

Te Hā o Whānau: A culturally responsive framework of maternity care

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ABSTRACT

AIM: A nuanced healthcare framework, Te Hā o Whānau, aims to make the maternal-infant healthcare system more accessible and culturally responsive for Māori following unexpected events that led to the harm or loss of their baby.

METHOD: Te Hā o Whānau was developed from three components. Firstly, it was grounded and informed by Kaupapa Māori qualitative research involving whānau who had experienced the harm or loss of their baby. These learnings were then combined with mātauranga Māori (Māori knowledge) and built on three articles of Te Tiriti o Waitangi: Kāwanatanga, Rangatiratanga and Ōritetanga.

RESULTS: Te Hā o Whānau has been developed to specifically guide the maternal-infant healthcare system in providing culturally responsive practice points and guidelines. These practice points and guidelines align with three tikanga Māori (customs): Tikanga manaakitanga, Tikanga rangatiratanga and Tikanga whakawhanaunga.

CONCLUSION: To address the stark health inequities present, we must forge innovative models and strategies, rather than reproducing (less successful) paths that have the less resistance. Te Hā o Whānau is provided with the aim of providing better outcomes for all, not just Māori.

The maternal-infant healthcare system is failing Māori, evident in the maternal and infant health inequities between Māori and non-Māori.¹ It is an unwelcome truth that for Māori, (Indigenous people of Aotearoa New Zealand), “too many die young, suffer avoidable illnesses and injuries and live in unnecessarily difficult circumstances”.² Māori wāhine (women) and their babies face higher rates of morbidity and mortality than non-Māori.³ In addition to death, Māori babies are more likely to be born preterm (born before 37 weeks gestation),⁴⁻⁵ which is associated with poor health, often requiring intensive medical care at a neonatal intensive care unit (NICU) or special care baby unit (SCBU). The higher rates of morbidity and mortality can be attributed to health inequities faced by Māori wāhine and their babies. For example, it has been found that Māori women often receive suboptimal clinical care during preterm labour.³ These health inequities are a breach of Te Tiriti o Waitangi, the founding document of Aotearoa New Zealand, and a representation of how the maternal-infant

healthcare system is failing Māori. This paper purposefully refers to Te Tiriti rather than the Treaty of Waitangi, as both are different documents that carry different meanings, with the latter privileging the alleged cession of Māori sovereignty to the Crown.⁶⁻⁷ The Crown has held fast to the notion that the Treaty of Waitangi is a treaty of cession to legitimise its rule and governance. Many Māori believe that they are not bound by the Treaty of Waitangi, as there are inaccurate interpretations, and are instead committed to uphold what responsibilities their ancestors signed to in Te Tiriti o Waitangi.⁷

In conjunction with Te Tiriti o Waitangi, recent qualitative research by the authors involving 10 whānau following the harm or loss of their baby informs this paper. This research found that when these whānau entered the maternal-infant healthcare system under unexpected circumstances, the system failed at delivering culturally responsive care.¹ A systemic failure considered in need of immediate remediation.

Aim

Responding to this systemic failure, the authors aim to develop a healthcare framework to guide the maternal-infant healthcare sector in providing culturally responsive care for Māori whānau who have experienced the harm or loss of their baby.

Methods

Te Hā o Whānau, a framework of healthcare, has been developed from the convergence of three components. Firstly, it was grounded and informed by a Kaupapa Māori qualitative research involving whānau who had experienced the harm or loss of their baby. Kaupapa Māori research is decolonising because it rejects dominant notions of knowledge held by those in colonial power that dehumanises Māori, and is instead about representing the lived realities of whānau, within the context of a structural analysis of the systems that prevent whānau achieving wellbeing.⁸ This contrasts with deficit-based research where Māori are seen as a problem in need of ‘fixing’.⁹ Secondly, the learnings from the lived realities of whānau were combined with mātauranga Māori (Māori knowledge). Thirdly, to give Te Hā o Whānau further legitimacy, it was built upon three articles of Te Tiriti o Waitangi: Kāwanatanga, Rangati-ratanga and Ōritetanga.

Article 1, kāwanatanga, outlines the right for the Crown to govern, therefore having the right to make laws and practices that are beneficial and fair for all.¹³ When signing to this agreement, Māori expected good governance and the provision of policies and services that contribute to the health and wellbeing of all in Aotearoa New Zealand. It has been recognised that Māori did not cede sovereignty to the Crown.^{3,6} This means that in return of consenting the Queen kāwanatanga in Article 1, Article 3 promises Ōritetanga, the Queen’s protection of all Māori and ensure their equal rights as English.^{7,13} Article 3 addresses issues of equity and equality; it is a responsibility of the Crown to actively protect and reduce inequities between Māori and Pākehā (non-Māori).¹³ However, Ōritetanga has not been upheld as there are stark inequities present between Māori and Pākehā, particularly within the maternal-infant health space.

Appropriate tikanga Māori (customs) practice points and examples are offered as guidelines for stakeholders within the maternal-infant healthcare that align with what is promised in these three articles. The practice points and examples are strengths-based to ensure culturally responsive care is delivered to whānau following the harm or loss of their baby. The naming of Te Hā o Whānau was deliberate, whereby Te hā means the breath, to which was taken to mean the voice, and o whānau carries the meanings of both family and maternity. Thus, Te Hā o Whānau, means whānau voices leading maternity care in Aotearoa New Zealand.

Data collection

Qualitative whānau interviews were conducted with 10 wāhine (women) and between one and eight members of their whānau. Whānau were asked to share their stories in a manner that best suited them, with this inquiry resulting in a rich collection of whānau lived realities following the harm or loss of their baby. Each interview was transcribed and analysed through interpretative phenomenological analysis (IPA). IPA is particularly suited to this type of analysis because it involves the interpretation of participants’ narratives in which participants have been allowed to speak freely, tell and reflect and express any ideas or concerns.^{10–11} IPA allowed the researchers to look deeply into those narratives and analyse the meanings whānau ascribed to their experiences. Data analysis began with the reading and re-reading of the transcribed interviews, making notes and logging significant aspects throughout to examine the meanings whānau ascribed to their experiences. Commonalities and differences across whānau were then organised. The themes that emerged from this approach were shared back with whānau to help ensure validity and the responsiveness of the analysis to their experiences. All whānau endorsed what was found in the analysis. The themes then informed the practice points and examples within Te Hā o Whānau framework.

Mātauranga Māori data was sourced through a consultation journey that involved having kōrero (discussions) with kaumātua (elders), Māori health experts, Māori researchers and reviewing available

literature.¹² Data for Te Tiriti o Waitangi was sourced from available literature.^{6,13}

Results

This section will share the resultant framework that emerged from the convergence of the three data sources. The framework has been designed this way to provide equity for Māori health outcomes and Māori participation in the design and delivery of maternal-infant healthcare in Aotearoa New Zealand. Corresponding tikanga have been suggested as practice points and examples within each component of the framework: Tikanga manaakitanga, Tikanga rangatiratanga, Tikanga whakawhanaunga.

Tikanga manaakitanga

Manaakitanga is a tikanga that may align with Article 1, kāwanatanga. In the healthcare context, acting with manaakitanga will ensure environments where cultural practices and values are respected to have a contributory role in the health and wellbeing of whānau. Manaakitanga involves acting in a manner that uplifts the mana (prestige) of others (and in doing so, uplifting your own mana). It involves the act of sharing and caring and exercising governance concurrently.¹⁴ The shared experiences of the 10 whānau commonly cited an absence of manaakitanga, whereby

healthcare practitioners showed a lack of concern for their cultural practices and beliefs. For example, *“it would have been nice if I could have done karakia and karanga when my baby was birthed”*.¹ Consequently, the mana and wairua (spiritual wellbeing) of the wāhine and their whānau were diminished because they were denied the opportunity, and right, to be and openly thrive as Māori. Another expression of poor manaakitanga was the absence of offered support or kindness—*“we didn’t even get offered the motel support until the very end”*; *“by the time I left there I wanted to burn the place down...yeah it was not good how I was treated”*.¹

Positive reports were expressed when the wāhine felt the healthcare practitioners respected their cultural values and practices. Examples of this occurring was when they felt genuinely respected, when whānau were offered back their whenua (placenta) to practice whenua ki te whenua tikanga (placenta to earth); and were offered food and empathy. Having access to their whānau support and/or support from social service practitioners was also positively reflected on. As one participant shares, *“[husband] was allowed to stay with this baby and it just makes the experience for us so much more tolerable...”*.¹ Therefore, the provision of good healthcare was affiliated with a mana enriching environment.

Table 1: Tikanga manaakitanga–practice points and examples.

Practice points	Practice examples
Demonstrate value for ‘patients’	<ul style="list-style-type: none"> • Provide healthcare from a position of humility and demonstrate empathy.
Provide an environment that respects, encourages and facilitates Māori cultural values and practices	<ul style="list-style-type: none"> • Observe appropriate tikanga (for example, karakia (prayer), waiata (song) and karanga (welcoming call). • Understand the kaupapa behind Māori values and practices so these can be encouraged and pursued. • Provide access to kaumātua if requested.
Govern the environment whereby support—both from whānau and social support services—are standardised.	<ul style="list-style-type: none"> • Review the two-visitor rule during adverse events to lift restrictions about whānau visiting. • Enable the transfer of whānau as support. • Provide more community outreach services to deliver healthcare services to whānau.

Table 2: Tikanga tino rangatiratanga—practice points and examples.

Practice points	Practice examples
Recognise and alleviate the epistemic injustice within the maternal-infant healthcare system	<ul style="list-style-type: none"> Respect and be open to other bodies of knowledge and ways of doing. Becoming health literate by engaging in meaningful communication that is comprehensible and allows participation by all.
Value the whānau voice and participation	<ul style="list-style-type: none"> Provide whānau the opportunity to share their knowledge, concerns and ideas. Encourage choice when possible to facilitate the co-construction of care with whānau.
Increase the Māori healthcare workforce	<ul style="list-style-type: none"> Review education and training to disrupt barriers that restrict Māori participation. Indigenise the education curriculum so healthcare practitioners are more aware of hauora Māori. Encourage Māori inclusion in governance roles. Make it policy to have more meaningful consultation with Māori during healthcare policy development.

Tikanga rangatiratanga

The experiences of the 10 whānau participants highlighted the absence of the right for whānau to participate in the decision making of the healthcare of their baby. As a result of entering the maternal-infant healthcare system, mothers lost their rangatiratanga to care for their baby that they deemed appropriate; fathers lost their rangatiratanga of being loving and supportive partners; and wāhine were encouraged to follow hospital understandings of maternities and infant cares. In this context, those enforcing the healthcare policies and procedures hold the power. This was noted by the participants, and many reflected on how they often felt powerless in comparison to the healthcare practitioners. For example, *“it was pretty trying times, everything is so clinical and every eight hours you have a different nurse telling you what to do...we didn’t feel like parents until we got home”*.¹ This reflects the frustration these parents felt by being told what to do, when to do, without having the opportunity to have any participation in decisions.

Article 2 is not being recognised and upheld as Māori continue to be without their tino rangatiratanga and are made to interact with and within systems that are derivative of Eurocentric worldviews. To overcome this, Māori should be free to express their

right to rangatiratanga over their health and wellbeing. Revitalising the Māori voice and increasing the Māori healthcare workforce may lead to greater Māori participation in the healthcare context.

Tikanga whakawhanaungatanga

Collaboration between Māori and non-Māori people and practices can contribute towards equity as communities, whānau, sectors and agencies can have a better chance of working together to reach equitable health outcomes. The qualitative research found that the current maternal-infant healthcare system presents few opportunities for whānau to have any collaboration with stakeholders in the maternal-infant healthcare system.¹ Collaboration can be aligned with the tikanga Māori whakawhanaungatanga (development of meaningful relationships).

The 10 whānau were provided minimal opportunities to establish whanaungatanga (meaningful relationships) with those caring for them and their baby. When whakawhanaungatanga is avoided, Māori tend to feel unconnected to the place and people within that place. Instead of being made to feel welcome, whānau reported feeling isolated and alienated. For example, *“they would just come into our room and not introduce themselves then leave again”*.¹ Even if introductions were made, their

Table 3: Tikanga whakawhanaunga—practice points and examples.

Practice points	Practice examples
Alleviate power imbalances	<ul style="list-style-type: none"> • Be whānau-centred. Shape services based on the needs of the whānau. • Improve inter-professional relations and communications to work as one perinatal team, rather than separate midwifery, obstetrics and neonatal teams.
Engage in meaningful relationship building with whānau	<ul style="list-style-type: none"> • Take the time to build rapport. • Introduce yourself and your role.
Change the environment from being task-focused to being whānau-focused	<ul style="list-style-type: none"> • Greet and/or converse in te reo Māori if that is the preferred language of whānau. • Care for visiting whānau and make them feel welcome. • Encourage and facilitate whānau having a role in the recovery of health and wellbeing of their loved one(s). <p>Add cultural needs to the standardised care guidelines.</p>

efforts were rushed and the practitioners did not take the time to allow the whānau to introduce themselves. This caused confusion for whānau because they often did not know who was leading the care for their baby, and often received inconsistent communication and treatment plans from different health practitioners.¹ This increased their anxiety about the wellbeing of their baby. The maternal-infant healthcare system can become a culturally responsive collaborative partner by actively engaging in whakawhanaungatanga (the act of building relationships) to establish whanaungatanga with both people and space.¹ One participant stated that *“it would have been nice to have more space for my whānau who had travelled down to visit me and baby”*.¹ This would have provided a welcoming space for that participant. Ensuring a welcoming space that is accommodating for whānau will help remove feelings of alienation and isolation in the maternal-infant healthcare system because places have a healing role too.¹⁵ The core of whakawhanaungatanga is about interdependence, not independence, to develop whanaungatanga. Within this interdependent relationship are defined roles for all participants.

Discussion

Although there are numerous healthcare models in Aotearoa New Zealand, Te Hā o Whānau is a nuanced framework that specifically focuses on providing practice

points and examples that could enable the maternal-infant healthcare system delivering culturally responsive care for whānau under unanticipated and unexpected circumstances. The practice points and examples have been designed directly from the whānau experiences within the qualitative research and are appropriate for all stakeholders within the maternal-infant healthcare system. These practice points can be transformative practice. The framework aligns with te ao Māori (Māori worldview) and Te Tiriti o Waitangi, a dual alignment that should be made customary within the healthcare sector.

Today, the maternal-infant healthcare system continues to be designed and delivered through mainstream, monocultural and biomedical processes that tend to be inflexible for accommodating te ao Māori.^{1,16} In 1988, Puao-te-ata-tu clearly stated that national structures have been developed from values, systems and views of the majority culture only. Participation of the minority cultures is conditional on them subjugating their own values and systems to the power system.¹⁷ Today this has not changed, as the recent WAI2575 report deemed the primary healthcare system has failed, and is failing, to achieve Māori health equity as the mainstream design and delivery of services are flawed. Policies and legislations that underpin the system do not allow for Māori having the freedom to exercise rangatiratanga.¹⁸ Through imposing

policies that govern the healthcare system with tikanga Māori, it is envisaged that better outcomes will eventuate for all, not just Māori. We are more likely to achieve better health outcomes by building new pathways that include mātauranga Māori while also enabling the creation of new, appropriate knowledge and practices¹⁹ to align Māori and Pākehā worldviews.

Implementing Te Hā o Whānau within this particular context has the potential to contribute towards informing the maternal-infant healthcare system becoming a culturally responsive partner for Māori. It can be implemented and trialled within district health boards and evaluate its success in building culturally responsive and better wellbeing outcomes. To resolve poor health and restore balance (health equity) within Aotearoa New Zealand, policymakers must have the courage to make innovative change and resist settling for the status quo, or worse, reverberating back to paths that have already attempted and failed to bring about change.²⁰ If Te Hā o Whānau is evaluated as a success, then options for national rollout could be explored. It is said that it takes a kāinga (village) to raise a child. Abiding by that philosophy, this framework requires the commitment of all stakeholders (maternity healthcare practitioners, neonatal healthcare practitioners, district health boards and the Ministry of Health) to ensure

the application, growth and success of this potentially beneficial healthcare framework.

Conclusion

To address the stark health inequities present, we must forge innovative models and strategies, rather than reproducing (less successful) paths that have the less resistance. There is a need to indigenise, if not decolonise²¹ the maternal-infant healthcare system to make it a compatible, culturally responsive partner for whānau. Te Hā o Whānau framework is an attempt to meet this need. It is a fundamental right, as guaranteed to Māori under Te Tiriti o Waitangi, to have access to culturally responsive healthcare. It is also the Crown's responsibility, under Te Tiriti, to provide quality healthcare and ensure that all organisations involved in the health sector is committed to doing so. It is a further responsibility of the Crown to ensure equitable health outcomes for Māori are achieved, and that the Treaty and Te Tiriti are visible, understood and complied with by all stakeholders in the healthcare system.¹⁸ As Paul Whitinui claimed in 2011, "closing the gap between Māori and non-Māori will not be achieved if as a nation we continue to create health models, frameworks, programmes, initiatives and interventions that are mere reflections of mainstream health processes".²⁰

Competing interests:

Nil.

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www.nzma.org.nz/journal-articles/te-ha-o-whanau-a-culturally-responsive-framework-of-maternity-care

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