Manatu Hauora. (2021). *Primary Maternity Services Notice 2021*. New Zealand Gazette. https://gazette.govt.nz/notice/id/2021-go2473?stageDraft

Ministry of Health - Manatu Hauora. (2023). *New Zealand Health Survey Annual Data Explorer [Data file]*. https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/_w_fa290e34/#!/key-indicators

Moore, C., Coates, E., Watson, A., de Heer, R., McLeod, A., & Prudhomme, A. (2022). "It's important to work with people that look like me": Black patients' preferences for patient-provider race concordance. *Journal of Racial and Ethnic Health Disparities*, 1–13. https://doi.org/10.1007/s40615-022-01435-y

Murphy, N. (2011). *Te awa atua, te awa tapu, te awa wahine: An examination of stories, ceremonies and practices regarding menstruation in the pre-colonial Māori world.* [Masters Thesis, University of Waikato]. https://hdl.handle.net/10289/5532

Naomi Simmonds. (2019). Mana Wahine:Decolonising politics. In L. Pihama, L. T. Smith, J. Seed-Pihama, G. Kirsten, & N. Simmonds (Eds.), *Mana wahine reader. Volume II, a collection of writings 1999-2019* (pp. 105–122). Te Kotahi Research Institute & University of Waikato.

Native Schools Act (1858). http://www.nzlii.org/nz/legis/hist_act/nsa186731v1867n41290/

New Zealand Bill of Rights Act (1990). https://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html

New Zealand College of Midwives. (n.d.). *Find Your Midwife*. https://www.findyourmidwife.co.nz/

New Zealand College of Midwives - Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa. (2004). *The Competencies for Entry to the Register of Midwives*. https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Midwifery%20 Leaders/Competencies%20for%20Entry%20to%20the%20register%20of%20Midwives%202007.pdf

New Zealand College of Midwives - Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa. (2015). *Midwives Handbook for Practice*. New Zealand College of Midwives. https://books.google.co.nz/books?id=KHf-jgEACAAJ

New Zealand Ministry of Justice. (2023, July 18). *Hāpaitia te Oranga Tangata*. https://www.justice.govt.nz/justice-sector-policy/key-initiatives/key-initiatives-archive/hapaitia-te-oranga-tangata/

New Zealand Settlements Act (1863). http://www.nzlii.org/nz/legis/hist_act/nzsa186327v1863n8377/

Núñez, A.-M., Rivera, J., & Hallmark, T. (2020). Applying an intersectionality lens to expand equity in the geosciences. *Journal of Geoscience Education*, *68*(2), 97–114. https://doi-org.ezproxy.waikato.ac.nz/10.1080/10899995.2019.1675131

Nurses Amendment Act (1990). https://www.legislation.govt.nz/act/public/1951/0081/latest/DLM265587.html

Nurses and Midwives Registration Act (1925). http://www.nzlii.org/nz/legis/hist_act/namra192516gv1925n10438/

Nurses Registration Act (1901). http://www.nzlii.org/nz/legis/hist_act/nra19011ev1901n12347/

Nursing Coucil of New Zealand - Te Kaunihera Tapuhi o Aotearoa. (2012). *Code of Conduct for Nurses*. https://online.flippingbook.com/view/359830702/2/

NZ Parliamentary Library. (2009, November 31). *Origins of the Māori seats*. New Zealand Parliament - Pāremata Māori. https://www.parliament.nz/mi/pb/research-papers/document/00PLLawRP03141/origins-of-the-m%C4%81ori-seats

NZ Parliamentary Library. (2022, August 12). *Te Petihana Reo Māori—The Māori Language Petition*. New Zealand Parliament - Pāremata Māori. https://www.parliament.nz/mi/visit-and-learn/history-and-buildings/te-rima-tekau-tau-o-te-petihana-reo-maori-the-50th-anniversary-of-the-maori-language-petition/te-petihana-reo-maori-the-maori-language-petition/

Oranga Tamariki - Ministry for Children. (2019). *Teen parents evidence brief*. https://www.orangatamariki.govt.nz/about-us/research/our-research/teen-parents-evidence-brief/

Oranga Tamariki Act (Vulnerable Children's Act) (1989). https://www.legislation.govt.nz/act/public/1989/0024/latest/DLM147094.html

Papa, R., & Meredith, P. (2012, June 20). *Kīngitanga – the Māori King movement*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatū Taonga. https://teara.govt.nz/en/kingitanga-the-maori-king-movement

Parsonson, A. (1996). *Hērangi, Te Kirihaehae Te Puea*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/biographies/3h17/herangi-te-kirihaehae-te-puea

Pere, R. R. (1994). *Concepts and learning in the Māori tradition* (Issue 17). Te Kohanga Reo National Trust Board.

Perinatal and Maternal Mortality Review Committee. (2012). *Perinatal and Maternal Mortality Review Committee: Reporting mortality 2010*. Health Quality & Safety Commission. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/PMMRC/Publications-resources/PMMRC_6thReport_2010_-_edited_20170825.pdf

Pihama, L. (2011). *Overview of Māori teen pregnancy*. Families Commission. thehub.sia.govt.nz

Pihama, L. (2022, April 19). Kaupapa Māori theory, research methodology, practice and expressions of rangatiratanga. *Kaupapa Māori as Transformative Indigenous Analysis*. https://kaupapamaori.com/2022/04/19/kaupapa-maori-theory-research-methodology-practice-and-expressions-of-rangatiratanga/

Pihama, L., Lee, J., Te Nan, R., Greensill, H., & Campbell, D. (2014). *Tiakina te pā harakeke: Māori childrearing practices within a context of whānau ora [Report]*. Ngā Pae o Te Māramatanga. https://hdl.handle.net/10289/13506

Pihama, L., & Lee-Morgan, J. (2022). *Tiakina te pā harakeke: Ancestral knowledge and tamariki wellbeing*. Huia Publishers.

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). *Meihana model: A clinical assessment framework*. *36*(3). https://www.psychology.org.nz/journal-archive/Pitamaetal_NZJP36-3_pg118.pdf

Pollock, K. (2011, May 5). *Pregnancy, birth and baby care—Childbirth, 19th century to 1950s*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/pregnancy-birth-and-baby-care/page-3

Pool, I., & Jackson, N. (2018). *Population change—Māori population change*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/population-change/page-6

Privacy Act (2020). https://www.legislation.govt.nz/act/public/2020/0031/latest/LMS23223.html

Purvis, R. S., Abraham, T. H., Long, C. R., Stewart, M. K., Warmack, T. S., & McElfish, P. A. (2017). Qualitative study of participants' perceptions and preferences regarding research dissemination. *AJOB Empirical Bioethics*, *8*(2), 69–74. https://doi.org/10.1080/23294515.2017.1310146

Ramsden, I. (1993). *Kawa Whakaruruhau: Cultural Safety in Nursing Education Aotearoa (NZ)*. *8*(3), 4–10. https://doi.org/10.36951/NgPxNZ.1993.009

Rawiri, C. (2007). *Adolescent Māori mothers experiences with social support during pregnancy, birth and motherhood and their participation in education* [Masters Thesis, The University of Waikato]. https://hdl.handle.net/10289/2490

Reweti, A. (2023). Developing a kaupapa whānau framework to explore social, cultural and health benefits of a whānau inspired initiative. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, *11*, 128–139. https://doi.org/10.20507/MAIJournal.2022.11.2.4

Rewi, T. (2014). Utilising kaupapa Māori approaches to initiate research. *MAI Journal*, *3*(3), 242–254. https://www.journal.mai.ac.nz/content/utilising-kaupapa-m%C4%81ori-approaches-initiate-research

Robb, Y., McInery, D., & Hollins Martin, C. J. (2013). Exploration of the experiences of young mothers seeking and accessing health services. *Journal of Reproductive and Infant Psychology*, *31*(4), 399–412. https://napier-repository.worktribe.com/preview/182260/Exploration%20of%20the%20experiences%20of%20young%20mothers%20seeking%20and%20accessing%20health%20services.pdf

Royal, T. A. C. (2005, February 8). *First peoples in Māori tradition—Kupe*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/first-peoples-in-maori-tradition/page-6

Royal, T. A. C. (2015, April). *Hawaiki*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/hawaiki

Russell, E. (2024, July 25). *"This cannot go on": Revealed - The biggest killer of pregnant women and new mums*. NZ Herald. https://www.nzherald.co.nz/nz/maternal-suicide-leading-cause-of-deaths-of-pregnant-women-new-mothers-report-reveals/WRSGGMMLYV6LC5MJNBTWBLJ5X4/

Sainsbury, R. (2015). *A history of The Medical Council of New Zealand*. Medical Council of New Zealand. https://www.mcnz.org.nz/assets/Publications/266593c823/History-of-the-Medical-Council.pdf

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.

Schrader, B. (2013, September 5). *Māori housing – te noho whare*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/maori-housing-te-noho-whare

Simmonds, N. B. (2009). *Mana wahine geographies: Spiritual, spatial and embodied understandings of papatūānuku* [Masters Thesis, University of Waikato]. https://hdl.handle.net/10289/2798

Singh, D. R., Sah, R. K., Simkhada, B., & Darwin, Z. (2023). Potentials and challenges of using co-design in health services research in low- and middle-income countries. *Global Health Research and Policy*, *8*(1), 5. https://doi.org/10.1186/s41256-023-00290-6

Smith, G. H. (2003). *Kaupapa Māori theory: Theorizing Indigenous transformation of education and schooling*. Proceedings Kaupapa Maori Symposium-NZARE/AARE Joint Conference. https://www.aare.edu.au/data/publications/2003/pih03342.pdf

Smith, L., Pihama, L., Cameron, N., Mataki, T., Morgan, H., & Te Nana, R. (2019). Thought space wānanga—A kaupapa Māori decolonizing approach to research translation. *Genealogy*, *3*(4), Article 4. https://doi.org/10.3390/genealogy3040074

Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. Zed Books.

Smith, L. T. (2011). Story-ing the development of Kaupapa Māori–A review of sorts. *Kei Tua o Te Pae Hui Proceedings*, 10–15. https://www.nzcer.org.nz/system/files/Hui_Procedings__v3_Web_1.pdf

Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples*. Zed Books. http://ebookcentral.proquest.com/lib/waikato/detail.action?docID=3563227

Smith, L. T. (2015). *Kaupapa Māori research—Some kaupapa Māori principles* (pp. 47–52). Te Kotahi Research Institute. https://researchcommons.waikato.ac.nz/server/api/core/bitstreams/c3eb833e-73ff-4239-a595-f64b4a00a36b/content

Smith, L. T. (2021). *Decolonizing methodologies: Research and indigenous peoples*. Bloomsbury Publishing.

Smith, L. T., Maxwell, T. K., Puke, H., & Temara, P. (2016). Indigenous knowledge, methodology and mayhem: What is the role of methodology in producing Indigenous insights? A discussion from mātauranga Māori. *Knowledge Cultures*, *4*(3), 131–156. https://hdl.handle.net/10289/11493

SmithBattle, L. (2013). Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal/Child Nursing*, *38*(4), 235–241. https://doi.org/10.1097/NMC.0b013e3182836bd4

Smokefree Environments and Regulated Products Amendment Regulations (2023). https://www.legislation.govt.nz/regulation/public/2023/0201/latest/whole.html

Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Act (1990). https://legislation.govt.nz/bill/government/2022/0143/latest/whole.html

Southorn, D. (2016). *I'm just a young mother* [Masters Thesis, University of Otago]. https://hdl.handle.net/10523/6674

Stats NZ - Tatauranga Aotearoa. (2022, June 5). *Te reo Māori proficiency and support continues to grow*. https://www.stats.govt.nz/news/te-reo-maori-proficiency-and-support-continues-to-grow/

Stats NZ - Tatauranga Aotearoa. (2024, May 16). *Māori population estimates: Mean year ended 31 December 2023 (2018-base)*. www.stats.govt.nz/information-releases/maori-population-estimates-mean-year-ended-31-december-2023

Steen, M., Manschot, M., & Koning, N. (2011). Benefits of co-design in service design projects. *International Journal of Design*, *5*. https://www.ijdesign.org/index.php/IJDesign/article/view/890/346

Stenhouse, J. (2018, April 4). *Māori and religion*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/religion-and-society/page-4

Stevenson, K., Filoche, S., Cram, F., & Lawton, B. (2016). Lived realities: Birthing experiences of Māori women under 20 years of age. *AlterNative: An International Journal of Indigenous Peoples*, *12*(2), 124–137. https://doi.org/10.20507/AlterNative.2016.12.2.2

Stewart, E. (2024, February 4). Kotahitanga in action: Hundreds descend upon the Treaty grounds alongside the Kiingitanga and Rātana. *RNZ*. https://www.rnz.co.nz/news/te-manu-korihi/508387/kotahitanga-in-action-hundreds-descend-upon-the-treaty-grounds-alongside-the-kiingitanga-and-ratana

Stojanovic, J. E. E. (2002). *Leaving your dignity at the door: Maternity in Wellington 1950-1970* [Masters Thesis, University of Otago]. https://doi.org/10.26686/wgtn.16920775.v1

Takutai Moana (Marine and Coastal Area) Act (2011). https://www.legislation.govt.nz/act/public/2011/0003/latest/DLM3213131.html

Taonui, R. (2012, June 20). *The Native Land Court*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-ture-maori-and-legislation/page-3

Te Awekotuku, N. (1991). *He tikanga whakaaro: Research ethics in the Māori community: A discussion paper*. Ministry of Māori Affairs.

Te Tiriti o Waitangi [Māori Version] (1840).

Te Ture Whenua Māori Act (1993). https://www.legislation.govt.nz/act/public/1993/0004/latest/DLM289882.html

Te Whatu Ora - Health New Zealand. (2023a). *Report on Maternity 2017: Further information*. https://www.tewhatuora.govt.nz/assets/Our-health-system/Data-and-statistics/Maternity-web-tools/report-on-Maternity-further-information.pdf

Te Whatu Ora - Health New Zealand. (2023b). *Small for gestational age and fetal growth restriction in Aotearoa New Zealand—A clinical practice guideline: Transcript of the webinar for health practitioners*. https://www.tewhatuora.govt.nz/assets/Publications/Obstetrics/Small-for-Gestational-Age-and-Fetal-Growth-Restriction-in-NZ-Webinar-transcripts.pdf

Te Whatu Ora - Health New Zealand. (2024a, January 29). *Well child tamariki ora*. Health Information and Services. https://info.health.nz/pregnancy-children/well-child-tamariki-ora/well-child-tamariki-ora-visits/

Te Whatu Ora - Health New Zealand. (2024b, February). *Kahu Taurima—Maternity and early years*. https://www.tewhatuora.govt.nz/for-health-professionals/health-workforce-development/maternity/kahu-taurima/

Te Whatu Ora - Health New Zealand. (2024c, June 6). *Report on Maternity web tool*. https://tewhatuora.shinyapps.io/report-on-maternity-web-tool/

Te Whatu Ora - Waitaha Canterbury. (2024, March 26). *Youth Advisory Council (YAC)*. https://www.cdhb.health.nz/about-us/clinical-consumer-input/youth-advisory-council/

Te Whatu Ora Waikato - Health New Zealand. (2023). *Waikato Maternity Quality and Safety—Annual Report 2021/22*. https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Reports/Waikato-Maternity-annual-report-2022_web.pdf

Terreri, C. (2024). *A childbirth educator's response to the onion's "shocking things."* Lamaze International. https://www.lamaze.org/Connecting-the-Dots/Post/a-childbirth-educators-response-to-the-onions-shocking-things-1

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. S. Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (Vol. 2, pp. 17–36). Sage. https://doi.org/10.4135/9781526405555

The ACT Party. (n.d.). *The Treaty Principles Bill*. https://www.treaty.nz/

The Native Lands Act (1862). http://www.nzlii.org/nz/legis/hist_act/nla186529v1865n71251/

The Suppression of Rebellion Act (1863). http://www.nzlii.org/nz/legis/hist_act/sora186327v1863n7403/

The Treaty of Waitangi [English Version] (1840).

The Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi. (2016). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry [WAI2572]*. Legislation Direct. https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

The Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi. (2024, May 9). *Meaning of the treaty*. https://www.waitangitribunal.govt.nz/treaty-of-waitangi/meaning-of-the-treaty/

Therapeutic Products Bill (2022). https://www.legislation.govt.nz/bill/government/2022/0204/latest/whole.html

Tikao, K. W. (2013). *Iho-a cord between two worlds: Traditional Māori birthing practices* [Masters Thesis, University of Otago]. https://hdl.handle.net/10523/8069

Tohunga Suppression Act (1907). http://www.nzlii.org/nz/legis/hist_act/tsa19077ev1907n13353/

Treaty of Waitangi Act (1975). https://www.legislation.govt.nz/act/public/1975/0114/latest/whole.html

Tupara, H. (2011, May 5). *Te whānau tamariki – pregnancy and birth*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/te-whanau-tamariki-pregnancy-and-birth/print

United Nations Declaration on the Rights of Indigenous Peoples. (2007). United Nations. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

University of Melbourne. (2023). *Reviewing the literature: A critical review*. https://services.unimelb.edu.au/__data/assets/pdf_file/0009/821727/Reviewing_the_Literature_150613.pdf

Waetford, C. (2008). *The knowledge, attitudes and behaviour of young Māori women in relation to sexual health: A descriptive qualitative study* [Masters Thesis, Auckland University of Technology]. https://hdl.handle.net/10292/412

Waitangi Tribunal - Te Rōpū Whakamana i te Tiriti o Waitangi. (2020). *Past, present & future of the Waitangi Tribunal*. https://www.waitangitribunal.govt.nz/about/past-present-future-of-waitangi-tribunal/

Walker, H. (2022). *Āhurutia te rito: It takes a village: How better support for perinatal mental health could transform the future for whānau and communities in Aotearoa New Zealand*. Helen Clark Foundation. https://helenclark.foundation/app/uploads/2022/04/HCF_Ahurutia_Te_Rito_It_Takes_a_Village_policy_summary_web.pdf

Wardak, D., Wilson, S., & Zeivots, S. (2024). Co-design as a networked approach to designing educational futures. *Postdigital Science and Education*, *6*(1), 194–210. https://doi.org/10.1007/s42438-023-00425-5

Ware, F. (2019). *"It's hard being a young parent, it's even harder being a young Māori parent": Young Māori parents' experiences of raising a family* [Doctoral Thesis, Massey University]. http://hdl.handle.net/10179/16263

Ware, F., Breheny, M., & Forster, M. (2018). Mana mātua: Being young Māori parents. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, *7*(1). https://doi.org/10.20507/MAIJournal.2018.7.1.2

Wassilieff, M. (2008, November 24). *History of market gardening*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/market-gardens-and-production-nurseries/page-2

West, E. F. (2012). *Manu is my homegirl: Navigating the ethnic identity of the Māori adoptee* [Masters Thesis, Auckland University of Technology]. https://hdl.handle.net/10292/4614

Wilson, H., & Huntington, A. (2006). Deviant (m)others: The construction of teenage motherhood in contemporary discourse. *Journal of Social Policy*, *35*(1), 59–76. https://doi.org/doi:10.1017/S0047279405009335

Wilson, J. (2020, April 1). *History—Europeans to 1840*. Te Ara-The Encyclopedia of New Zealand; Ministry for Culture and Heritage Te Manatu Taonga. https://teara.govt.nz/en/document/1454/cooks-map-of-new-zealand-1773

Woodward, L. J., Horwood, L. J., & Fergusson, D. M. (2001). Teenage pregnancy: Cause for concern. *New Zealand Medical Journal*, *114*(1135), 301–303. https://pubmed.ncbi.nlm.nih.gov/11556441/

APPENDICES

Appendix A – Participant Information and Consent Sheet (long)

Participant Information Sheet

Project title: Karanga Atu, Karanga Mai: Responding to the call of young māmā who want to share their clinical health experiences and to create change.

Ethics No. 21/NTB/148

Project Lead: Dr. Gloria Hinemoa Clarke
Contact details: ----
Master's Student/ Researcher: Mia Kolo
Contact details: ----

Informed by the healthcare experiences shared with Tina Baty in 2022, the aim of this study is to improve the way in which healthcare professionals service and treat young mothers/ parents.

This information sheet will help you decide if you would like to participate. Participating in this study is completely your choice. If you do not want to take part, you do not have to give a reason. If do you change your mind, you can pull out at any time. Before you decide, please feel free to talk about it with other people such as whānau and or friends.

If you agree to participate, you will be asked to sign a Consent Form (attached). You will keep this Information Sheet and your copy of the Consent Form.

Who can participate?

Current and recently graduated He Puaawai students. However, for practical reasons, the number of participants is limited.

What is the purpose of the study?

The purpose of the study is for us to learn more about your healthcare experiences (positive and negative) in an effort to improve the way in which healthcare professionals service and treat young mothers. Working with you, we would like to design guidelines and educational materials that will help healthcare professionals understand how best to work with young mothers such as yourself. We want to understand:

- **When caring for young māmā and their tamariki what are doctors, nurses, midwives and other healthcare professionals doing well?**
- **What are they not doing well?**
- **What do they need to know and do in order to improve what they do?**

What will my participation in the study involve?

This project has two parts, and you can choose to participate in one or both parts.

In the first part, we will discuss ideas around healthcare experiences as a group, and then everyone is invited to participate in an individual interview. In the interview, you are welcome to bring a friend, partner, or whānau members. They will also be provided with a separate information sheet and be asked to sign a consent form. In this part of the project, we will talk about your experiences with healthcare professionals as young mothers. The group discussion is likely to take 1 hour, and the interview should take about 1 to 1.5 hours.

In the second part of the project, you are then invited to participate in analysing everyone's kōrero (names removed) to identify what the main issues are. Using this information, we will then design some educational materials for healthcare professionals (e.g. doctors, nurses, midwives) together.

Both parts of the project will take place at He Puaawai, Fraser High School. So, we can type up what has been said, all the discussions and interviews will be audio recorded. The group discussions may be video recorded to ensure that we connect the right person with the right voice. Only the lead researcher and her research assistant will use these recordings. You may choose to be identified in the research findings. Otherwise, your identity will not be shared with anyone other than the research team.

Who pays for the study?

This study is funded by the University of Waikato. There are no direct costs to you taking part. To acknowledge your contribution and participation in the study you will receive a koha.

What are the possible benefits and risks of this study?

The information that you share with us will be treated with respect, privacy, protection, and care.

You do not have to talk about anything that you do not want to. Everything you share will be kept confidential. Your identity will not be shared with anyone other than the research team, but you can choose to be identified in the research findings if you wish to.

You may not directly benefit from the study. However, the research findings and your guidelines and materials will be shared with healthcare providers including doctors, nurses, student doctors, and midwives with the intention that this will benefit the young women they treat moving forward. In this way, your contribution will benefit other young māmā (and young parents) and future generations.

Confidentiality

The information you provide will be only available to members of the research team. The recording, hui notes and any other information that you provide will remain strictly confidential, unless there is an immediate risk of serious harm to yourself or others. All computer records will be password protected. All use of the information collected will be strictly controlled in accordance with the Privacy Act.

The study findings will be published, but there will be no identifying information included. However, we are unable to guarantee complete confidentiality, but we will try our best to do so. The audio recordings will be transcribed. However, we will delete any details in the transcript that might potentially expose the identity of any participants (e.g. names, clinicians, services).

Who has approved the study?

This study has been approved by an independent group of people called the Health and Disability Ethics Committee. They check that studies meet ethical standards. The Northern B Health and Disability Ethics Committee has approved this study.

What if something goes wrong?

We understand that sometimes talking about health conditions and negative experiences can have an emotional impact. If you feel upset or distressed at any point, please feel free to pause and take some time out, pass on any questions or topics, or to end the interview or leave the discussion. If you would like some support with what you are feeling, please let Gillian or Gloria know. If you would like, we will connect you with an appropriate support person or service. Gillian will also check in with you in the course of the study, to ensure that you are feeling okay.

What are my rights?

If you have any questions or concerns about your rights as a participant in this study, please talk to either Gillian Cotter or Gloria Clarke. Alternatively, you may wish to contact an **Independent Health and Disability Advocate**. This is a free service provided under the Health and Disability Commissioner Act:

Free phone: 0800 555 050

Free fax: 0800 2787 7678 (0800 2 SUPPORT)

Email: advocacy@hdc.org.nz

Website: https://www.advocacy.org.nz/

For Māori health support, please contact:
Te Puna Oranga (Te Whatu Ora Waikato - Māori Health Unit)
Hockin Building, Level 1, Pembroke St, P.O. Box 934, Hamilton.
Ph: (07) 834 3628 Fax: (07) 834 3619.

You can also contact the **Health and Disability Ethics Committee** (HDEC) that approved this study: Phone: 0800 4 ETHICS Email: hdecs@moh.govt.nz

What if I change my mind?

If you take part in this study, you can choose not to answer any of the questions, and you can also change your mind and stop at any time. If you want to pull out of the study, you can do so at any time by contacting us. If you have any questions, concerns or complaints about the study at any stage, you can contact any one of the following project team members

Dr. Gloria Clarke
[email removed]
[phone number removed]
Dr. Amy Jones
[email removed]
[phone number removed]

Gillian Cotter
[email removed]
[phone number removed]
Mia Kolo
[email removed]
[phone number removed

At the end of the study, if you would like to have a copy, you will be presented with a summary of the research including copies of the materials that have been created. We will then present the findings and materials to the applicable healthcare professionals. As the source of this information, you are of course welcome to present with us and or to come and watch. This is your choice; it is not an expectation or a requirement to participate in the study. We expect that this study will lead to other research questions and projects.

Consent Form – Participant copy

Please indicate that you consent to the following [tick/cross]

☐ I have read or have had read to me in my first language, and understand the *Participant Information Sheet.*

☐ I have been given enough time to consider whether or not to participate in this study.

☐ I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.

☐ I understand that taking part in this study is voluntary and that I can pass on any questions/topics that I do not want to answer or discuss and can withdraw at any time.

☐ I understand that, unless I choose to be identified, my involvement in this study is confidential and that no material that could identify me personally will be used in any publications or presentations.

☐ I understand that the research team is unable to guarantee complete confidentiality within the group hui due to the number of other people involved.

☐ If I decide to withdraw from the study, I agree that the information I have shared up until that point may continue to be used. However, I understand that it will not be possible to withdraw the information I provide in the group hui as it will be part of a discussion with other participants.

☐ I consent to participating in the group discussions and for these to video and audio recorded and transcribed.

☐ I agree to keep the information shared during the group hui confidential.

☐ I consent to being interviewed, and to having these interviews recorded and transcribed.

I want to be identified in the research (i.e. using my real name). ☐ Yes ☐ No

If you **do not** want to be identified, what name would you like to be given?

☐ I know who to contact if I have any questions about the study in general.

☐ I understand my responsibilities as a study participant.

I wish to receive a summary of the research results. ☐ Yes ☐ No

Participant Declaration:

I hereby consent to take part in this study.

Name:

*Signature: *Date:

Researcher Declaration:

I have given a verbal explanation of the research project to the participant and have answered the participant’s questions about it. I believe that the participant understands the study and has given informed consent to participate.

Name:

Signature: Date:

Appendix B – U16 Participant Information and Consent Sheet (long)

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

U16 Participant Information Sheet

Project title: Karanga Atu, Karanga Mai: Responding to the call of young māmā who want to share their clinical health experiences and to create change.

Ethics No. 21/NTB/148

Project Lead: Dr. Gloria Hinemoa Clarke
Contact details: ----------------------

Master's Student/ Researcher: Mia Kolo
Contact details: --------------------------

Informed by the healthcare experiences shared with Tina Baty in 2022, the aim of this study is to improve the way in which healthcare professionals service and treat young mothers/ parents.

This information sheet will help you decide if you would like to participate. Participating in this study is completely your choice. If you do not want to take part, you do not have to give a reason. If do you change your mind, you can pull out at any time. Before you decide, please feel free to talk about it with other people such as whānau and or friends.

If you agree to participate, you will be asked to sign a Consent Form (attached). You will keep this Information Sheet and your copy of the Consent Form.

Who can participate?

Current and recently graduated He Puaawai students. However, for practical reasons, the number of participants is limited.

What is the purpose of the study?

The purpose of the study is for us to learn more about your healthcare experiences (positive and negative) in an effort to improve the way in which healthcare professionals service and treat young mothers. Working with you, we would like to design guidelines and educational materials that will help healthcare professionals understand how best to work with young mothers such as yourself. We want to understand:

- **When caring for young māmā and their tamariki what are doctors, nurses, midwives and other healthcare professionals doing well?**
- **What are they not doing well?**
- **What do they need to know and do in order to improve what they do?**

What will my participation in the study involve?

☐ I wish to receive a summary of the research results.

Participant Declaration:

I hereby consent to take part in this study.

Name: Age:

Signature: Date:

Researcher Declaration:

I have given a verbal explanation of the research project to the participant and have answered the participant's questions. I believe that the participant understands the study and has given their informed consent to participate.

Name:

Signature: Date:

Appendix C – Participant Demographic Questionnaire

Participant Questionnaire

Date:

Name: Age:

Ethnicity: Iwi (if applicable):

How would you like to be contacted?:

What town/suburb do you live in?:

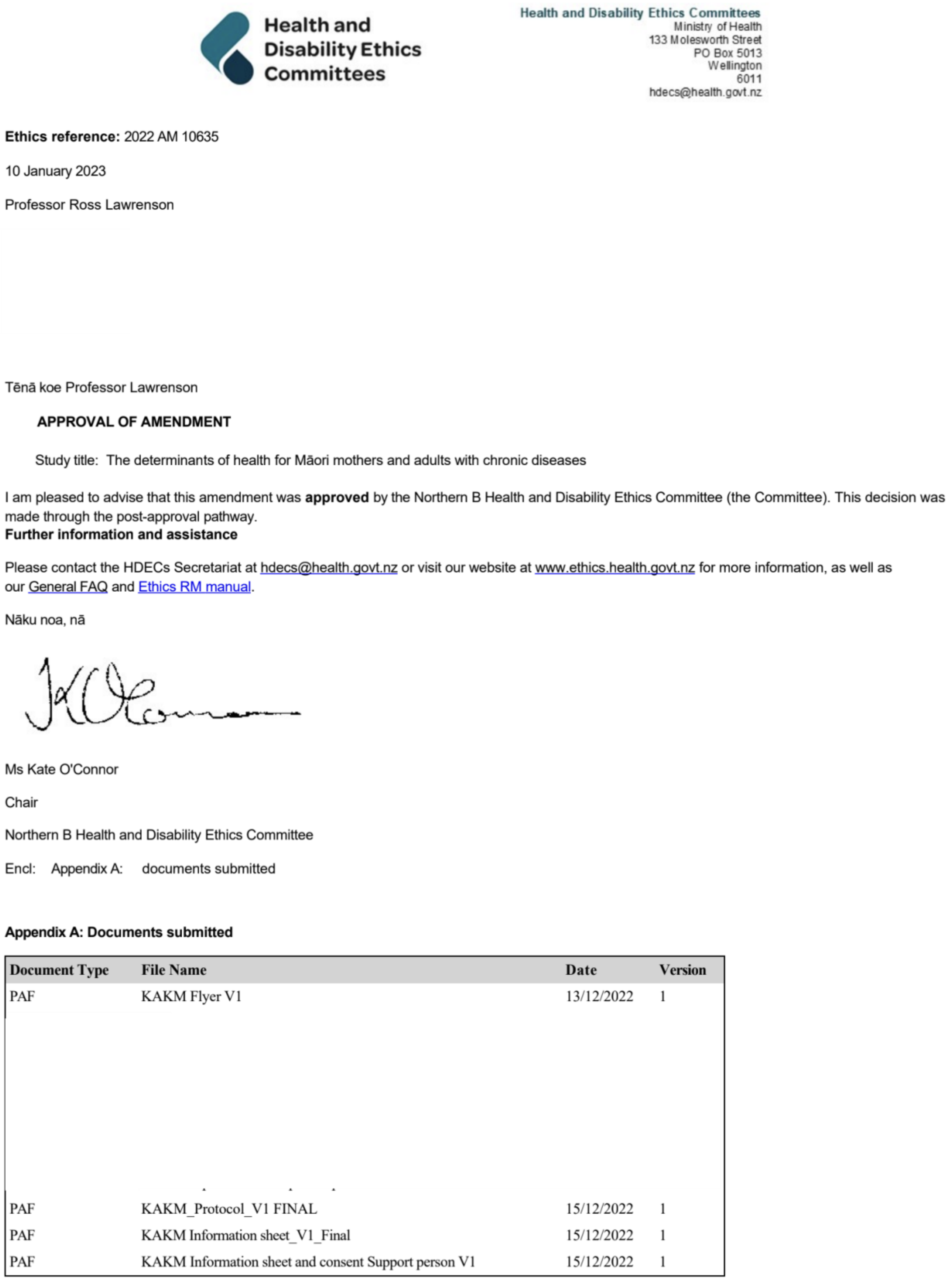
What is your current living situation? (*e.g. live with my nan, renting ect.*):

How many tamariki/ children do you have?:

Where were each of them born?:	How old are they?:

☐ No children yet/ pregnant

Appendix D – Karanga Atu, Karanga Mai Ethics Approval



Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011
hdecs@health.govt.nz

Ethics reference: 2022 AM 10635

10 January 2023

Professor Ross Lawrenson

Tēnā koe Professor Lawrenson

APPROVAL OF AMENDMENT

Study title: The determinants of health for Māori mothers and adults with chronic diseases

I am pleased to advise that this amendment was **approved** by the Northern B Health and Disability Ethics Committee (the Committee). This decision was made through the post-approval pathway.

Further information and assistance

Please contact the HDECs Secretariat at hdecs@health.govt.nz or visit our website at www.ethics.health.govt.nz for more information, as well as our General FAQ and Ethics RM manual.

Nāku noa, nā

Ms Kate O'Connor

Chair

Northern B Health and Disability Ethics Committee

Encl: Appendix A: documents submitted

Appendix A: Documents submitted

Document Type	File Name	Date	Version
PAF	KAKM Flyer V1	13/12/2022	1
PAF	KAKM_Protocol_V1 FINAL	15/12/2022	1
PAF	KAKM Information sheet_V1_Final	15/12/2022	1
PAF	KAKM Information sheet and consent Support person V1	15/12/2022	1

Appendix E - Ethics Amendment for U16-year-old participants

Health and
Disability Ethics
Committees

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011
hdecs@health.govt.nz

Ethics reference: 2023 AM 10635

11 April 2023

Professor Ross Lawrenson

Tēnā koe Professor Lawrenson

APPROVAL OF AMENDMENT

Study title: The determinants of health for Māori mothers and adults with chronic diseases

I am pleased to advise that this amendment was **approved** by the Northern B Health and Disability Ethics Committee (the Committee). This decision was made through the post-approval pathway.

Further information and assistance

Please contact the HDECs Secretariat at hdecs@health.govt.nz or visit our website at www.ethics.health.govt.nz for more information, as well as our General FAQ and Ethics RM manual.

Nāku noa, nā

Ms Kate O'Connor

Chair

Northern B Health and Disability Ethics Committee

Encl: Appendix A: documents submitted

Appendix F – Member Checking Transcript Release Form

Member Checking Release Form

Name: Participant Name:

I. **Group Wānanga 1:**

- I **did not** participate in this session.
- I **did** participate in this session, I have read the transcript, and my korero **does not** require any changes.
- I **did** participate, have read the transcript, and give the research team permission to use my korero **only after the agreed changes** have been made.

Sign: Date:

II. **Interview:**

- I **did not** participate in this session.
- I **did** participate in this session, I have read the transcript, and my korero **does not** require any changes.
- I **did** participate, have read the transcript, and give the research team permission to use my korero **only after the agreed changes** have been made.

Sign: Date:

III. **Group Wānanga 2:**

- I **did not** participate in this session.
- I **did** participate in this session, I have read the transcript, and my korero **does not** require any changes
- I **did** participate, have read the transcript, and give the research team permission to use my korero **only after the agreed changes** have been made.

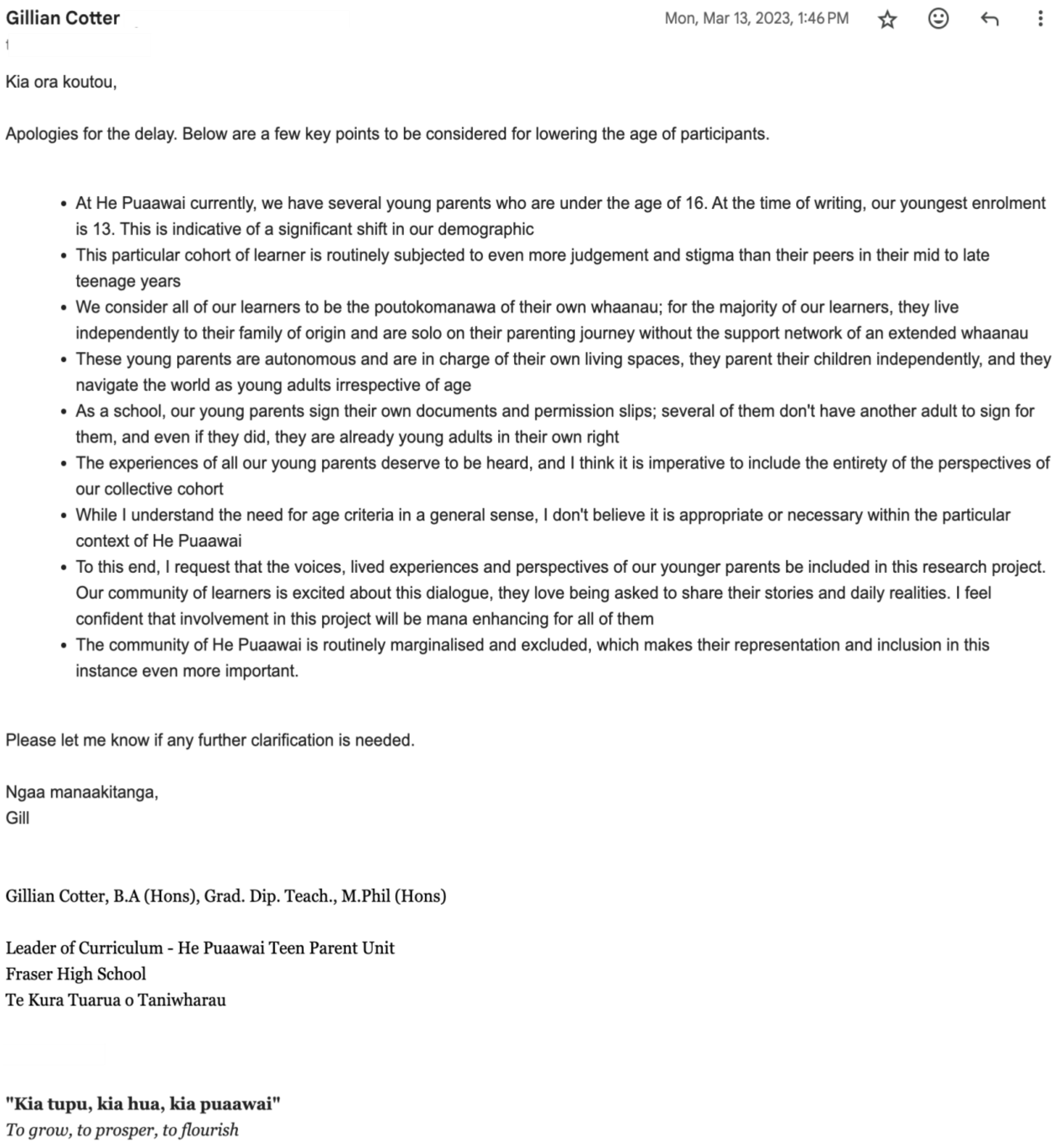
*Sign: *Date:

Researcher:

As acknowledged above, I confirm that I have shared the relevant script(s) with this participant, and where requested, have made all the relevant changes and also provided the participant with an edited copy of those particular transcript(s).

Sign: Date:

Appendix G – Principal Letter of Support



Gillian Cotter

Mon, Mar 13, 2023, 1:46 PM

Kia ora koutou,

Apologies for the delay. Below are a few key points to be considered for lowering the age of participants.

- At He Puaawai currently, we have several young parents who are under the age of 16. At the time of writing, our youngest enrolment is 13. This is indicative of a significant shift in our demographic
- This particular cohort of learner is routinely subjected to even more judgement and stigma than their peers in their mid to late teenage years
- We consider all of our learners to be the poutokomanawa of their own whaanau; for the majority of our learners, they live independently to their family of origin and are solo on their parenting journey without the support network of an extended whaanau
- These young parents are autonomous and are in charge of their own living spaces, they parent their children independently, and they navigate the world as young adults irrespective of age
- As a school, our young parents sign their own documents and permission slips; several of them don't have another adult to sign for them, and even if they did, they are already young adults in their own right
- The experiences of all our young parents deserve to be heard, and I think it is imperative to include the entirety of the perspectives of our collective cohort
- While I understand the need for age criteria in a general sense, I don't believe it is appropriate or necessary within the particular context of He Puaawai
- To this end, I request that the voices, lived experiences and perspectives of our younger parents be included in this research project. Our community of learners is excited about this dialogue, they love being asked to share their stories and daily realities. I feel confident that involvement in this project will be mana enhancing for all of them
- The community of He Puaawai is routinely marginalised and excluded, which makes their representation and inclusion in this instance even more important.

Please let me know if any further clarification is needed.

Ngaa manaakitanga,
Gill

Gillian Cotter, B.A (Hons), Grad. Dip. Teach., M.Phil (Hons)

Leader of Curriculum - He Puaawai Teen Parent Unit
Fraser High School
Te Kura Tuarua o Taniwharau

"Kia tupu, kia hua, kia puaawai"
To grow, to prosper, to flourish

Appendix H – Support Persons Information and Consent Sheet

Participant Information Sheet for Support person

Study title: Karanga Atu, Karanga Mai: Responding to the call of young māmā who want to share their clinical health experiences and to create change.

Ethics No. 21/NTB/148

Project Lead: Dr. Gloria Hinemoa Clarke
Contact details: --------------

Masters Researcher: Mia Kolo
Contact details: --------------------

You have been invited to participate as a support person in an interview to discuss your family member / friend's clinical healthcare experiences as a young mother. This interview is primarily with the participant (your friend or family member) though we recognise that you may also wish to contribute to this kōrero. This information sheet outlines how your comments and contributions might be used and what your rights are with regard to our use of this information.

If you agree to participate, you will be asked to sign a Consent Form (attached). You will keep this Information Sheet and your copy of the Consent Form.

What is the purpose of the study?

Informed by the healthcare experiences shared with Tina Baty in 2022, the aim of this study is to improve the way in which healthcare practitioners service and treat young mothers.

The purpose of the study is for us to learn more about your partner/whānau member/friend's healthcare experiences (positive and negative) in an effort to improve the way in which healthcare practitioners service and treat young mothers. Working with them, we will design guidelines and educational materials that will help healthcare practitioners understand how best to work with young mothers/parents. We want to understand:

- When caring for young māmā and their tamariki what are doctors, nurses, midwives and other healthcare practitioners doing well?
- What are they not doing well?
- What are the messages and lessons you want to get across to improve how health professionals treat and service young māmā and whānau?

What will my participation in the study involve?

In this first part of this study, your partner/whānau member/friend has been invited to participate in a one-off interview where she will be asked to speak about her healthcare experiences as a young mother. If you have been asked to join or to be present as a support person then we welcome your thoughts and contributions.

The interviews are anticipated to take around 1 to 1.5 hours, though you are not required to attend the full interview with the participant. The interviews will be conducted face to face at the He Puaawai Teen Parent Centre at Fraser High School. The interviews will be recorded using a voice recorder, and any comments or contribution you make during the interview will be recorded alongside that of the participant. A full copy of the interview transcript can later be sent to the participant to check for accuracy if requested, and you may request a copy of this also by contacting the researcher. You may add, delete or amend this information if you believe it does not accurately reflect what you were trying to say. All interviews are confidential, anonymous, and we will never report on any personal or identifying information.

If you are present at the interview but do not contribute to the conversation then your presence will not be recorded, other than asking you to verbally consent to maintaining confidentiality of anything discussed in your presence during this interview.

Confidentiality

The information you provide will be only available to members of the research team. The recording, hui notes and any other information that you provide will remain strictly confidential, unless there is an immediate risk of serious harm to yourself or others. All computer records will be password protected. All use of the information collected will be strictly controlled in accordance with the Privacy Act.

The study findings will be published, but there will be no identifying information included. However, we are unable to guarantee complete confidentiality, but we will try our best to do so. The audio recordings will be transcribed. However, we will delete any details in the transcript that might potentially expose the identity of any participants (e.g. names, clinicians, services).

Who has approved the study?

This study has been approved by an independant group of people called the Health and Disability Ethics Committee. They check that studies meet ethical standards. The Northern B Health and Disability Ethics Committee has approved this study.

What are my rights?

If you choose to be present as a support person in this interview, then you may request to see a full copy of the interview transcript. You may also request to have any recorded information from you removed from our study data analysis – though this must be requested within THREE weeks of the interview (or receiving your transcript for review). To withdraw please contact one of the team below.

During an interview, if you wish to stop and/or take a break at any point, please let the researcher know and we will be happy to do so. Please be assured that the information that you or the participant share with us will be kept confidential.

On completion of the study we can provide you with a report to outline the findings of this study. If you would like to receive a copy of this report, please tick the box on the consent form.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, please do not hesitate to contact any of the following members of the research team, who will be happy to talk to you:

Dr. Gloria Clarke
[email removed]
[phone removed]

Dr. Amy Jones
[email removed]
[phone removed]

Gillian Cotter
[email removed]
[phone removed]

Mia Kolo
[email removed]
[phone removed]

Alternatively, you may wish to contact an **Independent Health and Disability Advocate**. This is a free service provided under the Health and Disability Commissioner Act:

Free phone: 0800 555 050

Free fax: 0800 2787 7678 (0800 2 SUPPORT)

Email: advocacy@hdc.org.nz

Website: https://www.advocacy.org.nz/

For Māori health support, please contact:

Te Puna Oranga (Te Whatu Ora Waikato - Māori Health Unit)
Hockin Building, Level 1, Pembroke St, P.O. Box 934, Hamilton.
Ph: (07) 834 3628 Fax: (07) 834 3619.

You can also contact the **Health and Disability Ethics Committee** (HDEC) that approved this study:

Phone: 0800 4 ETHICS. Email: hdecs@moh.govt.nz

Consent Form – Support Person's copy

Please tick to indicate you consent to the following

- ☐ I have read or have had read to me in my first language, and understand the Participant Information Sheet for support person.
- ☐ I have been given enough time to consider whether or not to participate in this study.
- ☐ I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.
- ☐ I understand that my presence at the interview is as a support person for the study participant, and that I may contribute to the recorded conversation if appropriate.
- ☐ I understand that, unless I choose to be identified, my involvement in this study is confidential and that no material that could identify me personally will be used in any publications or presentations.
- ☐ I may request to have my contribution / comments withdrawn from the study within THREE weeks of the interview or reviewing the transcript.
- ☐ I agree to maintain confidentiality of any information discussed in the interview, regardless of whether I participated in the conversation or not.
- ☐ I consent to having the interview recorded and transcribed.
- ☐ I know who to contact if I have any questions about the study in general.
- ☐ I wish to receive a summary of the research results. ☐ Yes ☐ No

Declaration by participant:

- *I have given a verbal explanation of the research project to the support person and have answered any relevant questions.*

Support person's name:

Signature: Date:

Declaration by researcher:

I believe that the support person understands the nature of this study and has given informed consent to be present and/or contribute to the interview.

Researcher's name:

Signature: Date:

Appendix I – Participant Poster Release Form

Participant Material Release Form

Name: **Research ID:**

Please indicate how you would like your resource presented:

Who (indicate number): ____ Doctors ____ Midwives ____Nurses

Size paper: _____ **Suggested locations in practices:** ___________________________

---

1. Print Materials

I give permission for my Poster / Brochure to be used in the:

- ☐ **Summary document for He Puaawai participants**
- ☐ **Educational Reports (Public documents)**
- ☐ **Presentations (e.g. Health Professionals & Funders)**
- ☐ **Academic articles**
- ☐ **Mia's Thesis**
- ☐ **I do not give permission for my print materials to be used for any of these purposes**

---

2. Childs image (if applicable)

I give permission for my mine and/ or my child's image to be used in my poster which I understand will be displayed in:

- ☐ **Summary document for He Puaawai participants**
- ☐ **Educational Reports (Public documents)**
- ☐ **Presentations (e.g. Health Professionals & Funders)**
- ☐ **Academic articles**
- ☐ **Mia's Thesis**
- ☐ **The Childs image section above is not applicable to me and the material I am creating**

---

3. Voice Recording

I give permission for my audio recording and typed copy of that kōrero to be used in the:

- ☐ **Summary document (for He Puaawai participants - typed only)**
- ☐ **Educational Report (Public document - typed only)**
- ☐ **Presentation (Health Professionals & Funders - typed and audio)**
- ☐ **Academic articles (typed only)**
- ☐ **Mia's Thesis (typed only)**
- ☐ **I do not give permission for my recording to be used for any of these purposes.**

---

4. Personal Image

I give permission for my profile photo to be used in the:

- ☐ **Summary document for He Puaawai participants**
- ☐ **Presentations (e.g. Health Professionals & Funders)**
- ☐ **I do not give permission for my personal image to be used for any of these purposes.**

Participant Declaration:

I confirm that the researcher has explained the purposes for using my materials and kōrero, and answered my questions (if any).

*Sign: *Date:

Researchers Declaration:

I confirm that I have explained to this research participant the purposes for using their materials and data and answered their questions (if any).

Sign: Date:

Appendix J – Themes from Participant Analysis

Themes Identified by Participants

When caring for young māmā and their tamariki what are health professionals doing well?

1. Nurses are best
    - Understanding
    - They have more time than doctor
    - Patience
    - Comfort
    - Understanding
    - Time
2. Older nurses tend to be less thorough
3. Midwife's
    - They listen
    - Communication
    - They have more care & concern.
    - They treat me normal
4. Doctors
    - Younger doctors are better
    - more understanding of the situation
5. Older docs
    - Tend to be 'know it alls'
    - Tend to be Grumpier

When caring for young māmā and their tamariki what are health professionals *not* doing well?

6. Rushing
7. Not listening
8. Think 'I can't make decisions because of my age'*
9. They brush us off
    - Say 'it's not a big deal', 'just go home, you'll be fine'
10. Blinded by money
11. Do what/ when is convenient for them

- All leads to mistrust long-term

What are the key messages and lessons/ teachings that you want to get through to these healthcare professionals?

12. Young doesn't mean dumb!*
13. Don't brush us off
14. Stop being judgemental*
15. Treat as nicely
16. Be supportive
17. Treat us equally(like older mothers)
    - Listen & Respect

18. Don’t judge a book by cover it’s cover
19. Don’t Force opinions on to us(eg. breastfeeding)
20. Don’t think we're stupid
21. We're all human
22. Have more understanding
    - Surrounding what's wrong with us (health)
    - Where were coming from

Appendix K – Themes from My Analysis

Themes Identified by Research Assistant (Mia)

When caring for young māmā and their tamariki what are health professionals doing well?

1. Patience
2. Understanding
3. Time
4. *Attention
5. *Care
6. *Communication
7. Advocacy
8. *Younger = more care + attention/ more understanding

When caring for young māmā and their tamariki what are health professionals *not* doing well?

9. **Just do your job
10. *Rush
11. *Dismissal/ Brushing off
12. *Not old enough to make informed decisions
13. Presume
14. *Don't listen
15. *Discriminative
    - Māori
    - Age
16. Opinionated

*Overall leads to mistrust of the health system

What are the key messages and lessons/ teachings that you want to get through to these healthcare professionals?

17. *Don't judge
18. *Give māmā authority, it's her body
19. *Don't discriminate or stereotype
20. Be understanding
21. *Do your job
22. *Age is just a number
23. *Treat us the same (as older māmā)

Demographic

- 36.3% 15 and under
- 60.9% babies born in WKT Hospital
- 23 participants overall
- 63% Māori, 18.2 % Māori & Pasifika, 18.8% Non-Māori
- Most bad things to say linked to Waikato hospital - all ages
- Predominantly good experiences in Birthing Center

Appendix L – Themes from Steering Group Analysis

Themes Identified by Steering Group

Present: Nina Scott, Amy Jones, Tina Baty, Gloria Clarke & Mia Kolo
Absent: **Gillian Cotter & Ross Lawrenson**

When caring for young māmā and their tamariki what are health professionals doing well?

1. *Manaaki
    - Care
    - Respect
    - Protection
    - Welcoming
    - Empathy
    - Patience
2. Communication
    - Wanting to be informed
3. Advocacy
4. Reassurance
    - Knowing rights are being adhered to
5. Understanding
6. Options - autonomy to choose
7. *Listening
8. Engagement
9. Passion
10. Nurses are better
    - younger = more tolerant
    - Studying nurses - younger
    - Patient-provider congruance
11. Environment = birthing centre
12. Wairuatanga
    - The unseen/ hinengaro

Nina - *variability in experience - spectrum of good and bad - most negative end - lack of minimum standards kept

When caring for young māmā and their tamariki what are health professionals *not* doing well?

13. *Do your job
14. Indicated they want to be a priority
15. *Don’t judge
16. Lack of empathy
17. Dismissive
18. *Ageism
19. No confidence

20. Invisibility
21. No trust
22. Racist - undertones
23. Intergenerational trauma
24. *Blame
25. Profiling
26. Indicated they want to be informed - negative options
27. Scare tactics used
28. Breastfeeding approach
29. Projecting personal opinion
30. Uncultured - nonverbal comms
31. *Discrimination
    - Internalised messages
32. Felt they needed to put on persona
    - Dress the part
33. Cultural awareness
34. Objectifying
35. Older Health professionals = tired
36. Different circles of influence

What are the key messages and lessons/ teachings that you want to get through to these healthcare professionals?

37. Stop judging
38. Just do your job
39. We're people too
40. Respect me
41. Give me autonomy
42. I'm a human being too
    - Not invisible
43. You think I'm dumb
44. I'm not dramatic
45. I'm a fresh page
46. Don't assume

Solutions

- Organisational support - values
- Make obvious - Māori friendly training space
- Trauma informed training care for staff
- Breastfeeding project for nurses, midwives & NICU staff
- Co-design project for receptionists

Appendix M – Letter for GP Clinics

Te Huataki Waiora
School of Health
The University of Waikato
Private Bag 3105
Hamilton, New Zealand, 3240
0800 WAIKATO (924 528)
www.waikato.ac.nz

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Tēnā koe, ōtira tēna koutou,

My name is Mia Kolo and I am a Masters student at the University of Waikato in the last trimester of my Masters of Health. My research explores the clinical experiences of young teenage mothers, and is called *Karanga Atu, Karanga Mai: The healthcare experiences of young māmā and their call to healthcare professionals.*

About the study

This qualitative study examines the retrospective experiences of 20 māmā and 2 pāpā aged 14-21 years old and living in Hamilton. The research methods included a short series of wānanga followed by semi-structured interviews. Both the participants and the research steering group conducted (separate) thematic analyses and identified similar themes. The majority of the participants' stories included experiences of unsolicited judgement and advice, and a general lack of communication, respect, and support from doctors, nurses, midwives, and receptionists. A relatively smaller number of positive experiences highlighted the importance of compassion, empathy, support and caring for young māmā regardless of their age.

To create awareness and influence change, the final step in this project was to collaborate with these young mothers to get their key messages out to clinicians and administrators in the form of articles, presentations, and these packages.

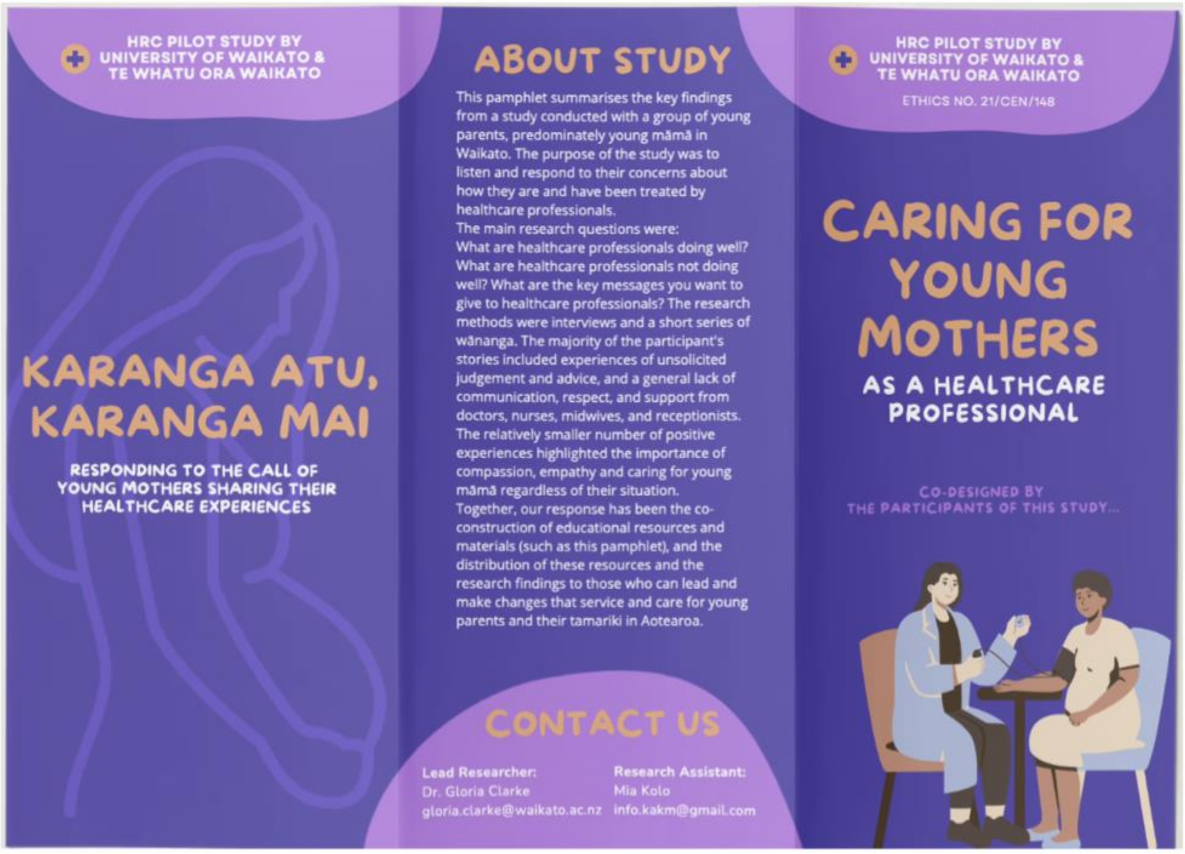
Your practice has been selected at random to receive this information. We invite you to use these materials and to discuss them with the members of your organisation. We acknowledge that this study involves a small cohort and intend to conduct a larger study next year.

If you would like to comment on the research and these research outputs, please feel free to email me.

Ngā manaakitanga,

Mia Kolo

Appendix N – Study Overview Pamphlet



HRC PILOT STUDY BY
UNIVERSITY OF WAIKATO &
TE WHATU ORA WAIKATO

KARANGA ATU, KARANGA MAI

RESPONDING TO THE CALL OF YOUNG MOTHERS SHARING THEIR HEALTHCARE EXPERIENCES

ABOUT STUDY

This pamphlet summarises the key findings from a study conducted with a group of young parents, predominately young māmā in Waikato. The purpose of the study was to listen and respond to their concerns about how they are and have been treated by healthcare professionals.
The main research questions were:
What are healthcare professionals doing well? What are healthcare professionals not doing well? What are the key messages you want to give to healthcare professionals? The research methods were interviews and a short series of wānanga. The majority of the participant's stories included experiences of unsolicited judgement and advice, and a general lack of communication, respect, and support from doctors, nurses, midwives, and receptionists. The relatively smaller number of positive experiences highlighted the importance of compassion, empathy and caring for young māmā regardless of their situation.
Together, our response has been the co-construction of educational resources and materials (such as this pamphlet), and the distribution of these resources and the research findings to those who can lead and make changes that service and care for young parents and their tamariki in Aotearoa.

CONTACT US

Lead Researcher:
Dr. Gloria Clarke
gloria.clarke@waikato.ac.nz

Research Assistant:
Mia Kolo
info.kakm@gmail.com

HRC PILOT STUDY BY
UNIVERSITY OF WAIKATO &
TE WHATU ORA WAIKATO

ETHICS NO. 21/CEN/148

CARING FOR YOUNG MOTHERS

AS A HEALTHCARE PROFESSIONAL

CO-DESIGNED BY
THE PARTICIPANTS OF THIS STUDY...

WHAT WE APPRECIATE

COMMUNICATION

- As a patient communication is key, we like it when healthcare professionals tell us about all options so we can make informed decisions for ourselves and for our pēpi.

MANAAKI

- Being respected, looked after, reassured, and treated like a human being should be the baseline of care given to young mothers. We appreciate being treated like everyone else.

EMPATHY

- Having empathy for our situation makes us feel unjudged. We know that people have different opinions but we appreciate that you are there to care for us regardless of your personal views.

WHAT NEEDS IMPROVEMENT

JUDGEMENT

- Please keep your judgements to yourself. Regardless of our age, our ethnicity, or what we look like we need you to just do your job.

DISMISSIVE

- Please do not dismiss us or tell us we're 'overreacting'. Our concerns and fears are real. We ask questions because we care and want to fully understand what's happening. It is not a sign of ignorance or arrogance.

MISTRUST

- Negative experiences can lead to years of mistrust in the health system and in healthcare professionals. Don't be the reason that we and our children stop seeking and accessing healthcare.

OUR MESSAGES FOR YOU!

(Direct quotes from this study..)

- YOUNG DOESN'T MEAN DUMB
- DON'T JUDGE US
- DON'T FORCE YOUR OPINIONS ON TO US
- JUST DO YOUR JOB
- WE'RE PEOPLE TOO

Te Whatu Ora
Health New Zealand
Waikato

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

GLOSSARY

angiangi	*native moss to Aotearoa-New Zealand – known to be antibacterial, antiviral & antifungal*
aroha ki te tangata	*love/respect for people*
atua	*deity or god(s)*
hapū	*1. sub-tribe 2. pregnant*
Hapū Wānanga	*kaupapa Māori antenatal or birthing class*
hapūtanga	*pregnancy*
harakeke	*native flax plant*
Haumietiketike	*deity god of wild and uncultivated foods*
Hawaiki	*ancient homeland in Māori culture*
He Puaawai	*Teen Parent Centre – Fraser High School*
He Whakaputanga o Te Rangatiratanga o Nu Tireni	*also known as New Zealand Declaration of Independance 1835 or 'He Whakaputanga' for short*
Hineahuone	*the first woman, fashioned form the earth by atua*
Hinenuitepō	*the goddess of death*
Hinetītama	*the daughter of Hine-ahu-one and Tāne - the first human being and keeper of 'te whare tangata' (later turns into Hinenuitepō)*
hōhā	*fed up or increasingly annoyed*
hui	*gathering, meeting, assembly*
i te tīmatanga	*in the beginning (Māori origin story)*
ira wāhine	*feminine essence or bloodline*
iwi	*tribe(s)*
ka whawhai tonu mātou, ake, ake, ake!	*we will fight on, forever, and ever!*
kai	*food*
kairangahau	*researcher(s)*

kaitiaki	*guardian or protector*
kaitiakitanga	*guardianship, protection, care, trusteeship*
kākahu	*clothing, in the early accounts kākahu related to korowai rather than the clothes we wear today*
kākano	*seed(s)*
kanohi kitea	*the seen face, that is present yourself to people face to face*
kanohi-ki-te-kanohi	*face to face*
karakia	*incantation, prayer*
karakia whakakapi	*closing karakia or prayer*
Karanga Atu, Karanga Mai	*'Karanga' means to call. 'mai' and 'atu' when put behind a verb is directional; with mai being towards and atu being away. So, karanga atu, karanga mai is the call out and call back (in reply).*
kaua e takahia te mana o te tāngata	*do not trample over the mana of people*
kaupapa	*topic, plan, purpose, programme, or initiative*
kautā	*cooking place/house*
kawakawa	*native leafy plant often used in rongoā – has heart-shaped leaves*
kete	*basket/bag woven from flax plant*
kia māhaki	*don't flaunt your knowledge*
kia tūpato	*be cautious*
kia ū ki te tika me te pono	*holdfast to what is right and true*
Kiingitanga	*Māori king movement/monarch*
kīwaha	*phrase or idiom*
koha	*gift, offering, or contribution – usually give in reciprocation of anothers contribution*
Kohanga Reo	*Māori language pre-school*
kōrero	*tell, say, speak, read, talk, address*

Kororāreka	*original name for townships commonly known as Russell, Bay of Islands, New Zealand*
koru	*coil but often referred to as the inner section that sprouts from a native fern tree*
kōtiro	*girl*
kuia	*great-grandmother/grandmother or elderly woman*
kūmara	*sweet potato*
Kura Kaupapa / Kura Kaupapa Māori	*Māori language full immersion primary, intermediate and high school*
Kurawaka	*place in which the first woman was created*
Mahuika	*goddess of fire*
māmā	*mother(s)*
mana	*prestige, authority, control, power, status, spiritual power*
mana motuhake	*control over ones destiny, autonomy, self-determination, independence, sovereignty*
mana wāhine(tanga)	*powerful/self-determined woman*
manaaki ki te tāngata	*share and host people, be generous*
manaakitanga	*care, consideration, respect, kindness, support*
Manatū Hauora	*Ministry of Health*
mangopare	*hammerhead shark*
manu	*bird(s)*
marae	*courtyard - open area in front of the wharenui, where formal greetings and discussions take place*
māreikura	*esteemed women, very special, and often matriarchs – in this case I am referring to my kuia, nana, and mother*
mārohirohi	*strength, power, determination*
mātāpono	*values, principles*
mātauranga Māori	*Māori knowledge, traditional creative practice knowledge, usually esoteric*

mauri	*life force or vital essence*
moana	*ocean, sea, waters*
moko / mokopuna	*grandchild(ren)*
ngā kete mātauranga	*baskets of knowledge that were collected from the heavens by Tāne/Tāwhaki to disperse into the world*
Ngā Tamatoa	*Ngā Tamatoa (the warriors) was a Māori activist group that operated throughout the 1970s to promote Māori rights*
Ngā-toki-matawhaorua	*canoe of Ngāpuhi tribe*
Ngāpuhi	*Northland tribe*
noa or whakanoa	*be free from the extensions of tapu, removing tapū*
Oranga Tamariki	*Ministry for Children*
oriori	*special lament or lullaby – usually made for a specific person/baby*
pā	*fortified village where Māori lived*
Pākehā	*non-Māori person/people – originating from a foreign country (e.g. European)*
pāpā	*father(s)*
Papatūānuku (Papa)	*earth mother*
pātaka kai	*raised store house for food*
pēpi	*baby*
pito	*1. belly button 2. umbilical cord*
pou	*pole(s) or post*
pou tokomanawa	*centre pole supporting the ridge pole of a meeting house*
pou-tama-tāne and pou-tama-wāhine	*traditional māori birthing practice where the pou-tama-wāhine is held on to and the pou-tama-tāne is used to lean against during labour*
pounamu	*greenstone – often lashed with rope to form a necklace*
puku	*belly or stomach*

pūrākau	*narrative or story*
rangatira	*chief(s)*
rangatiratanga	*chieftainship, right to exercise authority, chiefly autonomy, chiefly authority, ownership*
Ranginui (Rangi)	*sky father*
Rarohenga	*underworld*
raupatu	*confiscation, take without any right – usually related to land*
rongoā / rongoā Māori	*Māori medicine or natural remedy, traditional treatment*
Rongomatāne (Rongo)	*god of peace and cultivation*
Rūaumoko	*god of earthquakes, volcanoes and seasons*
takutai moana	*coast, foreshore and seabed*
tamariki / tamaiti	*children/child*
tāne	*male*
Tānemahuta (Tāne)	*god of the forest and the creature within*
Tangaroa	*god of the sea and the creatures within*
tāngata whenua	*people of the land*
taonga	*gift or treasure*
taonga pūoro	*Māori carved or fashioned instruments*
taonga tuku iho	*heirloom, something handed down, cultural property, heritage*
tapu	*sacred, prohibited, forbidden, under atua protection*
taumata	*a group or bench of speakers that talk and welcome people onto a marae – it is not common that women sit on taumata but my kuia was special*
Tāwhirimātea (Tāwhiri)	*god of the wind and weather*
Te Aka Whai Ora	*The Māori Health Authority (now disestablished)*
Te Ao Māori	*the Māori* world/worldview

Te Ao Mārama	*world of light*
te ira tangata	*people, the essence of human beings*
Te Kore	*the nothing, realm of potential being, the void (from Māori creation narrative)*
Te Pāti Māori	*The Māori Party (political party)*
Te Petihana o Te Reo Māori	*the Māori language petition*
Te Pō	*darkness, numerous stages of night (from Māori creation narrative)*
Te Reo Māori	*the Māori language*
Te Tai Tokerau	*Northland region in New Zealand*
Te Tiriti o Waitangi	*The Treaty of Waitangi (Māori original, not the 'Treaty of Waitangi')*
Te Wehenga	*the separation (Rangi and Papa)*
Te Whānau Marama	*the family of light (Māori creative narrative)*
te whare tangata	*the womb, house of humanity*
Te Whare Tapa Whā	*theory about the four components of health and wellbeing–spiritual, family, physical, and mental*
Te Whatu Ora	*Health New Zealand*
tīhei mauri ora	*breath of life, common phrase that refers to the Māori creation narrative*
tino rangatiratanga	*self-determination, sovereignty*
tītiro, whakarongo…kōrero	*look, listen…speak*
tohi	*ritual ceremony for a child, to bestow upon them different traits and skills for their future*
toki	*adze*
tuākana	*usually elder sibling but in this sense refers to leader*
Tūmatauenga (Tū)	*god of war*
tupuna	*ancestors*

ukaipō	*source of sustenance*
wāhine	*female(s)*
waiata	*song(s)*
Waikato	*upper midland region of the North Island in New Zealand*
wairua	*spirit*
waka	*canoe(s)*
wānanga	*thought space, gathering or meeting*
whakapapa	*genealogy*
whakataukī	*Proverb and sayings that often stem from auspicious events or chiefs/prominent people*
whānau	*1. family 2. birth/to be born*
Whānau Āwhina	*Plunket*
whanaungatanga	*connection or reciprocal relationships*
whakawhanaungatanga	*method of making connections, and relationship building*
whare kōhanga	*house for giving birth and/or raising children*
whare mate	*house of the sick or dying*
whare tū taua	*house of traditional battle practices/weaponry*
whare wānanga	*house of learning/knowledge*
whenua	*1. land 2. placenta*