

**IN THE CONTEXT OF MIDWIFERY PRACTICE:  
RECOGNITION AND MANAGEMENT OF MENTAL HEALTH**

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**TE RAU MATATINI**  
AOTEAROA MĀORI MENTAL HEALTH WORKFORCE DEVELOPMENT

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## Foreword

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This report, the second for Te Rau Whakawhānui: Māori Primary Mental Health Care Workforce Development project, builds on the strengths of previous workforce reports produced by Te Rau Matatini. An important aspect in the development of this report is that it has for the first time, provided a unique forum for sector leadership and advocacy for Māori mental health needs within the primary health sector.

The current phase of Te Rau Whakawhānui has helped identify ways that midwives, in particular, can further their collaboration with primary mental health services and other primary health care providers to better meet the needs of Māori women who experience mental illness. It also outlines strategies for Māori midwives to build their capacity to work within the Māori mental health context of primary maternity service provision.

These strategies align with the National Māori Health Strategy, *He Korowai Oranga*, the *Primary Health Care Strategy* and Pathway Five: Primary Care in Mental Health of *Kia Puāwai Te Ararau*, the National Māori Mental Health Workforce Development Strategic Plan.

To be able to achieve these strategic goals, health services must continue to develop a workforce that is culturally *and* clinically competent. This report supports these strategies and outlines further strategies that will enable Māori midwives to make important contributions to improving the health and wellbeing of whānau, hapū and iwi. Midwives, through other national initiatives, have demonstrated a commitment to work with primary health care organisations to further develop these strategies and are to be commended on these contributions.

Maureen Holdaway PhD.

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For a comprehensive evaluation process and report, we thank Moko Business Associates, their report has strengthened the Māori Primary Mental Health Care Te Rau Whakawhānui Project.

In addition, Te Rau Matatini would like to acknowledge the generous cooperation of the following organisations in releasing and supporting staff to participate in the pilot programme and reference group: Waitemata Health DHB, Counties Manukau DHB, and Hawkes Bay DHB Wairoa Health Centre. NGO organisations: Te Hā o Te Oranga o Ngāti Whatua, Tāmaki Makarau Trust, Papakura Marae, Tūruki Health Care, Raukura Hauora o Tainui, Korowai Aroha, Tipu Ora Trust, Immunization Advisory Centre Rotorua, Te Runanga o Raukawa, Kahungunu Health Choices, and self-employed independent midwives in the three pilot areas.

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## 1. Introduction

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At present in Aotearoa only one person in three receives appropriate mental health treatment (Ministry of Health, 2004a). Overseas research has found that 50% of serious cases of mental disorders in developed countries and 85% of serious cases in less-developed countries are untreated (World Health Organisation World Mental Health Survey Consortium, 2004b). This is in light of research that mental illness has been found to have a greater effect on role functioning than many serious chronic physical illnesses (ibid).

Recent health reforms, including the establishment of Primary Health Organisations (PHOs), have strengthened the opportunity for health providers to better integrate mental health services in primary health provision. This provides an opportunity for primary health care practitioners such as midwives, tamariki ora–well child nurses and community health workers to have an increasingly important role in the recognition and delivery of mental health care, and therefore to develop innovative ways to fulfil this role.

Primary health services provided by Māori are developing throughout New Zealand and are a key point of referral to secondary mental health services (Holdaway, 2003). It is important that these primary health services employ skilled and experienced staff, including registered nurses/midwives and community health workers who are able to assess, screen, detect and refer people who have mental health problems or disorders. Early recognition of mental health need and greater management of mental health support through primary health care will help further facilitate early intervention, and reduce distress, disability and burden of illness, and also has the potential to increase the effectiveness and efficiency of secondary mental health services for all populations (Te Rau Matatini, 2004)<sup>1</sup>. For both primary and secondary health services to be effective, stronger links with specialist mental health services are needed to strengthen effective care that is responsive to people with moderate to severe mental

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<sup>1</sup>. Kia Puāwai Te Ararau: Draft National Māori Mental Health Workforce Strategic Plan developed by Te Rau Matatini.

health need (Holdaway, 2003; Ministry of Health, 2004a).

### **1.1. Māori Women and Maternal Mental Health**

Childbirth is a significant life event when considering the extraordinary physiological, psychological and sociological changes that occur throughout pregnancy and following birth. The preparation for, and overall adjustment and recovery from birth, is both complex and closely related to the overall health status of the individual.

Webster, Thompson, Mitchell and Werry (1994) found that postnatal depression (PND) is more likely to occur in women who are single, less than 20 years old at the birth of their first child, are unhappy with their relationship with their partner, have had a previous history of psychiatric hospitalisation, and are Māori.

Māori women therefore are at higher risk of developing postnatal depression because they are likely to have factors that predispose them to developing mental illness (Webster et al., 1994). Midwives have more contact with Māori women throughout pregnancy and up to 4 - 6 weeks postpartum, than any other health professional group (Ministry of Health, 2003). Midwives can therefore play an important role in identifying postnatal depression and referring Māori women to mental health services.

Although this report, the second in a series of three<sup>2</sup>, focuses specifically on Māori midwives, the importance of effective relationships and networking with tamariki ora-well child nurses and support workers is acknowledged as seminal to the ongoing care and support provided to Māori mothers and whānau in the community. This report also highlights the need to increase the capacity of midwives to provide early recognition and intervention in mental illness during the course of their routine care of pregnant or postpartum women. In addition, Māori midwives have expressed specific needs to increase their own capacity to work from Māori health perspectives with

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<sup>2</sup> The first report, *Mental Health In Primary Health Care* (Holdaway, 2003) contains a full background to Te Rau Whakawhānui: Māori Primary Mental Health Care project; the importance of primary care in mental health; and presents the initial findings from the training needs assessment. The third report, *Mental Health in Emergency Departments* will be available in the next Te Rau Matatini publication series.

Māori women who have mental health needs (Moko Business Associates, 2004). Understanding features of types of mental illness including postnatal depression, and being informed of referral processes to mental health services enables midwives to initiate appropriate support and treatment for women at risk at the earliest possible time.

## **1.2. Te Rau Matatini**

Te Rau Matatini is a national Māori mental health workforce development programme. Established in December 2001, and officially launched in March 2002, Te Rau Matatini is one of a number of initiatives funded by the Ministry of Health as expressed in *Tuutahitia te wero: Meeting the Challenges, Mental Health Workforce Development Plan 2000—2005* (Health Funding Authority, 2000). Te Rau Matatini was established to ensure that Māori mental health consumers, tangata whaiora and whānau have access to a well-prepared and well-qualified Māori mental health workforce. Te Rau Matatini aims to increase the size, clinical and cultural expertise of Māori working in mental health and related sectors, and to contribute to improved services for tangata whaiora and whānau. These aims are being achieved through a number of projects facilitated by Te Rau Matatini.

## **1.3. Te Rau Whakawhānui: Māori Primary Mental Health Care Workforce Development**

Te Rau Whakawhānui is one of 14 projects managed by Te Rau Matatini<sup>3</sup>. The overall purpose of the Māori primary mental health care project is to increase the capacity of Māori primary health workers to provide early recognition and intervention in mental illnesses. Underlying the project are twin concerns about late interventions for Māori, and the ability of mental health services to treat only a fraction of people who have mental health problems or disorders. Two series of pilot training have been delivered, targeting primary mental health care support workers in three NGO services based in Ngāti Raukawa ki te Tonga and Auckland<sup>4</sup>; and Māori midwives and tamariki ora-well child nurses and support workers in Manawatū,

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<sup>3</sup> More information about other Te Rau Matatini projects can be found at [www.matatini.co.nz](http://www.matatini.co.nz)

<sup>4</sup> Holdaway. (2003) *Mental Health in Primary Health Care*. Te Rau Matatini Māori Mental Health Workforce Publication Series TRM/03/05. Palmerston North, New Zealand.

Rotorua and Auckland<sup>5</sup>. The pilot training presents a dual competency approach within a kaupapa Māori framework building on Māori models of health/practice and their application to clinically based scopes of practice.

#### **1.4. Te Rau Whakawhānui Stage II: Māori Primary Mental Health Midwifery and Whānau /Tamariki Ora-Well Child Pilot**

The key objectives of Te Rau Whakawhānui Stage II were to:

- increase the capacity of Māori midwives and whānau/tamariki ora-well child nurses/workers to identify and recognise mental illness present in Māori women in primary care settings
- increase the capacity for timely and appropriate consultation or liaison, and or referral to specialist mental health services
- establish a national training standard in relation to mental health as a baseline for future professional development of Māori midwives and whānau/tamariki ora-well child services
- identify and clarify key areas of need for future development of mental health expertise among Māori midwives and whānau/tamariki ora-well child services and,
- enable recommendations to be made for future mental health training and education in the primary health care sector.

Mental illnesses such as anxiety disorders, and antenatal and postpartum depression comprise a group of disabling conditions where the presentation of which can be assumed normal; such conditions can escape the notice of primary health professionals. Early recognition of mental health disorders and being informed of referral processes to mental health clinical and support services, enable midwives and whānau/tamariki ora-well child nurses and support workers to initiate appropriate support and treatment for women at risk. This will reduce distress, disability and the burden of illness, and has the potential to reduce the need for secondary mental health services (Holdaway, 2003).

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<sup>5</sup> Moko Business Associates. 2004), *Evaluation of Te Rau Whakawhānui Stage II Midwifery and Early Childhood Māori Mental Health Training Pilot*. Prepared for Te Rau Matatini Māori Mental Health Workforce Development, Palmerston North New Zealand.

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## 2. Demographics of Māori Women and Hapūtanga<sup>6</sup>

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Māori women are more likely to be younger than women in other ethnic groups when they have their first baby. They are also more likely to be single, living in rural/urban areas, smokers and on a low income. These have been common features of childbearing Māori women for the past 20 years (Ministry of Health, 2001b, 2003, 2004; Pomare & de Boer, 1988).

From 1999 to 2002 the most common age for Māori women to have children was 20–24 years of age, which has been fairly constant over 20 years (Ministry of Health 2001b, 2003, 2004; Pomare & de Boer, 1988). The average age of all women across New Zealand was between 27 and 29 years.

Of all births to teenage mothers (under 20 years of age) during the last 4 years (from 1999 to 2002) approximately 44% were to Māori women (Ministry of Health, 2003, 2004). Māori have consistently had a higher proportion of teenage births. Despite the fact that births amongst younger women overall have decreased. Moreover, the reducing rate for teenage women has been attributed to an increasing rate of termination of pregnancy rather than a declining fertility rate (Ministry of Health, 2004).

Between 1988 and 2000 the termination rate among 15 to 19 year olds increased by about 62%, and the rate among 20 to 24 year olds increased by about 66% over the same period. *The termination rate is slightly higher among Māori teenagers, although they are less likely to choose to have a termination* (Ministry of Health, 2002b). It is not common for midwives to be directly involved in termination of pregnancy. However, midwives may be the first health professional pregnant women see and, as such, they can refer women to appropriate agencies. In addition, grief associated with elective termination of an uncomplicated pregnancy is seen to be problematic (Bewley, 1993). In view of the frequency with which termination of pregnancy is

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<sup>6</sup> A period of time that includes associated antenatal and postnatal conditions/actions.

occurring in teenagers and the likely grief to be associated with this, the short-term and long-term impacts on their mental health deserve more attention.

Teenagers are likely to be young enough not to have encountered loss before, and without adequate support and counselling before and after a termination of pregnancy, may have unresolved psychological and emotional issues that resurface during subsequent pregnancies or childbirth. These factors have relevance for maternity service providers.

## **2.1 Regional Birth Comparisons**

Forty percent of Māori women who gave birth in 2000 and 2001 lived in the Auckland/Waikato area. From 1999 to 2002 the highest birth rates for women of reproductive age (between 15 and 44 years) were for women living in the Tairāwhiti District Health Board (DHB)<sup>7</sup> and Counties/Manukau DHB regions (Ministry of Health, 2001b; 2003; 2004). Significant numbers of Māori women utilise maternity facilities in both these DHBs (Ministry of Health, 2003, 2004).

Of all women of childbearing age (15–44 years) during 1999, 79% lived in an urban area and 21% lived in a rural area, compared with 69% of women who lived in an urban area and 31% who lived in a rural area from 2000 to 2002 (Ministry of Health, 2001b, 2003, 2004).

Based on deprivation scores from 1999 to 2002, women who lived in the most deprived areas of the country had higher birth rates, and this was across all ethnicities, although the figures for Māori and Pacific women were comparatively higher than for other women (Ministry of Health, 2001b, 2003, 2004b). New Zealand deprivation scores have been generated from the 1996 Census data as an attempt to measure health needs calculated as a function of nine socioeconomic variables. The variables include communication, income, home ownership, employment and support, which are shown to be associated with mortality and morbidity (Ministry of Health, 2001b, 2003, 2004b).

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<sup>7</sup> Twenty-one District Health Boards (DHBs) in New Zealand have existed since January 1, 2001. The DHBs are responsible for providing government-funded health care services for the population of a specific geographical area.

## **2.2. Hospital Births**

From 1999 to 2002 more than 90% of babies born in New Zealand were born in a hospital. Māori women had more than 19% of all births in those years. Māori and Pacific women are also the most likely to have a normal vaginal birth and less likely to have an operative vaginal delivery such as ventouse extraction and forceps delivery. Māori women had the lowest caesarean section rate from 2000 to 2002 and they are also less likely to have an induction and an epidural compared with women of other ethnic groups (Ministry of Health, 2001b, 2003, 2004b).

The overall caesarean section rate in New Zealand has increased from 11% of all births in 1988 to 22% in 2002 (Ministry of Health, 2004). This follows international trends of increased use of obstetric interventions, and there is evidence that intervention rates rise in secondary care environments (Enkin, Keirse, Renfrew & Neilson, 1996; Ministry of Health 2004b; Sutton, McLauchlan & Virtue, 2002). In 1985, the World Health Organisation recommended through a consensus statement, that there are no additional health benefits associated with a caesarean section rate above 10–15%. Whilst there is no agreement in New Zealand as to what our rate should be to maximise health outcomes, there is a consensus that research is needed to understand the reasons for the growing rate of caesareans (Ministry of Health, 2004b).

## **2.3. Perinatal Morbidity/Mortality**

Māori women have one of the highest recorded rates of lung cancer in the world (Cancer Society of New Zealand, 2003), and a high percentage of Māori women smoke during pregnancy. Socio-economically deprived women are also more likely to continue to smoke beyond the first trimester of pregnancy (McLeod, Pullon & Cookson, 2003). These factors have been associated with sudden infant death syndrome or SIDS.

SIDS was the main cause of death for Māori infants from 1987 to 1991. The Māori perinatal death rate, which includes stillbirths and early neonatal deaths (within 7 days from birth), decreased from 1980 to 1984 and remained lower or similar to the non-Māori rate up to 1991 (Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, 1995). Perinatal causes of death amongst Māori babies reduced by one third and these

included respiratory conditions of the newborn, low birth weight conditions and congenital anomalies present at birth. Low birth weight has been identified as one of the contributory factors in SIDS and it is likely that a number of Māori infants of low birth weight can be attributed to smoking during pregnancy (Pomare & de Boer, 1988).

Perinatal mortality for all births<sup>8</sup> has continued to fall up to 2001 with an equally relative decrease for Māori. The main cause of perinatal mortality during 2002 was related to prematurity (birth before 37 weeks gestation) (Ministry of Health, 2004b). Although the perinatal death rate for Māori decreased further in 2002, Māori and Pacific babies are more likely than other babies to die within 7 days of birth (Ministry of Health, 2004b).

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### **3. Relevance of Childbirth Experience to Mental Health and Early Intervention**

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Mental health is a public health issue. Postnatal depression (PND) affects 10–15% of mothers and there is considerable evidence that PND can become chronic, damages the relationship between women and their partners, and has adverse effects on the emotional and cognitive development of the child (Cox & Murray, 1993; Murray et al., 1999). Antenatal depression is also emerging as an important issue. Factors that can contribute to antenatal depression include moderate–severe premenstrual tension before pregnancy, relationship difficulties, poor social support, and previous child loss such as stillbirth, abortion, sudden infant death or adoption. These factors can also feature in the onset of postnatal depression (Mental Health Foundation, 2003).

Post-traumatic stress disorder (PTSD) is a response to a traumatic event and it can happen to anyone, even with no predisposing mental health problems. It has a psychiatric diagnosis, and its cause can be environmental. As such, childbirth can be a traumatic event for some women (Compton, 2002; White, 2004).

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<sup>8</sup> Recent data are based on the new definition of perinatal mortality changed under the Births, Deaths and Marriages Act 1995 where the definition of ‘stillborn child’ (fetal death) was changed.

Postnatal depression, however, is distinctive from other serious depressive disorders because it is related to having a baby and can be debilitating if not detected and treated effectively. Furthermore, for women with existing mental health support needs, for example, schizophrenia, anxiety or mood disorders, pregnancy and childbirth pose greater concern about their risk of relapse and their ability to care for their baby (Oates, 1995a, 1995b).

The most severe form of PND and PTSD can occur in the first 3 months following birth, although they both can have delayed onset. The risk of women being referred to a psychiatrist in the year following pregnancy and childbirth is five times greater than at other times in their lives (Oates, 1994). Mortality and morbidity outcomes of pregnancy will contribute to mental health issues, and here there is added potential for psychological, emotional and financial stress from illness, hospitalisation or death.

A survey of the views of 2909 women who gave birth in New Zealand during February and March 2002 showed Māori and Pacific women were receiving less postnatal visits than they were entitled to. The same survey showed that women aged between 15 and 19 years were less likely than older woman to have been satisfied with maternity services (Ministry of Health, 2002c). One example is that 63% of 15–19 year olds either agreed or strongly agreed they were involved in decisions that were made about their labour care. This is compared to 79% of 20–24 year olds and 91% of women over 40 years (Ministry of Health, 2002c). Whilst the reasons for these factors need further consideration and exploration, both issues pose a number of questions concerning the quality of care that is being given and the ability of maternity providers to effectively screen for mental illness those women who are neither happy with the services, nor receiving an adequate number of postnatal visits.

Identifying mental health need throughout the childbearing experience and timely referral to mental health services can help women get the necessary support and treatment they need, as early as possible. It is therefore important for midwives and other maternity service providers to have a sound knowledge of mental illnesses and screening tools to understand mental health recovery and referral processes, and to meet the needs of pregnant women.

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#### **4. Lead Maternity Carer and Midwives**

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Under the Maternity Services Notice<sup>9</sup> a woman chooses a Lead Maternity Carer (LMC) to take responsibility for the primary care provided to her throughout her pregnancy and postpartum period, including the management of labour and birth. The purpose of this Notice is to introduce nationally consistent terms and conditions for primary maternity care.

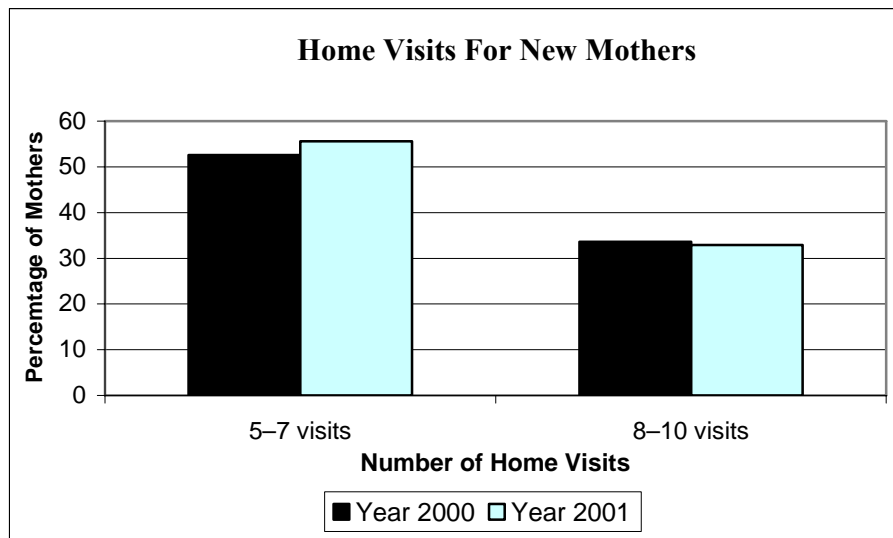
The LMC model is shown to be beneficial to women as by having continuity of a carer they are likely to be more satisfied and experience fewer interventions (Enkin, 1996). The LMC may be a general practitioner with a diploma in obstetrics, a midwife, or an obstetrician (Ministry of Health, 2002a). All visits and decisions should be negotiated and planned between the woman and her LMC according to her individual needs.

LMCs are required to provide services following birth for both the mother and the baby where a payment for this service is claimed. These visits are to assess and care for mother and baby in a maternity facility and at home until 4–6 weeks after the birth. This includes a total of between 5 and 10 home visits by a midwife, and more if clinically indicated (Ministry of Health, 2002a). As outlined in graph 1, in 2000 52.6% of women received 5–7 home visits and 33.6% received 8–10 visits. In 2001 55.6% of women got 5–7 home visits and 32.9% received 8–10 visits (Ministry of Health, 2003).

The 2002 survey of women indicates that a higher percentage of Pacific and Māori women received less than the minimum of five postnatal home midwifery visits compared with other ethnic groups, and Māori women were less likely to receive more than ten postnatal home visits (Ministry of Health, 2002c).

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<sup>9</sup> Pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000 which replaces earlier payment arrangements and sets out the terms and conditions for the provision of maternity services.



*Graph 1. Home Visits by LMCs*

As a result of changes to the 1990 Amendment to the Nurses Act 1977, midwives are able to care for women on their own responsibility without medical supervision. Following this amendment and subsequent changes to the Maternity Payment Schedule, some midwives became self-employed and began visiting women in their homes. Midwives may also have sub-contractual arrangements with general practitioners or obstetricians to provide primary care. They are also employed by District Health Boards within a primary, secondary or tertiary environment.

Māori women use primary maternity services more than any other group of women, but they also use secondary services equally as much. In 2001 and 2002 midwives were the Lead Maternity Carer for 73% and 72% respectively of all pregnant women and in the same years 80% and 81% of Māori women had a midwife for their LMC, more than any other group of women (Ministry of Health 2003, 2004b). This followed similar trends in 2000 and 1999 (Ministry of Health, 2001b, 2003). This means that midwives are well positioned to identify women at risk of mental illness during the course of their routine care.

#### **4.1. Midwifery Workforce**

In 2003, there were 3528 nurses who held midwifery qualifications and met the criteria of an active nurse or midwife. Included in these 3528 were 187 midwives who gained their midwifery qualification from a direct-entry course that has been available

in New Zealand since 1995 (New Zealand Health Information Service (NZHIS, 2003). The majority of midwives are in clinical practice, either self-employed or employed by a core hospital facility. Of those, 64% of midwives are aged between 30 and 54 years of age; 15% are over 54 years; and 8% are under 25 years of age. The average age of a midwife in 2002 was 44.8 years compared with 42.6 years in 1998 (Nursing Council of New Zealand, 2002b; NZHIS, 2003).

Based on 36,514 active nurses working in nursing and midwifery in 2003, 7.6% self identified as New Zealand Māori, 6.5% identified as other, and 9.4% did not report their ethnicity. Some nurses and midwives have dual registration and nurses need not be working as a midwife to be included in the number of midwives. The NZHIS collects this workforce information from a questionnaire that accompanies the Annual Practising Certificate application form sent by the Nursing Council of New Zealand (NCNZ) each year to nurses and midwives on the register or roll of nurses. Nurses are classified as midwives because of their qualification, they are recorded on the Register of Nurses as having a nursing qualification and as having undertaken further education to gain a midwifery qualification or they are graduates of a direct-entry midwifery programme.

#### **4.2. Regulation of Midwifery Practice**

Until September of 2004 the NCNZ was the statutory body that governs the practice of nurses and midwives, and sets standards in the interests of these professions and in the interests of public safety. The Midwifery Council of New Zealand (MCNZ) was appointed to take over the regulation of midwives under the Health Practitioners Competence Assurance (HPCA) Act 2003. This new legislation replaces 11 statutes and covers all health professionals. The principle purpose of the HPCA Act is:

*to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions (New Zealand Government, 2003, p. 7).*

Regulatory authorities are required to define the scope of practice for their specific discipline and in some professions such as medicine and nursing there are a number of scopes of practice to cover the range of specialities or practitioners that exist within

each discipline. For example, the scope of practice of a midwife provides a broad statement of the boundaries of what a New Zealand midwife can do on her own professional responsibility, and each midwife needs to demonstrate competence to practice against a set of competencies set out by the Midwifery Council (Midwifery Council of New Zealand, 2004a, 2004b). Each authority has its own criteria and process for assessing that practitioners are competent to practise, and these criteria are required to include cultural competence.

### **4.3 International Relationships**

The NZCOM was formed in 1989 in response to the needs of midwives, and during an environment of increased lobbying by women, to bring about legislative changes relating to maternity service provision. NZCOM is neither, a union or an employer organisation, and since its formation it has developed the *Midwives Handbook for Practice* (NZCOM, 1993, 2002), which describes a philosophy of Midwifery, and includes a Code of Ethics and Standards for Midwifery Practice. NZCOM includes consumer and Māori representation at its governance level, and is one of 85 member groups of the International Confederation of Midwives (ICM).

One of the goals of ICM is to improve women's health globally, it supports and advises midwifery organisations in liaison with governments, and it represents midwifery at international bodies and agencies such as the World Health Organisation. ICM is a platform for indigenous midwives to gain insight and understanding about indigenous issues that are or are not common, and ICM representation or delegation is one way the profession can support the development of Māori midwives to contribute to indigenous issues at an international level. The NZCOM also represented New Zealand on the United Nations Royal Commission (Bangkok) and the World Alliance for Breastfeeding Action in Malaysia (NZCOM, 2004).

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## **5. Collaboration between Maternity Services (including Midwives) and Other Health Professionals/Agencies**

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Primary maternity services are provided up to the first 6 weeks following the birth of a baby, and women and their babies are likely to continue contact with other health agencies. The process of transition from the maternity sector to follow-up by relevant community primary health providers is a further critical step to ensure continued and ongoing screening for mental illness. Two examples are tamariki ora – well child providers<sup>10</sup> and general practitioners. Both groups are likely to be involved in the 6-weeks-old assessment of the baby (Ministry of Health, 2002d) and the 6-week immunisation programme under the National Immunisation Schedule (Ministry of Health, 2002e). In the first instance this is generally initiated, by receipt of discharge notifications from LMCs as part of the LMCs contractual responsibilities under the Maternity Services Notice (Ministry of Health, 2002a).

Family Start, Parents-as-First-Teachers and support carers with iwi health providers may also be further links. Participation in education and training workshops, that assist health professionals and other support workers to identify mental illness and understand referral processes, enhances the capacity of the primary health sector. Collaborative links between key primary health services are a key factor toward improving maternal and newborn health (World Health Organisation, 2004). If there is to be meaningful collaboration within and across services, training programme need to incorporate cultural and clinical skills as well as opportunities to build relationships. For an integrated and interdisciplinary education and training approach to achieve optimum benefit for all, course training materials need to be tailored and relevant to each participating discipline to maximize learning outcomes and enhance the integrated and collaborative practice approach (Moko Business Associates, 2004).

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<sup>10</sup> A free service that provides health education, health promotion, clinical assessment and support for babies and whānau according to the Well Child–Tamariki Ora National Schedule.

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## 6. Increasing the Capacity of Māori Midwives

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Māori are under-represented in the midwifery workforce in the same way they are under-represented in other disciplines of health, holding back both Māori provider development and improvements in mainstream delivery to Māori (Durie, 2003). Anecdotal information suggests there are about 120 Māori midwives currently practising, and whilst it is not presumed that all Māori women will choose a Māori midwife for their care, or that a Māori midwife will meet the needs of all Māori women, Māori midwives provide an option for Māori women to receive pre- and post-pregnancy care from a midwife who operates from a similar health perspective to their own and/or is aware of issues specific to Māori women. This choice is not currently widely available.

Health outcomes are enhanced when services are delivered in ways that meet the cultural needs of Māori as culture influences how behaviours and symptoms are perceived, and responded to by both whānau and health workers (Durie, 1998; Ihimaera, Maxwell-Crawford & Tassell, 2004). Furthermore, international and national research has concluded that when there is a match between health consumers and workers, clinical outcomes are strengthened (Gurung & Mehta, 2001; Huriwai, Sellman, Sullivan, & Potiki, 1998). Effective health service provision therefore needs to be based on dual competency, as good outcomes depend not only on the use of evidence-based clinical interventions but also on the cultural context within which the interventions are delivered (Maxwell-Crawford, Hirini, & Durie, 2003). This is aligned with the Māori Health Strategy, *He Korowai Oranga*, which states the health and disability support sector must, “take account of the need for cultural as well as clinical safety” (Ministry of Health, 2002f, p. 22). To be able to achieve this goal, health services must continue to develop a workforce that is culturally *and* clinically competent.

Increasing the number of Māori midwives will not ensure effective dual competency-based responsive health services to pregnant women. Training that enhances and

reinforces the attainment of dual competency and learning opportunities to prepare and equip Māori midwives to work effectively in Māori communities is also needed.

Durie (2003) describes two challenges that face Māori health professionals. First, they need to be able to relate to the worlds in which Māori women live and second, their midwifery practice should align to wider Māori development aspirations. Māori midwives are required to live in two worlds since most Māori women spend their everyday lives on the border between the Māori world and a set of norms constructed by a wider society. Given this reality and the growing expectation of Māori communities for a clinically and culturally competent Māori health workforce (Health Workforce Advisory Committee, 2002), if Māori midwives are unfamiliar with either world they will find it difficult to understand the reality of Māori women (Durie, 2003) and to reconcile the dual expectations and service needs.

From a 'traditional' Māori perspective of childbirth, the origins of life are represented and immortalised in a variety of Māori contexts such as tikanga (etiquette), whakairo (forms of Māori art) and marae relationships. All things are personified and given significance and birth is a metaphor for creation of the universe. This underlying belief and value is a common theme amongst indigenous peoples across the world. Each baby is special and each birth warrants noting, as is done through whakapapa (genealogy). Oral traditions such as whaikōrero (oratory) and waiata (music) are important mediums for transmitting whakapapa. Oriori (a form of music) is specific to birth stories, and a collection of some of these has been captured by Apirana Ngata and Pei Te Hurinui (1970).

This underlying epistemology underpins Māori models of health (Durie, 1998) that have been used to help the wider health sector understand the holistic health needs of Māori communities. In addition, the models have been useful for Māori health professionals who may not have been exposed to traditional forums, to help them understand the diversity of Māori.

Many Māori graduates of midwifery will have experienced the same lack of access to the Māori world as the women they work with (Durie, 2003; Tupara, 2001). The unique preparation needs of Māori midwives to access quality education and training

that recognises and reflects te ao Māori and are inclusive of Māori realities are not fully and universally appreciated or understood by tertiary education programmes. Comparative gaps between the health and education sectors are also evident for Pacific students training to become nurses in New Zealand (Southwick, 2001) and for Māori students studying in a wide range of health and mental health disciplines (Levy, 2002; Ihimaera et al., 2004).

Five undergraduate midwifery programmes in New Zealand are run across six campuses: Auckland University of Technology (AUT), Waikato Institute of Technology (WINTEC), Christchurch Polytechnic Institute of Technology and Otago Polytechnic, and Massey University which provides two campuses, one in Palmerston North and one in Wellington. These programmes have approximately 100 graduates a year (Nursing Council of New Zealand, 2002b) and anecdotal information suggests the attrition rates for Māori students are higher than for other groups, although this requires further exploration.

### **6.1 Importance of Cultural Identity**

The development of a positive cultural identity is necessary for optimal mental health growth (Commission on Human Rights, 2004; United Nations General Assembly, 1948; Ministry of Health, 2002f, 2002g; Durie, 1997). The longitudinal study of Māori whānau, Te Hoe Nuku Roa, indicates a secure and positive cultural identity appears to offer Māori some protection against ill health, and is also more likely to be associated with educational and employment participation. The measure of cultural identity based on the level of participation in Māori networks and the degree of cultural competence, suggests only about one-third of Māori household residents have a secure identity (Te Hoe Nuku Roa, 1998) and that many Māori do not currently have a secure cultural identity or access to Māori resources (such as language, land or customary knowledge) despite a strong sense of being Māori.

### **6.2 Kawa Whakaruruhau**

Cultural safety guidelines were developed for implementation into nursing and midwifery education in 1991. In that same year The Nursing Council of New Zealand commissioned the late Dr Irihapeti Ramsden to write the guidelines to address the issues related to the transfer of power from service providers to consumers (Nursing

Council of New Zealand, 1996). These guidelines are applicable to all health professions and have since been developed to emphasise the existence of ‘difference’ between individuals and the tensions and power this creates between health professionals and those receiving health services (Nursing Council of New Zealand, 2002a). While the profession requires midwives to be ‘culturally safe’, only one culture has the power to determine what ‘safety’ means. This systemic oppression leaves Māori especially vulnerable because their own values become compromised (Southwick, 2001).

*Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual* (New Zealand College of Midwives, 2002, p. 41).

Midwifery needs to support the development of education and training programmes that are specifically pedagogically designed to meet the needs of Māori midwives whilst also ensuring graduates are competent midwives so they can be effective in working in Māori communities (Southwick, 2001; Durie, 2003). Training and education programmes such as the Te Rau Whakawhānui pilots, can progress this type of development in a possible partnership approach in the design, delivery and promotion of such programmes between midwifery and Māori mental health.

### **6.3 Māori Midwives Initiatives**

The government’s Māori Health Strategy aims to assist Māori health objectives whereby whānau and hapū can participate in improving maternity outcomes (Ministry of Health, 2002f). Kahungunu Health ‘Choices’ is an Iwi Health Provider that employs and offers professional development support for Māori midwives. Links with Māori providers often occur in an ad hoc fashion without professional support. The inability of midwives to become involved with whānau and hapū is partially reflective of the Māori capacity in the midwifery profession. ‘Choices’ currently has outreach clinics based in significant areas of high Māori population<sup>11</sup> to provide timely and efficient access for Māori women. Outreach clinics enable Māori midwives to network and link effectively with hapū, iwi and community Māori providers. Māori

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<sup>11</sup> Kahungunu Health ‘Choices’ has clinics based in Hastings, Flaxmere, and Waipukurau, with one pending in Napier (personal communication, April 2004).

midwives can make important contributions to improving the health of whānau and hapū and some of them have developed professional networks, an advantage that comes from already developed personal networks with hapū. However, this is not universal for all Māori midwives, and support for their needs is not met by current generic professional forums.

Sufficient Māori midwives are needed to provide support, peer review, sustained action, political clout and the development of guidelines and standards appropriate to Māori communities (Durie, 2003). These are partially being achieved through the development of support groups such as Ngā Maia o Aotearoa me Te Waipounamu and Māori Midwives Collective. The former was established in 1994 at a Waikato hui and its intent is to represent the interests of Māori midwives, Māori student midwives and birthing whānau, which includes reclaiming traditional birth knowledge and practices (Ngā Māia o Aotearoa me Te Waipounamu, 2004). Both Ngā Māia and Māori Midwives Collective continue to articulate their partnership with the midwives' professional body, the New Zealand College of Midwives (New Zealand College of Midwives, 2003).

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## **7. Primary Care Initiatives by Midwives**

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Midwives have made unique contributions to improving maternity services for women and assisting primary health care gains (Ministry of Health, 2001c). Two initiatives include:

- Partners In Change Education, and
- Workshops Proactively Addressing Family Violence.

Partners in Change Education is a Ministry of Health funded joint venture recognising the threat to pregnancy of smoking. The New Zealand College of Midwives (NZCOM), Midwifery and Maternity Provider Organisation (MMPO) and Education for Change (EFC) are joint partners in this initiative and, since 2001, over 50 workshops have been held throughout New Zealand, involving more than 900 midwives providing education, and addressing smoking in pregnancy in their delivery of routine pregnancy care to mothers and their families.

Domestic violence is a major social problem, and male assaults of partners comprise 85%–98% of domestic violence-related arrests. It is estimated that as much as 10% of family violence incidents are committed against pregnant women (Eddy, 2004). The NZCOM and the National Collective of Independent Women’s Refuges have been developing a relationship for the mutual objective of improving the response to, and support for, pregnant women who experience family violence. The NZCOM has been contracted by the Ministry of Health to provide education workshops for midwives to proactively address family violence (Eddy, 2004; Lake, 2004).

These two examples of ‘partnership’ initiatives demonstrate the commitment by midwives to work with primary health organisations. These initiatives provide a model for a national approach to mental health early intervention and early recognition education. Education and training programmes like these can enhance midwives’ understanding of their role in their own scope of practice as a midwives, highlight the importance of relationships with practitioners in specialist areas such as mental health, and provide strategies and tools that can be easily incorporated into day-to-day clinical practice. In addition, emphasis is placed on the contribution and value that each midwife makes to the overall primary health strategy.

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## **8. Te Rau Whakawhānui Midwifery Early Childhood Pilot Training Programme—a Primary Mental Health Care Initiative**

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The provision of timely and effective primary mental health care depends on the development of integrated systems of care with closer links between mental health and primary health care services (Te Rau Matatini, 2004). *Kia Puāwai Te Ararau* recognises the link between primary and secondary care as seminal to delivering effective mental health services, and defines integration as having two meanings. First it refers to ‘seamlessness’ and continuity of care. Second, it refers to the acquisition of mental health knowledge and skills by primary health care workers so that mental health intervention can be delivered effectively within primary health care settings (Te Rau Matatini, 2004).

This section provides an overview and summary of the pilot programme key survey and training needs assessment findings from the pilot sites<sup>12</sup>. The major conclusions were drawn from the results of both the immediate post-training feedback distributed by Te Rau Matatini at the end of each training and the postal evaluation/telephone follow-up survey conducted externally by Moko Business Associates. The information in the evaluation report was based on written and oral feedback from the child and maternal health workforce who participated in the training pilot.

### **8.1 Target Audience**

Training was delivered to Māori primary health care professionals and community support workers at three demonstration sites – Auckland, Feilding, and Rotorua. The target audience was Māori midwives, registered nurses and community workers in maternal and whānau/tamariki/mokopuna ora health, employed by either a NGO or DHB. The DHBs involved in the pilot were Waitemata Health, Counties Manukau, and Hawke’s Bay DHB Wairoa Health Centre. The NGO organisations were Te Hā o Te Oranga o Ngāti Whatua, Tāmaki Makarau Trust, Papakura Marae, Tūruki Health Care, Raukura Hauora o Tainui, Korowai Aroha, Tipu Ora Trust, Immunization Advisory Centre Rotorua, Te Runanga o Raukawa, Kahungunu Health Choices, and self-employed Independent Midwives in the three pilot areas (Moko Business Associates, 2004).

### **8.2 Gender**

A total of 28 (77.8%) participants out of 36 responded (NB: % rounded to the nearest whole number). All the respondents were female.

### **8.3 Primary Health Care Workplace Roles**

Nurses comprised the highest number of respondents (15 respondents or 53.6%) participating in the training. This category included Midwives, Whānau/Tamariki Ora nurses, registered nurses and staff nurses. The second highest number of respondents was community health workers.

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<sup>12</sup> The information for this section is taken from the Te Rau Whakawhānui Stage II Māori Primary Mental Health Care Evaluation Report undertaken by Moko Business Associates in August 2004.

#### **8.4 Primary Health Care Career Duration**

Just over 46% of the respondents had been in the workforce for 3–5 years and more; 21.4% of the respondents had been in the workforce for 1–3 years; while almost 11% of the respondents had been in the workforce for less than a year.

#### **8.5 Key Findings in Relation to Professional Development and Achievement of Project Objectives and Learning Outcomes<sup>13</sup>**

From both the qualitative and quantitative information contained in the data sets it was evident that the training achieved the project objectives. This was supported by the following evaluation findings:

- almost 82% of the respondents were able to identify and recognize mental illness present in Māori women in their workplace as an outcome of the training
- 85% of the respondents were able to apply timely and appropriate referral processes in relation to Māori mental health in their respective workplace settings as a result of the training
- feedback on the module content, planning, presentation style, knowledge, process and application of learning not only indicates a significantly high level of satisfaction from the respondents but also serves to establish a national training standard as a baseline for future professional development of Māori midwives and whānau/tamariki ora – well child services, and
- analysis of the feedback from respondents assisted in identifying key areas of need for future development of mental health expertise among Māori midwives and whānau/tamariki ora-well child services, which enabled the development of recommendations to be made for future primary care training (Moko Business Associates, 2004).

#### **8.6 Achievement of Learning Objectives**

The key finding of the evaluation is that the training achieved the learning objectives. This is supported by the following:

- over 82% of the respondents said they had gained a better understanding of Māori mental health concepts from both a personal and practice perspective

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<sup>13</sup> See page 7 of Te Rau Whakawhānui Stage II Māori Primary Mental Health Care Evaluation Report (Moko Business Associates, 2004).

- almost 86% of the respondents said they had gained a better understanding of appropriate mental health detection and referral processes for Māori mental health
- 79% of the respondents said they had gained a better understanding of the role of the worker within a Māori mental health team
- 89% of the respondents said they had gained a better understanding of working with whānau and tangata whaiora in the recovery process, and
- 89% of the respondents said they had gained a better understanding of supervision processes for safety and practice issues (Moko Business Associates, 2004).

However, feedback from respondents, in particular from midwives, indicated they felt the legislation pertaining to mental health was discussed in a context beyond the work and scope in which a midwife would work in most instances.

### **8.7 Learning Outcomes Achieved<sup>14</sup>**

- 86% of respondents said the training enhanced their existing skills and expertise in both the cultural and clinical aspects of Māori mental health
- 78% said they were better able to integrate both the cultural and clinical aspects of Māori mental health services into their daily practice, and
- 71% said the training had enhanced their ability to work with whānau and tangata whaiora in the recovery process (Moko Business Associates, 2004).

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## **9. Conclusion**

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Based on the literature and the pilot studies evaluation, a key indicator of an effective midwifery service relates to the ability of a woman to choose an appropriate service, to have access to those services, and to receive timely and appropriate primary and/or secondary support and/or treatment when it is needed by her and her baby. This is imperative if Māori women's maternal health needs are to be holistically met.

Te Rau Whakawhānui midwifery pilot training and its independent evaluation report support development of a national mental health training programme for midwives.

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<sup>14</sup> See page 8 of Te Rau Whakawhānui Stage II Māori Primary Mental Health Care Evaluation Report (Moko Business Associates, 2004).

As demonstrated in the evaluation findings, the pilot training provided Māori midwife participants with current evidence about mental health, understanding of cultural and clinical issues that impact on a woman and her family, and the need to develop and implement timely, consistent and effective referral processes to mental health services for women experiencing mental illness.

The link between primary and secondary care is of key importance in delivering early intervention mental health services to Māori women and their whānau. For maternal health services to be more effective, a proactive approach requires the establishment and maintenance of stronger links to secondary services. This will ensure opportunities to share appropriate training that promotes dual cultural and clinical competency as well as the acquisition of early intervention mental health knowledge and skills to deliver safe and effective pre-natal and post-natal care to Māori women with mental health needs.

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## **10. Concluding Points<sup>15</sup>**

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Strategies to increase and develop the Māori midwifery workforce to support Māori women and their whānau through timely and effective access to mental health services require a collaborative and integrative approach on a national level. Essentially this collaborative approach would take place between a midwifery professional body and a Māori mental health workforce development unit on a national level.

The ‘Partners in Change education’ or ‘Family Violence workshops’<sup>16</sup> are training models that could be adapted for a mental health context. This report therefore supports an integrated and collaborative approach and development of national partnerships to extend future education and training opportunities for Māori midwives.

Benefits of such a partnership will:

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<sup>15</sup> The majority of these recommendations are related to the findings of the Te Rau Whakawhānui Stage II Māori Primary Mental Health Care Evaluation Report (Moko Business Associates, 2004).

<sup>16</sup> See pages 22 & 23 of this report.

- provide confidence that the programme aligns with the midwifery scope of practice
- further assist in establishing an appropriate balance between midwifery perspectives and mental health perspectives within the programme structure
- ensure Māori aspirations for enhanced cultural competency through the integration of Māori models of health and the kaupapa Māori approach throughout all training programmes
- support midwives to apply the learning appropriately within the scope of their practice and to take on board the integrated and collaborative approach
- provide specific training opportunities for rural/urban health practitioners including midwives, to help primary health practitioners be more effective in both identifying mental illness and understanding referral processes to mental health services, and
- identify and include maternal health providers who have relevant experience with mental health issues and/or services as guest speakers in further education programs to help clarify concerns regarding the scope of professional practice.

Furthermore, health education and training initiatives need to include other health professionals who provide follow-up for women beyond 6 weeks to ensure there are opportunities for early detection of mental illness beyond the care of an LMC. This includes the transition phase from LMC to other health agencies, as well as opportunities for ongoing screening beyond the first year following the birth of a baby.

Additional research/evidence-based activities to investigate the extension of an integrative and collaborative approach with other professional organisations such as Plunket and Tamariki Ora-well-Child will assist in:

- promoting an education and training course structure that makes explicit the link between Mental Health processes to maternal health such as Midwifery and Tamariki Ora-Well Child services, including 6 weeks post delivery, and the importance of implementing an integrated and collaborative approach to workplace practice, and

- achieving optimum benefit for all trainees through course training materials that are tailored and relevant to each participating discipline to maximize learning outcomes and enhance the integrated and collaborative practice approach.

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## References

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- Bewley, C. (1993). The midwife's role in pregnancy termination. *Nursing Standard* 8(12):25-28. In Fraser, D.M., & Cooper, M.A. (Eds) (2003). *Myles Textbook for midwives*. London, Churchill Livingstone:
- Cancer Society of New Zealand Inc. (2003) July. *Health effects of smoking*. Retrieved 27/6/04: <http://www.ash.org.nz>
- Compton, J. (2002). Post-traumatic stress disorder and childbirth. *New Zealand College of Midwives Journal*, 26: 17–19.
- Commission on Human Rights (2004). *Draft Declaration on the Rights of Indigenous Peoples*. Report of the working group on indigenous populations on its eleventh session. Retrieved 30/8/04: <http://www.usask.ca/nativelaw/ddir.html>
- Cox, J.L., Holden, J.M. , Sagovsky, R. (1987). Edinburgh postnatal depression scale. *British Journal of Psychiatry* 150.
- Cox, J.L., Murray.L (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry* 163: 27–31.
- Durie, M. H. (1997). *Māori cultural identity and its implications for mental health services*. Department of Māori Studies, Palmerston North: Massey University.
- Durie, M.H. (1998). *Whaiora: Māori health development* (2<sup>nd</sup> ed.). Auckland, New Zealand: Oxford University Press.
- Durie, M.H. (2001). *Mauri Ora: The dynamics of Māori health*. Auckland, New Zealand: Oxford University Press.
- Durie, M. H. (2003). *Ngā Kāhui Pou launching Māori futures*. Huia Publishers: Wellington, New Zealand.
- Eddy, A. (2004). Midwives' role in responding to family violence. In *Midwifery News*. New Zealand College of Midwives, March, pp 13.
- Enkin, M., Keirse, M.J.N.C., Renfrew, M. & Neilson, J. (1996). *A Guide to Effective Care in Pregnancy & Childbirth*. Oxford: Oxford University Press (2<sup>nd</sup> ed.)
- Gurung, R.A.R., & Mehta, V. (2001). Relating ethnic identity, acculturation, and attitudes toward treating minority clients. *Cultural Diversity and Ethnic Minority Psychology*, 7 (2), 139–151.

- Health Funding Authority. (2000). *Tuutahitia te wero: Meeting the challenges. Mental Health Workforce Development Plan 2000 – 2005*. Christchurch, New Zealand: Health Funding Authority.
- Health Workforce Advisory Committee. (2002). *The New Zealand health workforce framing future directions discussion document*. Wellington, New Zealand: Health Workforce Advisory Committee.
- Holdaway, M. (2003). *Mental health in primary health care*. Te Rau Matatini Māori Mental Health Workforce Publication Series TRM/03/05. Palmerston North New Zealand: Te Rau Matatini.
- Hodnett, E.D. (2004). Continuity of caregivers for care during Pregnancy and Childbirth. *Cochrane Review*. 2, 25/6/04.
- Huriwai, T., Sellman, J. D., Sullivan, P., & Potiki, T. (1998). A clinical sample of Māori being treated for alcohol and drug problems in New Zealand. *The New Zealand Medical Journal*, 111 (1065), 145–147.
- Ihimaera, L.V., Maxwell-Crawford, K.M., & Tassell, N. A. (2004). *He Waka Ārahi: Training workplace nexus framework. The interface between Māori mental health training and education workforce development*. Palmerston North: Te Rau Matatini.
- Lake, J. (2004). Domestic violence – cost and consequences. *Midwifery News*, March, p. 12.
- Levy, M. (2002). *Barriers and incentives to Māori participation in the profession of psychology*. A report for the New Zealand Psychologists Board. Hamilton: Waikato University.
- Maxwell-Crawford, K.M., Hirini, P.R., & Durie, M.H. (2003) *Te Rau Matatini Projects*. Palmerston North: Te Rau Matatini.
- McLeod, D., Pullon, S. & Cookson, T. (2003). Factors that influence changes in smoking behaviour during pregnancy. *The New Zealand Medical Journal*. May 2, Vol 116, No 1173. [URL:http://www.nzma.org.nz/journal/116-1173/418/](http://www.nzma.org.nz/journal/116-1173/418/).
- Mental Health Foundation. (2003). *Postnatal depression*. August. Auckland: Author.
- Midwifery Council of New Zealand. (2004a). *Midpoint*. Newsletter: September.
- Midwifery Council of New Zealand. (2004b). *Consultation document*. May.
- Ministry of Health. (2001a). *The Primary health care strategy*. Wellington: Author.
- Ministry of Health. (2001b). *Report on maternity 1999*. Wellington: Author.

- Ministry of Health. (2001c) *The Primary health care strategy*, February. Wellington: Author.
- Ministry of Health (2002a). *Maternity Services Notice pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000*. Wellington: New Zealand Government.
- Ministry of Health. (2002b). *New Zealand youth health status report*. Wellington: Author.
- Ministry of Health. (2002c). *Maternity services consumer satisfaction survey*. Wellington: Author.
- Ministry of Health. (2002d). *Well Child-Tamariki Ora Health Book*. Wellington: Author.
- Ministry of Health. (2002e). *Immunisation handbook 2002*. Wellington: Author
- Ministry of Health. (2002f). *He Korowai Oranga: Māori Health Strategy*. Wellington: Author
- Ministry of Health. (2002g). *Te Puāwaitanga: Māori Mental Health National Strategic Framework*. Wellington: Author
- Ministry of Health. (2003). *Maternity Report 2000 & 2001*. New Zealand Health Information Service. Wellington: Author
- Ministry of Health. (2004b). *Report on Maternity Maternal and Newborn Information 2002*. New Zealand Health Information Service.
- Ministry of Health. (2004b). *Primary Health Care Organisations Service Development Toolkit for Mental Health Services in Primary Health Care*. Wellington: Author.
- Moko Business Associates. (2004) *Evaluation of Te Rau Whakawhānui Stage II Midwifery and Early Childhood Māori Mental Health Training Pilot*: Prepared for Te Rau Matatini Māori Mental Health Workforce Development: Palmerston North New Zealand.
- Murray, L., Sinclair, D., Cooper, P., Ducournau, P., Turner, P., & Stein, A. (1999). The socioemotional development of 5 year olds with postnatally depressed mothers. *Journal of Child Psychology and Psychiatry* 40:1259–1271.
- New Zealand College of Midwives Inc. (1993). *Midwives handbook for practice*. Christchurch.: Author.
- New Zealand College of Midwives. (2002). *Midwives handbook for practice*. Christchurch: Author.

- New Zealand College of Midwives. (2003). *Māori Midwifery Workgroup reports back*. Christchurch: Author.
- New Zealand College of Midwives. (2004). About the college. Homepage retrieved 14/10/04: [www.nzcom.org.nz](http://www.nzcom.org.nz)
- New Zealand Government. (2003). Health Practitioners Competence Assurance Act. Wellington.
- New Zealand Health Information Service. (2003). *New Zealand workforce statistics 2003 nurses and midwives*. <http://www.nzhis.govt.nz/stats/nursestats.html>
- Ngā Maia o Aotearoa me Te Waipounamu. (2004). *Ngā Maia o Aotearoa me Te Waipounamu*. Homepage retrieved on 13/10/04  
<http://www.ngamaia.co.nz>
- Ngata, A., & Te Hurinui, P. (1970). *Ngā Moteatea III*: Polynesian Society Inc.
- Nursing Council of New Zealand. (1996). *Guidelines for cultural safety in nursing and midwifery education*. Wellington: Author.
- Nursing Council of New Zealand. (2002a). Guidelines for cultural safety, the Treaty of Waitangi, and Māori health in nursing and midwifery education and practice. Wellington: Author.
- Nursing Council of New Zealand (2002b). *New Zealand Registered Nurses, Midwives and Enrolled Nurses Workforce Statistics 2002*. Wellington: Author.
- Oates, R. (1994/2003). Postnatal mental illness: organisation and function of services. In Fraser, D.M., & Cooper, M.A. (Eds.) (2003). *Myles textbook for midwives*. London; Churchill Livingstone.
- Oates, R. (1995a). Psychiatric disorder and childbirth. *Current Obstetrics and Gynaecology* 5:64-69. In Fraser, D.M., & Cooper, M.A. (Eds.) (2003). *Myles textbook for midwives*. London: Churchill Livingstone.
- Oates, R. (1995b). Risk and childbirth in psychiatry. *Advances in Psychiatric Treatment* 1:146-153. In Fraser, D.M., & Cooper, M.A. (Eds.) (2003). *Myles textbook for midwives*. London: Churchill Livingstone.
- Personal Communication. (April 26, 2004). Jean Te Huia, Manager of Kahungunu Health 'Choices' at Māori Primary Mental Health Midwifery Early Childhood Workshop, Mihiroa Whare, Hastings, Hawke's Bay District Health Board.

- Pomare, E., & de Boer, G. (1988). *Hauora: Māori Standards of Health—A Study of the Years 1970 – 1984, Special Report Series 78*. Wellington Medical Research Council and Department of Health.
- Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora Māori standards of health: A study of the Years 1970 – 1991*. Wellington: Te Rōpu Hauora a Eru Pomare/Eru Pomare Māori Health Research Centre:
- Southwick, M. (2001). *Pacific women's stories of becoming a nurse in New Zealand: A radical hermeneutic reconstruction of marginality*. Doctoral Thesis. New Zealand: Victoria University of Wellington.
- Sutton, F., McLauchlan, M., & Virtue, C. (2002). Primary maternity care outcomes in New Zealand: a comparison of midwife and medical practitioner care. *New Zealand College of Midwives Journal*, 5–8.
- Te Hoe Nuku Roa. (1998). *Baseline study, Manawatu-Whanganui, Gisborne, Wellington, Auckland, Regional Results*, Massey University, Palmerston North: School of Māori Studies.
- Te Puni Kōkiri. (1998). *Progress towards closing social and economic gaps between Māori and Non-Māori*. Wellington: Ministry of Māori Development.
- Te Rau Matatini. (2004). *Kia Puāwai Te Ararau: National Māori Mental Health Workforce Development Strategic Plan 2005–2010*. Palmerston North: Author.
- Tupara, H. (2001). Meeting the needs of Māori women: The challenge for midwifery education, *New Zealand College of Midwifery Journal*, 25, pp 6–9.
- United Nations General Assembly (1948). *Universal Declaration of Human Rights*. Retrieved 30.8/04: <http://www.un.org/Overview/rights.html>
- Walker, R. (1975). Marae: A place to stand, in. *Te Ao Hurihuri: The world moves on*. M. K. (Ed.). Wellington: Hicks Smith, pp 21–34.
- Webster, M.L., Thompson, J.M.D., Mitchell, E.A., & Werry, J.S. (1994). Postnatal depression in a community cohort. *Australian and New Zealand Journal of Psychiatry*, 28(1): 42–49.
- White, G. (2004). Understanding postnatal depression. *Massey News*, 12: 16.
- World Health Organisation. (2004). Making pregnancy safer. *Fact Sheet 276*. [www.who.int/mediacentre/factsheets/fs276/en/](http://www.who.int/mediacentre/factsheets/fs276/en/).

World Health Organisation. *Prevalence, severity and unmet need for treatment of mental disorders in the world health organisation –World mental health surveys*. (2004). *Journal of the American Medical Association*, 291(21): 2581–2590.