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HAPŪ WĀNANGA

A Kaupapa Māori childbirth education class for Māori and non-Māori māmā hapū and whānau

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Abstract

Global studies attest that early engagement with childbirth education (CBE) classes enhances maternal and infant health outcomes. In Aotearoa New Zealand, Māori participation rates in CBE classes are lower than those of their non-Māori counterparts. Current CBE classes are designed and delivered using a predominantly Western medicalised approach that negates Māori birthing knowledge, expertise, and values. However, sporadically, Kaupapa Māori CBE classes are being delivered. This article draws on a wider study that explores the Hapū Wānanga (HW) CBE programme, a by Māori, for Māori pregnancy and parenting initiative. This mixed-method interpretive study used retrospective post-course survey data of 1,152 participants over a three-year period from the HW based in the Waikato District Health Board region. Data explored the programme's quality, the impact on levels of knowledge and understanding, and the overall experiences and views of participants. This artice interrogates the factors that shaped participation, engagement and acceptability of the HW for participants.

Keywords

antenatal education, childbirth, hapū, Kaupapa Māori

Introduction

There is a growing body of evidence showing a strong correlation between an individual's health while in utero and their adolescent and adulthood health outcomes (Morton et al., 2022). Antenatal or childbirth education (CBE) classes aim to prepare prospective parents with skills and knowledge for childbirth and parenthood, in turn supporting greater health outcomes for mother and baby (Ahldén et al., 2012; Brixval et al., 2014; Detman et al., 2008; Ferguson et al., 2013; Kohen et al., 2002). These classes have become standard

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routine for pregnant women and their partners in the developed world (Brixval et al., 2014; Gagnon & Sandall, 2007).

A systematic review carried out by Gagnon and Sandall (2007) found that literature centred on antenatal education has focused predominantly on the impact these classes have on health and health behaviours. The authors also identified three areas that are lacking in current studies, requiring further exploration. First, most studies did not explore women's or partners' expectations and views in depth. Second, few explored whether what is taught in class meets the needs and expectations of attendees, and finally, there is a paucity of evidence for the best method of delivery of antenatal education (Gagnon & Sandall, 2007). These insights are needed to improve engagement with health services, thereby contributing to the service design and delivery, and potentially promoting improved health outcomes.

In Aotearoa New Zealand, Māori participation rates in CBE classes are lower than those of their non-Māori counterparts (Dwyer, 2009). Pihama (2011) explains that the majority of CBE classes offered lack Māori input in design and delivery, and argues that a Māori-led solution is needed to encourage Māori participation and engagement.

This article explores responses from participants of the Hapū Wānanga (HW) pregnancy and parenting programme to understand factors that shape participation, engagement and acceptability for Māori māmā hapū, wider whānau and non-Māori participants.

Maternity

Aotearoa, like most developed countries, has identified a need for quality antenatal maternity care through the provision of free maternity services to eligible citizens and residents (Ministry of Health, 2021). However, Māori and many other Indigenous populations from colonised countries experience significantly more health disparities than their non-Indigenous counterparts (Bramley et al., 2005; Morrissey, 2003). Maternal and infant health is one area where Māori have poorer health outcomes. Colonisation is one contributing factor. Reid et al. (2017) explain that Indigenous peoples dominate negative statistics of settler states and are significantly more likely to be overrepresented in poor health, lower levels of educational achievement, incarceration, abuse, and numerous other areas: "Put simply, indigenous inhabitants typically live well below the median lines in all settler states" (p. 11).

Indigenous peoples continue to experience negative health outcomes as a direct result of colonisation (Bourassa et al., 2004; Lavallee & Poole, 2010; Reading & Wien, 2009), and several influential scholars have stated that colonisation and poor health outcomes are still intrinsically linked (Pihama et al., 2017; Reid et al., 2017; Reid & Robson, 2007). According to Reid and Robson (2007), "It is impossible to understand Māori health status or intervene to improve it without understanding our colonial history" (p. 4). Infant and maternal health outcomes are significantly poorer for Māori than for non-Māori, and colonisation has, and continues to have, an impact on said outcomes (Graham & Masters-Awatere, 2020).

Colonisation affected almost all aspects of Māori maternities (Simmonds & Gabel, 2016). Three major factors contributed to the disestablishment of traditional Māori pregnancy, birthing, and parenting knowledge and practices.

The first was the introduction of the Western health system and specifically hospital births. Documented by Clarke (2012) are accounts from colonisers on Māori birthing practices, specifically the differences in labour and birthing between Māori women and settlers. Clarke (2012) notes that colonisers were particularly impressed with Māori and their short recovery time after birth and use of plants and water to encourage the afterbirth. Yet this system that was working for Māori was ridiculed and replaced with Western systems, such as hospitals (Wepa & Te Huia, 2006). With the introduction and forced use of these hospitals, for both Māori and non-Māori wāhine (Stojanovic, 2008), home births (defined for these purposes as a location that is not a hospital, such as a marae or whare) rapidly decreased for Māori (Simmonds & Gabel, 2016).

Second, the introduction of Western policies and legislations specifically affected Māori maternal and infant health practices. Arguably, the most damaging Act to pass through government, devastating pre-colonisation Māori labour, birthing, and parenting practices, was the Tohunga Suppression Act 1907, which "prohibited traditional healing practitioners who were also the principle repositories of cultural knowledge and practices" (Ware, 2014, p. 3). Ware (2014) states that "this outlawing of tribal repositories meant that Māori ways of teaching, learning, and transmitting knowledge were heavily restricted, including knowledge about pregnancy, birth and parenting" (p. 3). Validating mātauranga Māori (Hikuroa, 2017), and more specifically

mātauranga-ā-whānau—Māori knowledge transmitted intergenerationally (Lipsham, 2020)—is still a struggle for many Māori to this day.

Finally, the marginalisation of the role of wāhine and tapu of the maternal body (Simmonds & Gabel, 2016) remains an issue. Prior to colonisation, Māori society had maternity systems in place; these systems included key people such as tohunga and key practices such as te reo Māori, mātauranga Māori, and spiritual knowledge and practices (Mikaere, 2003). Simmonds and Gabel (2016) explain how the state disregarded these systems, instead purposefully, and intentionally, attacking Māori maternities and replacing them with a system that to this day privileges non-Māori cultural constructs.

Reid et al. (2017) highlight that historical events play a huge role in creating, and continuing, a colonising environment. While the three factors highlighted above provide insight into how Māori maternity knowledge and practices have been severely damaged by colonisation, scholars have identified other factors within the contemporary New Zealand health system that impede addressing Māori health needs.

Racism is a direct cause of poor Māori health outcomes (Came et al., 2019; Reid et al., 2019). Stevenson et al. (2016) found that Māori experience racism in various stages of their maternity journey. Maternity services use terms such as *vulnerable* and *high risk* (Pihama, 2011) to describe Māori, and labels such as *hard to reach*, *do not engage*, or *whakamā* as reasons for non-engagement with services (Pihama, 2011; Wilson & Huntington, 2006). These labels ultimately place blame for non-engagement on the individual, and by extension, justify low Māori attendance rates. Pihama's (2011) *Overview of Māori Teen Pregnancy* demonstrates that these participants experience negative stigma when engaging with health services. As a result, Māori mothers are opting not to engage with services for "fear of being judged" or "told what to do" (Ellis, 1998; Haereroa, 2015). In other studies, researchers have found that Māori are more likely to present to antenatal services later in their pregnancy than their Pākehā counterparts (Hodgetts et al., 2004; Makowharemahihi et al., 2014; Pihama, 2011; Ratima & Crengle, 2013).

Rolleston et al. (2020) highlight that in Aotearoa dominating reasons for poor Māori health include a failure to acknowledge the consequences of colonisation and enduring health system failings. Global Indigenous and Māori scholars alike emphasise that as a result of the deeply embedded colonial history, Indigenous solutions are needed to address issues that predominantly affect Indigenous peoples.

Childbirth education classes

Universally, the intended purpose of CBE classes is to ensure expectant parents are provided with the necessary skills and knowledge to prepare for birth and parenting (Soriano-Vidal et al., 2018). In Aotearoa, participation in CBE classes is one milestone on the maternity spectrum that expectant parents are encouraged to complete. The Ministry of Health oversee service specifications for District Health Board (DHB)-funded maternity services, allowing DHB-funded CBE classes to be provided at no cost. Two early studies that focus primarily on CBE classes in Aotearoa demonstrate that Māori participation rates in CBE classes are substantially lower than those of non-Māori. Ellis's (1998) case study states that only 30% of Māori attended CBE classes, while Dwyer's (2009) report on behalf of the Families Commission identified that only 10% of Māori attended CBE classes. Recent scholarly articles exploring the wider maternity spectrum also highlight a low response rate in CBE classes for Māori (Moewaka Barnes et al., 2013; Wylie et al., 2009).

As discussed in the previous section, Māori practices were abolished and replaced with Western structures and processes. Gagnon and Sandall (2007) explain how CBE classes have replaced previous Indigenous forms of knowledge transmission: "The existence of structured education in preparation for childbirth and parenthood has come about as traditional methods of information sharing have declined" (p. 3).

Gagnon and Sandall's (2007) research also found that the CBE courses offered typically attracted attendees who were "well educated women in the middle-to-upper socio-economic strata" (p. 4). It is therefore assumed that women from the lower socio-economic strata typically do not access CBE classes. This is reflective of Aotearoa, where more than half of Māori live in areas considered among the most deprived in the country (Ministry of Health, 2015b). Specifically, in the Waikato DHB region (where this study takes place) "two in five children and one in three adults in Māori . . . were in households with low equivalised household incomes (under $15,172)" (Robson et al., 2015, p. v). This is indicative of CBE classes in Aotearoa: Dwyer's (2009) study revealed that CBE participants were significantly more likely to have "a tertiary degree (one to four years), to be of New Zealand European ethnicity

and to be earning $70,000 per year or more" (p. 84). Despite efforts to achieve equitable outcomes, maternity services and the New Zealand health system in general are not currently meeting the needs of Māori (Goodyear-Smith & Ashton, 2019).

Though a resurgence of traditional Māori birthing practices has been recognised in academic scholarship by the likes of Dr Naomi Simmonds, Professor Leonie Pihama, and Dr Aroha Yates, to name a few, and provided an insight into Māori birthing knowledge and expertise, little attention has been paid specifically to CBE classes that meet the aspirations of Māori attendees. Some international studies have indicated that antenatal programmes do not meet the needs of all intended participants (Liu et al., 2017; Nguyen et al., 2019). Gagnon and Sandall (2007) note that "typically these [CBE] programs have not been based on the expressed needs of attendees, but rather on the messages that the educators themselves believed they should impart" (p. 3). Nguyen et al.'s (2019) study based in the United States on women from racial or ethnic minority and low socio-economic backgrounds concluded that "despite reporting higher levels of prenatal health education on a variety of health-related topics, disadvantaged women continue to experience disparities in adverse birth outcomes suggesting that education is insufficient in promoting positive behaviors and birth outcomes" (p. 157).

Delivery of CBE classes in Aotearoa

Prior to the recent introduction of the newly formed Te Whatu Ora Health New Zealand, CBE programmes funded by the Ministry of Health were managed through the individual DHBs. DHBs were responsible for the commissioning, funding and monitoring of both hospital and primary care services (Ministry of Health, 2022). Specifically to the Waikato DHB, CBE services were provided by a Waikato DHB service provider arm (HW) and community health providers, underpinned by the mandatory *Maternity Services—DHB Funded—Pregnancy and Parenting Information and Education Tier Level Two Service Specification* framework (Ministry of Health, 2015a).

The intended outcomes of CBE classes are to enhance maternal and infant health outcomes. Based on participation rates, CBE classes have a much higher success rate for non-Māori than for Māori. Current studies demonstrate that Māori participation rates are low and those Māori that do engage have an undesirable experience that amounts to little or no transformational change. Pihama (2011) and Moewaka Barnes et al. (2013) concur that a Māori-led solution is needed to achieve equitable maternal and infant health outcomes. Designing and delivering responsive CBE classes is a matter of urgency.

Kaupapa Māori

The definition of Kaupapa Māori has become a topic of deliberation for academics, health practitioners, educators and the community alike. At its core, Kaupapa Māori is a "philosophy most often expressed in the delivery of culturally appropriate and relevant services to Māori in the education, health, and welfare sectors. These services are colloquially referred to as 'by Māori, for Māori'" (Eketone, 2008, p. 1). As well as a "by Māori, for Māori" premise, according to Durie (2001), Kaupapa Māori healthcare initiatives should also include the following: the incorporation of tikanga Māori; the involvement of whānau, hapū, and iwi in all aspects of the service, including treatment; the use of traditional Māori healing practices; and the provision of cultural assessment cultural practices and whakawhanaungatanga (p. 227).

Hapū Wānanga is a free Kaupapa Māori pregnancy and parenting course that aims to provide participants with quality information to make informed choices (Te Whatu Ora, n.d.). At the time this study was conducted, the facilitators were both Māori, each holding health and education qualifications. In this article the term hapū refers to a *pregnant woman*. In te ao Māori, hapū is a sacred time and woman should be treated accordingly. According to Mahuika and Mahuika (2020), "Wānanga is a traditional method of Māori knowledge transmission . . . [it] is a dynamic living tradition that has developed across generations" (p. 369). Combining traditional Māori birthing practices and knowledge for a contemporary context, HW aims to inform, inspire and empower whānau to make informed decisions.

The HW initiative has several characteristics aligning with the by Māori, for Māori criteria of Kaupapa Māori (Smith, 1999). The incorporation of tikanga is evident throughout the programme. Practices such as whakatau, karakia and waiata are examples used within the programme. Whānau participation is encouraged, and facilitators leverage off the experiences of whānau participants, if appropriate, throughout the wānanga. Te reo Māori and customs are actively used to connect with and accommodate the various participants.

Another feature of HW is the purposeful inclusion of guest speakers, providing an opportunity for health and social support services to connect

with wāhine and whānau in an environment where whānau feel comfortable. This additional feature is unique to HW and embedded to help address issues of access to health services. This holistic approach aligns with Kaupapa Māori aims by recognising that whānau not only have a right to health services but also have the right to choose whether or not they wish to engage in those health services (Durie, 1998; Moewaka Barnes et al., 2013).

Although HW was designed, developed, and implemented by Māori, it is a government-funded programme, which can challenge the *by Māori* criteria of Kaupapa Māori. Exploring this debate is not within the scope of this article. Still, HW has attributes that align with Durie's (2001) characteristics of a by Māori, for Māori approach and, above all, seeks to advance Māori and make positive transformational change using Māori knowledge, values and processes. Therefore, HW is a Kaupapa Māori initiative.

Methods

Using an interpretive approach, this study provides a descriptive thematic analysis of qualitative comments from post-course surveys, guided by Kaupapa Māori principles. This analysis draws on te ao Māori using a strengths-based approach. The study involved a retrospective analysis of post-survey data over a three-year period from the HW programme based in the Waikato DHB region of Aotearoa. A paper-based post-course survey was completed by 797 māmā hapū and 355 support people. The survey explored the programme's quality, impact on levels of knowledge and understanding, and the overall experiences and views of participants. This strengths-based approach encompasses a wider set of factors that contribute to holistic individual and whānau health and wellbeing.

Participant selection and recruitment

Evaluation surveys were offered to all participants at the conclusion of the two-day HW. Survey results were collected with consent (participation was voluntary) and the understanding that the information would be used to explore the value of HW, with the intent to strengthen future delivery. Facilitators explained that survey results would be used to evaluate HW, and although the information provided would be de-identifiable, there would be a wider dissemination of findings.

Data collection

Post-course survey data held by Te Puna Oranga (Māori Health Service) at Waikato DHB was de-identified for the period of January 2016 to December 2018 with a total of 1,152 surveys, comprising 797 māmā hapū and 355 support people. During this three-year period, the survey questions had been amended to adhere with pregnancy and parenting guidelines and course information, which means there are slight variations in data collected during the period. However, the fundamental questions have remained consistent over this time and the most recent post-course survey is in Appendix 1.

Data consist of de-identifiable information that relates only to age and gestation (at time of participation), ethnicity and suburb of residence (important for geographical code), programme quality, impact on levels of knowledge and understanding delivered during the wānanga, and the overall experiences and views of participants.

Data analysis

This mixed-method interpretive study provides a descriptive thematic analysis of both quantitative data and qualitative comments from the surveys, guided by Kaupapa Māori principles. A Māori researcher and PhD candidate undertook a dependent *t*-test statistical analysis of quantitative data and led the thematic analysis of qualitative data.

Paired or dependent *t* tests are commonly used when determining whether a significant change between the paired samples has occurred at different stages, such as a pre- and post-test/intervention (Kim, 2015). A *t* test was conducted for each of the seven topics covered in the HW survey, to determine whether there was a significant difference between knowledge at the beginning and knowledge at the end of the HW programme. Results from the *t* test determined whether the following null hypothesis was accepted or rejected: *There is no significant difference between knowledge before and knowledge after the HW.*

The thematic analysis centred on te ao Māori using a strengths-based approach. Unlike a deficit model approach of researching whānau and testing or checking up on parents' knowledge (Jones et al., 2010), the focus of this analysis was the whānau, seeking to portray participants' viewpoint within a culturally appropriate paradigm, moving beyond traditional research approaches that perpetuate recurring negative themes (Smith, 1999; Stoneham & Percival, 2020). Both processes involved independent analysis followed by robust, collaborative discussion, and subsequent conversations with fellow authors and supervisors (LB, PAC, LTS), as well as key stakeholders.

This study is part of a wider PhD study and received

ethical approval from the Waikato DHB Research Committee on 17 July 2019, RD019056, and the University of Waikato Human Ethics Committee on 25 July 2019, HREC(Health)2019#40.

Results

Demographic data comprising participants sex, age and New Zealand Deprivation Index (NZDep) number (the number allocated to geographical locations; 1 refers to levels of low deprivation and 10 refers to levels of high deprivation) were collected. In the qualitative section of the survey, the demographic data corresponded with participant quotes. Where demographics data were not available, a participant ID number was allocated. The vast majority of respondents completed all or most sections of the survey. The following sections are divided into quantitative findings, based on the HW survey questionnaire, and qualitative findings, derived from a thematic analysis of the survey responses.

Quantitative findings

Table 1 is a summary of the 797 māmā hapū demographic data survey responses, demonstrating a high number of Māori māmā hapū participants (63%), with that percentage being potentially higher given that 13% was "unknown". Of the

TABLE 1 Demographic results for māmā hapū (expectant mothers) participants (n = 797)

Demographic	Description	No. of māmā hapū participants
Ethnicity	European	58
	Māori	503
	Pacific Peoples	16
	Asian	19
	Other Ethnicity	101
	Unknown	100
New Zealand Deprivation Index	10	104
	9–8	192
	7–6	35
	5–3	35
	2–1	12
	Unknown	419
Age (years)	14–18	77
	19–21	137
	22–27	262
	28–32	113
	33+	103
	Unknown	105
Gestation (weeks)	>12 weeks	4
	13–20 weeks	33
	21–29 weeks	129
	30–36 weeks	218
	37+ weeks	130
	Unknown	283
Primp (first time pregnant)	No	131
	Yes	395
	Unknown	271

TABLE 2 Programme quality results for māmā hapū (expectant mothers) participants and support people

Topics	Facilitator	Guest speakers	Venue	Kai (food)	Resources
Māmā hapū (n = 797)					
Awesome	570	509	517	547	570
Okay	3	61	50	23	0
Not Sure	0	1	2	0	0
Other	1	1	1	1	1
Data not entered	223	223	223	223	223
Did not answer	0	2	3	3	3
Support people (n = 355)					
Awesome	340	281	298	312	327
Okay	1	58	40	27	13
Not Sure	0	1	3	1	1
Other	0	0	0	0	0
Data not entered	0	0	0	0	0
Did not answer	14	15	14	15	14

TABLE 3 Mean scores of Hapū Wānanga (a *by Māori, for Māori* childbirth education class) participant survey knowledge pre and post Hapū Wānanga

Topics	*df*	Pre: Mean *(SD)*	Post: Mean *(SD)*	*p*-value
Maternity care and your rights	590	4.58(1.88)	8.88(0.95)	<0.001
Healthy kai (food) during pregnancy	418	5.37(2.08)	8.65(1.29)	<0.001
What to expect in labour and birth	585	4.45(2.09)	9.05(0.99)	<0.001
Smoking, drugs and alcohol in pregnancy	553	5.79(2.38)	8.97(1.21)	<0.001
Feeding your baby	561	4.53(2.42)	8.68(1.35)	<0.001
Childhood immunisations	525	4.72(2.35)	8.05(1.76)	<0.001
Safe sleep practices	577	4.93(2.20)	8.89(1.10)	<0.001
Sex/sexual/contraception	397	5.54(2.36)	8.61(1.57)	<0.001

known data within the socio-economic deprivation index (n=378), 78% resided in a Level 8 to 10 NZDep area. The age range of participants was similar among the differing age groups with a spike of participants in the 22–27-years age range, and a majority of participants noting this event as their first pregnancy.

Of the 355 support people who completed the surveys, Māori comprised 72%. The respondents consisted of various relatives, including husbands, partners, māmā and nannies, as well as observers and unspecified others, the majority of whom were 22 years or older.

The programme quality questions were presented to participants using a visual representation of emojis and corresponding headings, ranging from an "awesome" smiling face to a "not good" unhappy face. Of the responses noted in Table 2, the overwhelming reaction was "awesome" for all five key areas: facilitator, guest speakers, venue, kai, and resources. Of the 797 māmā hapū surveys, data from 223 respondents were unavailable for this section of the survey.

Of the available data, the following percentage of respondents (n=574) indicated "awesome" for the following programme qualities: facilitator—99%, guest speakers—89%, venue—90%, kai—95% and resources—99%. Support people shared the same sentiment as māmā hapū participants with an overwhelming response of "awesome" for all five areas.

A dependent *t* test was conducted on māmā hapū survey responses for each of the eight topics covered in the HW survey, to determine whether there was a significant difference in knowledge between the beginning and the end of the HW programme. Table 3 results show that the null hypothesis is rejected. Each of the topics report a *p*-value of less than 0.05, demonstrating that the HW programme provided a significant increase in knowledge for participants in each of the eight topic areas.

Qualitative findings

Several key themes were raised throughout the qualitative survey data. Figure 1 is a frequently used word map, with the Hapū Wānanga logo. Alongside the word map, this article describes six key themes—(a) *Kaupapa Māori*, (b) *facilitator*, (c) *thirst for, and appreciation of, new knowledge*, (d) *life changing*, (e) *benefits for all* and (f) *future directions*—acknowledging the need for further exploration of these themes in future studies.

FIGURE 1 Word cloud of Hapū Wānanga (a *by Māori, for Māori* childbirth education class) survey data

Kaupapa Māori: At its core, "the term Kaupapa Māori captures Māori desires to affirm Māori cultural philosophies and practices" (Pihama et al., 2002, p. 30). Weaving tikanga and Kaupapa Māori throughout the wānanga provided a uniquely Māori approach to antenatal education. The design and structure of the wānanga demonstrated that te ao Māori knowledge and customs were prioritised. This intentional feature created a sense of familiarity among many participants who may have found comfort within te ao Māori settings. Highlighting tikanga protocols, such as "whakatau, whanaungatanga, karakia, nga papamahi, nga kaikorero" (Māori, 37 yr old, NZDep 10) affirmed the significance and value of Māori protocols and customs. The identification of these as a valued practice may also suggest that participants had rarely experienced these conventions within other healthcare settings.

Prioritising te ao Māori birthing practices was also identified as a valued part of the HW. Many participants indicated their intention to incorporate practices shared in the HW as part of their labour or birthing journey. These practices include using *greenstone to cut the pito*, *making own muka* and acquiring *muka to tie the pito*, whenua ki te whenua burying the afterbirth in ipu made in HW, and using processes such as "karakia" and "waiata" to welcome pēpi.

The inclusion of Māori protocols and embedded Māori knowledge systems was well received by both Māori and non-Māori participants, with many revealing a sense of comfort and belonging. For example, one māmā hapū participant signalled her enjoyment of the "comfortable environment, friendly support people, fun, informative, easy to listen to. Loved the singing/Māori vibe" (NZ European, 23 yr old, NZDep 8).

The atmosphere had a profound effect on participants, as another māmā hapū explains: "I enjoyed the relaxed friendly environment. Having a Māori environment and Tikanga made it easier to relate to and understand content" (Māori 21 yr old, NZDep 9). Several participants noted the atmosphere as being informal, non-judgemental, inclusive, positive and comfortable. As noted in the quotes above, the deliberate design of HW with embedded Māori protocols and knowledge contributed to the atmosphere of the wānanga. These defining features of tikanga and Kaupapa Māori had a social and emotional impact on participants.

Participants felt comfortable, but the atmosphere also allowed participants to engage, learn, and ultimately have fun.

The inclusion of guest speakers was well received by many participants. Some noted future behaviour change intentions, such as *improving oral health care for myself*, *change smoke alarms*, *eat less sugar* and *safe sex and contraception*—after pēpi is born.

Facilitator: The vast majority of positive responses from participants related to the facilitator and the HW team. Although there was a specific section for participants to rate the facilitator (Table 2), many informants specifically acknowledged the facilitator and the impact she had on them:

> Nga mihi nui mo to koutou manaaki I a matou e hapu ana kia whiriwhirihia ai matou I te huarahi tika hei whai ki te whakawhānau mai I o matou taonga. Mei kore ake ko tenei mea a "Hapu Wānanga". Kua kore hoki matou e whai matauranga. Nui te aroha. (Participant ID 590)

> Ngā mihi nui ki a koe [facilitator]. Thank you for creating wānanga like these to make me as a wahine Māori more comfortable about learning about being hapū and more, and for all the information we have had the privilege of learning. Ngā Mihi. (Māori, 21 yr old)

Participants identified that it was not the content the facilitator delivered but how the content was delivered that participants valued. Understanding and recognising the different experiences of māmā hapū and need for different learning styles and approaches was central to supporting the transmission of knowledge. This is reflected in the following quote: "All the information regarding baby, labour, alternative interventions, breastfeeding and how [the facilitator] communicated it. She made something that could be heaps boring fun and super informative" (Pacific Peoples, 27 yr old, NZDep 8). Another māmā hapū echoed this sentiment: "I loved how [facilitators] delivered their korero, it was FULL of information and spoken in a way that we can relate to and understand. I LOVED IT!!" (Māori, 34 yr old).

The pedagogies displayed in HW move beyond the traditional classroom conventions of teacher speaks and student listens, and instead incorporate the use of body, singing and touch. These are elements that affect the wairua of HW participants.

Other words used to describe the facilitator included *captivating*, *relevant*, *real*, *supportive*, *approachable*, *funny*, *raw* and *honest*. As evidenced by the participant quotes noted previously, the facilitator was able to deliver appropriate content, catering to the multiple levels of health literacy and lived experiences, while also ensuring the experience was enjoyable and fun. Several participants identified the facilitator as having a genuine desire and care for those attending HW.

Thirst for, and appreciation of, new knowledge: Leading on from the Kaupapa Māori and facilitator themes, several participants expressed an appreciation for the learnings that were shared among HW attendees. As one participant articulated, "Learning heaps new things about midwives, birthing, labour, health all sorts, loved this two day course. Very helpful for a first time māmā" (Māori, 22 yr old, NZDep 10).

The process and way in which knowledge was shared was appreciated by participants. The varying modes of information transmission—verbal cues, visual props, video clips and kōrero—among the group were well received. This reaffirms that delivery of information using a top-down approach is not a conducive way for learnings to be shared. As one participant said, "I loved the wānanga style for learning and communication. I loved the cultural aspect to tikanga Māori. I loved the depth of learning to really enforce our learning—videos, demonstrations, devices" (Māori, 38 yr old, NZDep 2).

These different mediums were used in a manner that respected the multitude of varying backgrounds of māmā hapū and their whānau, and facilitated knowledge growth for many: "I enjoyed everything from beginning to end, I was engaged in every kaupapa, definitely enjoyed myself and I know I am walking away with more knowledge [than what] I had at the start of day one" (Participant ID 642).

Although the learnings and shared knowledge from HW were valued by participants, it is important to note that each māmā hapū is on their own journey and may not find all the information relevant or be in need of particular knowledge. This underlying message of sovereignty and self-determination through the mantra of *my body, my baby, my birth* reaffirmed that participants had the choice to onboard whatever knowledge and information they valued. Noting this, several voiced changes they planned to implement. These behaviour changes included *delay clapping*, *handling a new baby gently*, *breastfeeding*, *no polar fleece*—when dressing pēpi, and safe sleep practices: *own bed . . . on back . . . no side wedges*.

Life changing: An increase in knowledge within

the HW enabled participants' self-confidence to grow. The reclamation of self and empowerment of knowledge for māmā hapū had a major impact on their birthing plans and their overall journey through pregnancy, birth and parenting. They articulated changes such as moving *from hospital to birthing unit*, *no or limited medical intervention*, *using breathing techniques for pain management*, incorporating the *wave analogy to manage pain*, *Dad catching baby*, *not lying on back to birth*, and *having more support people with me*.

For many wāhine, birth can be both an exciting and a terrifying experience. The HW was a catalyst to support māmā hapū to (re)gain confidence to birth their pēpi. Remarks such as *have trust in myself* and *listen to my body* are examples of women's increase in confidence. The shifting of mindsets and support of wāhine moving from a state of fear to one of empowerment are evidenced by the following quote:

> I have gained extra confidence by attending, after finding out about my recent pregnancy I was very anxious and fearful of birth and did not have confidence in my body. I've now learned that my last birth being posterior and previous to that being induced without medical pain relief, that my body took a lot extra pain and this time around I will not be inducing and keeping an eye on position on baby that I can turn. (Participant ID 627)

The confidence instilled in them by HW enabled participants to more comfortably engage with people in positions of power, such as midwives or other health professionals. This was evidenced by comments from participants exclaiming their intentions of *speaking up* and *asserting my rights*. The HW was also a source of inspiration, with one participant expressing a desire to be involved and actively contribute to future HW programmes: "I am looking for what I am passionate about, and this class made me really want to get involved I think it's amazing. If you need a hand with anything, get in touch, even cleaning" (Māori, 17 yr old).

Benefits for all: The Kaupapa Māori design means that the HW is a by Māori, for Māori programme. However, HW facilitators have not limited the programme to Māori; participation from all ethnicities is encouraged. As highlighted in Table 1, HW survey data reflects that 37% of attendees identified as non-Māori or unknown. Several participants, including those selecting a non-Māori ethnicity, highlighted the positive impact HW has had on them and that it will have for future potential participants. Following are quotes evidencing the positive endorsement from rangatahi, as well as a māmā hapū who already had tamariki. This comment articulates the appreciation this first-time māmā had for HW: "Thank you very much for supplying us with the information we needed and I hope more teen parents like myself will come and check out Hapū Wānanga and take notes about everything" (Māori, 15 yr old).

Though not a current hapū māmā, a 47-year-old New Zealand European also identified value in the programme:

> This was just fantastic I wish they had hapū wānanga when I was having babies. The level of information was outstanding we can make robust informed choices moving forward with the new baby and pregnancy. It's a bloody good programme, love it, thank you.

The former māmā hapū also recognised that the HW programme is of value to other pregnant rangatahi. This was echoed by a rangatahi participant who intended to recommend HW to their "hapū friends and whānau" (Māori, 17 yr old).

The inclusion of whānau in the HW is a testament to the holistic approach of the programme. This was evidenced by the following comments from support people who gained confidence and clarity on how they can support māmā hapū:

> It was a really big eye opener as a support person. I am confident to support my sister's pregnancy. The environment was comfortable and enjoyable. [The facilitators] are awesome. Enthusiasm is great and I will definitely return when I have a pēpi coming along. (Māori, 18 yr old, sister)

The next quote also supports the idea that a holistic approach to antenatal education must recognise the different expectations of end users and that a one-size-fits-all universal approach does not consider wider perspectives:

> I never expected that I will learn a lot of things. One of the best lectures I've had. I initially thought that I'd rather go fishing, but I'm really thankful that my wife and our midwife pushed us to attend. (41+ yr old, husband)

Some participants with a background in maternity care, namely, midwives and a health lecturer, found benefit in the HW programme and suggested the programme be part of future

midwifery training. The comments from participants highlighted above suggest that the HW programme is filling a gap in antenatal education, with benefits being felt by māmā hapū, support people and health professionals.

Future directions: Some participants expressed a desire to re-engage with the HW programme, as the following quote attests: "Tumeke ladies. Thank you so much for everything, ya'll do an amazing job. Love, love, love. Coming back when I have more babies. Hahaha" (Participant ID 625). This sentiment was echoed by other participants who suggested an expansion of the programme for māmā hapū to attend a similar wānanga after the birth of their pēpi. Participants also identified that the growth of HW is of critical importance. For instance, a participant residing in a rural area exclaimed that more support for HW in rural communities is needed. Some respondents expressed the need for HW to be a nationwide programme but recognised the need for appropriate and adequate resourcing. These suggestions affirm the endorsement of HW for future participants, reinforcing the idea that the HW is a valuable programme.

Discussion

This study used the experiences and voices of HW participants to portray the participants' viewpoints on aspects of the HW class. Factors that were important to participants included the embedded Kaupapa Māori design and delivery; responsive and empathetic facilitators; a thirst for, and appreciation of, new knowledge; life-changing information; and benefits for all people, including but not limited to Māori and non-Māori participants, partners, grandparents, and other health professionals.

Statistical data from the *t* test revealed a significant increase in participant knowledge after the HW programme in all topic areas. A limitation of this study is the missing or incomplete data sets, which resulted in an average of 32% participant survey responses being excluded from the *t* test. An assumption can be made that those participants who did not complete the survey did not have a knowledge shift, did not understand the survey question, or preferred not to respond. The incompleteness of the data demonstrates a need for further consideration of data collection methods and processes to determine the extent and impact of the HW programme.

Still, the high number of post-evaluation surveys completed demonstrates that an overwhelming number of participants found HW to be a highly valuable programme that exceeded their expectations. The embodiment and use of traditional Māori protocols such as whakawhanaungatanga and waiata established a safe and comfortable environment for both participants who were familiar with a te ao Māori setting and those who were not.

Several participant responses align with mana motuhake (Carlson, 2019; Moore et al., 2014). For health services, this translates into "enabling the right for Māori to be Māori; to exercise authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori" (Ministry of Health, 2020, p. 1) . The themes used throughout this article embody the obligations set out by Te Tiriti o Waitangi—Aotearoa's founding document. HW is an example of a health service that supports participants with new, valuable and relevant learnings. As one key informant explains:

> being empowered as a wahine hapu who is Māori. I know my rights. I know now that it's my body, my baby, and my birth. [Hapū Wānanga] was delivered by experts who live and breathe what they teach, who are actively revitalizing traditional practices in the hope that these practices are normalised and that they are promoting local specialists i.e. acupuncture, wahakura, clay, photography etc. Also, the reality of childbirth, the piki and heke. (Māori 30 yr old, NZDep 10)

HW has challenged the preconceived notion that Māori do not engage in CBE classes, demonstrating that a Kaupapa Māori antenatal wānanga attracts Māori māmā hapū, wider whānau, and non-Māori engagement and endorsement. This article amplifies the experiences and voices of HW participants to affirm positive aspects of the class. The broad themes of participant responses were highlighted; however, further exploration in this area is needed. Findings from this study counter prevailing assumptions that Māori do not engage with health services and suggest that an Indigenous, strengths-based approach to CBE service design and delivery has positive and transformation results for whānau.

Recommendations

To enhance the likelihood of Māori participation, funding agencies must support CBE programmes that involve and prioritise Māori expectations, content and delivery. Participants identified the following characteristics as valuable within the HW: ensuring necessary tikanga Māori customs

and protocols are followed, such as pōwhiri and whakatau, whakawhanaungatanga, karakia and waiata; an atmosphere where participants feel comfortable and safe; a facilitator with an authentic and genuine appreciation of all participants; and different learning mediums and knowledge sharing sources, such as leveraging of experiences of participants as well as the knowledge of the facilitator. Underpinned by Kaupapa Māori principles, these characteristics are what make HW a unique and valued programme for both Māori and non-Māori participants. Therefore, HW, and other Kaupapa Māori CBE programmes, should be prioritised in future CBE policy and investment decisions.

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Glossary

Aotearoa	in common usage as the Māori name for New Zealand; literally, long white cloud
hapū	pregnant; sub-tribe
Hapū Wānanga	a by Māori, for Māori childbirth education class
heke	down
ipu	clay pot to put the placenta in
iwi	tribe
kai	food
karakia	prayer
kaupapa	topic
Kaupapa Māori	a philosophy most often expressed in the delivery of culturally appropriate and relevant services to Māori in the education, health, and welfare sectors; colloquially referred to as *by Māori, for Māori*
kōrero, korero	discussion
māmā	mothers, mother
māmā hapū	expectant mothers
mana motuhake	mana through self-determination and control over one's own destiny
Māori	Indigenous peoples of Aotearoa
marae	Māori meeting house
mātauranga-ā-whānau	family knowledge
mātauranga Māori	Māori knowledge
nga kaikorero	the speakers, orators
Ngā Mihi	Greetings
Ngā mihi nui ki a koe	respectful greetings to you
nga papamahi	father's role/work
muka	flax fibre
Pākehā	New Zealanders of European descent
Papatūānuku	earth mother
pēpi	baby
piki	up
pito	umbilical cord
pōwhiri	welcome ceremony
rangatahi	teenagers
tamariki	children
tapu	sacred
te ao Māori	Māori world view
te reo Māori	Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
tikanga; Tikanga	values, beliefs, custom, rule, principles
tohunga	Māori healer
tumeke	awesome
wahakura	woven bassinet for infants
wāhine	women
wahine hapu	pregnant woman
wahine Māori	Māori woman
wāhine Māori	Māori women
waiata	song
wairua	spirit

wānanga	a traditional method of Māori knowledge transmission
whakamā	shy
whakatau	informal Māori welcome
whakawhanaungatanga	a process of introducing and connecting with others, often based on genealogical connections
whānau	family
whanaungatanga	relationship, kinship, sense of family connection
whare	house
whenua ki te whenua	returning the placenta to the earth mother

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Appendix 1 – Hapū Wānanga: Post-course survey

What is your:

Name_____ **Date of Birth**____/____/_____

Ethnicity ○ Māori ○ Cook Island Maori ○ Samoan ○ Tongan ○ Niuean
○ NZ Euro ○ Indian ○ Chinese ○ Other _____

Are you the:

☐ Support person

☐ Hapu/pregnant wahine

1. How would you rate the teacher/facilitator?

2. How would you rate the guest speakers?

3. How would you rate the venue?

4. How would you rate the kai/food?

5. How would you rate the resources you were provided?

Permission to use and publish the survey for this study was granted by Waikato DHB Research Committee on 17 July 2019, RD019056.
Survey credit: Te Puna Oranga (Māori Health Service) Waikato DHB (now known as Te Whatu Ora).

1. By attending the Hapu Wananga Programme did you gain new knowledge in Maternity care & your rights?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert
AFTER	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert

2. By attending the Hapu Wananga Programme did you gain new knowledge in what to expect during labour and birth?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert
AFTER	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert

3. By attending the Hapu Wananga programme did you gain new knowledge around smoking, drugs and alcohol in pregnancy?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert
AFTER	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert

Are you intending to quit or reduce use of cigarettes / drugs / alcohol?

☐ NO ☐ YES ☐ NOT SURE

4. By attending the Hapu Wananga programme did you gain new knowledge around feeding your baby?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert
AFTER	○ 1 No Knowledge	○ 2	○ 3	○ 4	○ 5 Some Knowledge	○ 6	○ 7	○ 8	○ 9	○ 10 Expert

Before the programme, how did you want to feed your baby?

☐ Bottle feed ☐ Breastfeed ☐ Mixed feed ☐ Not sure

Now that you have completed the programme, how do you want to feed your baby?

☐ Bottle feed ☐ Breastfeed ☐ Mixed feed ☐ Not sure

5. By attending the Hapu Wananga Programme did you gain <u>new knowledge</u> in childhood immunisations?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○	○	○	○	○	○	○	○	○	○
	1	2	3	4	5	6	7	8	9	10
	No Knowledge				Some Knowledge					Expert
AFTER	○	○	○	○	○	○	○	○	○	○
	1	2	3	4	5	6	7	8	9	10
	No Knowledge				Some Knowledge					Expert

Do you intend to immunise your baby?

☐ NO ☐ YES ☐ NOT SURE

6. By attending the Hapu Wananga Programme did you gain new knowledge in safe sleep practices?

☐ NO ☐ YES ☐ NOT SURE

If you answered yes, what was your knowledge in this area before and after the programme?

BEFORE	○	○	○	○	○	○	○	○	○	○
	1	2	3	4	5	6	7	8	9	10
	No Knowledge				Some Knowledge					Expert
AFTER	○	○	○	○	○	○	○	○	○	○
	1	2	3	4	5	6	7	8	9	10
	No Knowledge				Some Knowledge					Expert

Do you intend to do any of the following as a result of the programme (tick what you intend to do):

☐ Sleep baby in their own bed

☐ Use a safe sleep device

☐ Sleep baby face-up/on their back

☐ Sleep baby in the same room as me

☐ Handle baby gently

What did you enjoy about the programme?

What did you least enjoy about the programme?

What would have made the programme better?

Name three things you will change or consider changing as a result of what you learned?

1.

2.

3.

Any other comments…