Marginalising Māori Parents

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Literature review

Marginalising Maori adolescent parents

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Abstract

Adolescent parenting is an international occurrence where more than 10% of all babies are born to young parents (Alan Guttmacher Institute, as cited in Hanna, 2001). Various international research has shown that adolescent parenting can often be significantly higher within indigenous groups and Maori adolescents are no exception to this (Families Commission, 2011). The Families Commission report (2011) on adolescent pregnancy and parenting discusses how New Zealand has the second highest rate of adolescent childbirth in the OECD, and that Maori have a significantly higher rate of adolescent childbirth and parenthood than any of New Zealand's other major ethnic groups. There are a variety of factors such as socio- economic deprivation that are suggested to contribute towards adolescent pregnancy. Both adolescent pregnancy and ethnicity can lead to marginalisation, putting young Maori parents in an even more vulnerable position. Browne and Fiske (2001) explain that health care encounters are crucial areas of study as they reveal the social, political, economic, and ideological relations between patients and the mainstream health care system. In this report, public health care experiences of Maori adolescent parents are discussed as being of particular importance. Most current research fails to consider whether negative views of adolescent pregnancy are universal; overlooking the possibility that Maori may have different perceptions. In spite of how crucial the opinions of young Maori are in regards to adolescent pregnancy, dominant health research's failure to see this suggests that their voices are not important. The way in which adolescent pregnancy and parenting is dealt with therefore requires scrutiny, with particular attention given to the voices of Maori and adolescent parents.

As a young person myself, who is concerned with the development of Maori people, this is an area of research that is both interesting and alarming to me. From working on this project, I have found that there is a gap in health research concerning the experiences of young Maori parents, in spite of the fact that it is their voice that is most important. It appears that a deficit model has been employed to frame this issue, where research has not held back in finding the causes and consequences of Maori adolescent pregnancy. This in my opinion may leave this vulnerable group feeling further stigmatised and open to marginalisation.

Background

This report was written while undertaking a Nga Pae o te Maramatanga internship with Whariki, SHORE and Whariki Research Centre, Massey University in the summer of 2011/2012.

The review topic of marginalising Maori parents arose out of a report on rangatahi and sexual coercion, which included an examination of gender roles, Maori concepts around sexuality and parenting (Moewaka Barnes, 2010). A current Whariki project, scoping Maori influences on babies in utero and in the early days with implications for the life course, also highlighted concerns around antenatal health services for Maori in general and for young Maori parents in particular.

Nationally adolescent parenting and teenage pregnancies are often framed as problems. New Zealand has the second highest rate of adolescent pregnancy in the OECD, where 52 children per 1, 000 are born to mothers aged 15- 19 years (Statistics New Zealand, 2003). This contrasts with rates in other developped countries such as the Netherlands (10.1 per 1, 000) (Statistics New Zealand, 2003).

In the Youth 2000 survey, half of the Maori participants had had sexual intercourse and a third were sexually active at that time. Previous research has identified that Maori youth engage in sexual activity earlier than their Pakeha peers, and are more likely to fall pregnant in their adolescent years (Kiro, 2011). Young Maori have a higher rate of childbirth than the overall national rate (Families Commission, 2011) and have a higher fertility rate (70 per 1,000) in comparison to their European counterparts (22 per 1,000) (Statistics New Zealand, 2003). Maori adolescent pregnancy is two and a half times higher than the overall adolescent birth rate (The Treasury, 2002).

Woodward et al (2001) state that risk factors of teen pregnancy include exposure to parental change such as single parenting and divorce (MSD, 2010), having a mother who gave birth at a young age (Kiro, 2011), socio-economic deprivation, and entering a single-parent family at birth (MSD, 2010). Maori score more highly on these than any other major ethnic group within New Zealand. In 2006, 24% of Maori households were run by a single parent (MSD, 2006).

It was found that 36% of Maori infants under 1 year old were living with a female sole parent. In 2006, the mean income of Maori was 73.2% of that of non- Maori, and 17% did not have enough money to manage every day needs (Kiro, 2011). As Kiro (2011) explained, because Maori women have children younger than Pakeha, they are less likely to have formal education, a secure income and a stable relationship. Previous research has uncovered concerning consequences of adolescent pregnancy (Howard, 2008) - solo parenting, lack of education, unemployment, poor health, low socio- economic status. Statistics have also shown that Maori as a group have far higher rates of teenage pregnancy than any other group (Families Commission, 2011). In spite of these grim circumstances that young Maori parents are therefore more likely to be in, an insufficient amount of research has been done to better understand their specific experiences.

Any new parent can experience the societal burden placed upon them to raise their child well. This burden is much heavier for young parents who must challenge stereotypes and negative preconceived ideas about themselves as inadequate, irresponsible parents (Breheny & Stephens, 2007; Hanna, 2001). Adolescent pregnancy is currently deemed to be a public health care problem (Lawlor & Shaw, 2000); a description which suggests that we are living in a time and place where adolescent pregnancy is not socially or economically acceptable. As a result of adolescent pregnancy being socially unacceptable, young parents report feeling stigmatised, marginalised and judged (Hanna, 2001). Marginalisation is even more evident in young Maori parents, who are already discriminated against due to ethnicity (Arlidge, Abel, & Asiasiga, 2009).

Despite the apparent concerns, there appears to be little research that has brought the voices of Maori adolescent parents to the fore. In order to contribute to an understanding of the research literature in relation to young Maori parents, this report provides an overview of:

- Maori health
- International and national research on adolescent pregnancy and parenting
- Contact with health systems and support

Maori health overview

Maori are more likely than European to report poor or fair health, poor mental health, poor cardiovascular health and poor physical functioning than Europeans (Harris, Tobias, Jeffreys, Waldgrave, Carson, & Yazroo, 2006). This study also indicated that Maori are over ten times more likely to experience three types of discrimination than Pakeha. It appeared that the mixture of discrimination and deprivation accounted for much of the disparities in health outcomes for Maori. Much international research has identified a correlation between racism and inequalities in health outcomes (Krieger, 2003; Nazroo, 2003), and this is also reflected in a number of New Zealand studies on Maori people. These literatures suggest that Maori as a general population are at risk of poor health outcomes, which is facilitated by societal racism. This emphasises the need to understand their experiences within the public health care system specifically, as this is where health inequalities are not only dealt with but also generated or exacerbated.

Mason (2006) discusses how the use of 'closing the gap' methods or intervention- type solutions is damaging, as they further highlight the disparities between Maori and non-Maori. This results in the employment of a deficit model, which portray Maori youth as problematic. The deficit model is discussed as detrimental to the outcomes of Maori youth, as it attributes negative outcomes as a consequence of character, as opposed to negative life circumstances. Because it is preoccupied with the gap between Maori and non- Maori youth, it provides a warped representation of Maori simply failing, denying those who are succeeding. Mason (2006) identifies how there are many agencies established to counteract negative behaviours and consequences, while there are so few which focus on positive outcomes and potential of young Maori. Providing young Maori with such opportunities would not only show them a more balanced representation of themselves and their capabilities, but it would also give the wider, dominant population a chance to see this vulnerable group as more than at risk and problematic.

The report from Te Ara Hou (2011) also discusses the difficulties in using the 'closing the gap' approach, because the gap becomes the issue. Framing barriers that Maori face by comparing to non- Maori, and using this as a benchmark is inadequate. Viewing issues such as Maori adolescent pregnancy through this lens frames the problem through a western perspective, overlooking how Maori themselves may feel about this. More obviously, using

non- Maori (usually Pakeha) as a source of comparison only serves to keep Maori in their subservient position, showing Maori youth that they are less than their non- Maori counterparts. Like Mason (2006), this report also states that it is important to represent such issues within a Maori framework; what constitutes a 'good life' and well- being to Maori is more valid than non- Maori's perception of a 'good life' and how Maori fit within this. New measurements therefore need to be developed which reflect Maori values, beliefs and potential.

The He Ara Hou report by Henare on New Zealand's children proposes that when devising government policies concerning youth, Nussbaum's list of central capabilities (Nussbaum, 2007) should be considered. This systematic list outlines what each human should have the freedom to possess, and this can serve as a benchmark. The list includes the right to good bodily health and integrity, and Henare discusses in the He Ara Hou report (2011) how using this approach would mean needing to develop a Maori Development Index utilising Maori values based data.

Te Whare Tapa Wha is a useful model in understanding what is important for Maori concerning their health (maorihealth.govt.nz). A person's wellbeing is likened to that of a whare/ house, where each of the four walls symbolise Taha Tinana (physical health), Taha Wairua (spiritual health), Taha Whanau (family health) and Taha Hinengaro (mental health). All four cornerstones must be sound in order for the person to be well overall. This is an important concept to bear in mind, particular in areas such as sexual health. Rochford (2004) explains how this can be used as a vital tool in health assessment, as modern health services may not always acknowledge the importance of taha wairua (the spiritual dimension). There is a clash in values between traditional Maori health care approaches in comparison to western techniques, because in a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are just as important as the physical symptoms of illness. Considering the concerning inequalities in health between Maori and Pakeha, this tool has been used as a way for Maori to regain control over their health care.

Mason (2006) emphasises the importance of whanau in determining a child's success, justifying this claim by discussing how children are a product of their environment. This means that positive, stable relationships with family are needed from a young age. When others expect little of the child, the child is less likely to resist and prove them wrong.

Mason believes a self fulfilling prophecy is utilised, which can explain the poorer outcomes for Maori youth. It is important to find ways which encourage youth to believe that they are capable of more than these predictable outcomes such as adolescent pregnancy, as opposed to enforcing interventions to prevent problematic behaviours.

The Families Commission report (2011) stresses that it is not Maori ethnicity which predicts adolescent pregnancy but the fact that Maori as a group are more likely to suffer from many of the negative circumstances which increase the risk of this occurring. Consequently, closing- the- gap methods are often used to help overcome these problems young Maori face, which is later to be discussed as creating problems in itself. The 'Improving the Transition' report on Maori youth by Cunningham (2011) outlined three models to explain the discrepancies between Maori and non- Maori. The following models can be used when critically analysing the validity of Maori ethnicity being an indicator of adolescent pregnancy:

Social*:* *The Determinants Model:* The social and economic conditions that Maori are more subjected to increase the risk of poor health. Further, social determinants are important as they impact on whether a person stays in good health. They include physical, social, and personal resources to identify personal needs, aspirations and ability to cope with environment. Limited resources mean increased risk of poor health, which can explain why Maori suffer from poorer health.

Cultural: *The Cultural difference Model:* It explains how ethnic stereotypes are hidden within certain environments including the media and professional settings such as secondary schools and universities. The deficit model is most evident when the inequalities between Maori and non- Maori are considered. The cultural- difference model describes how the social environment, patterns of learning and sociolinguistic environment are largely incompatible with Maori, which therefore hamper their ability to grow, and denying them of opprtunities to succeed.

Racism: *Colonisation- Racism model:* With colonisation came the loss of land, rights, spirituality and language for Maori which resulted in the negative outcomes that they currently face. This is facilitated through racism in a number of forms: 1. Institutional racism: Embedded within policies and practices preventing the oppressed from

access to resources. 2. Personal racism: an individual's own negative attitudes and stereotypes may cause him/her to judge discriminate. 3. Ethnocentricism: beliefs, values and ideas are embedded into social representations which favour the dominant group. The deficit model employed in health research frames ethnicity as a predictor of adolescent pregnancy, which is an example of institutional racism.

International research on adolescent pregnancy and parenting

Adolescent pregnancy has long been considered a public health problem (Lawlor & Shaw, 2002), and much previous research has sought to understand a number of issues surrounding it. A great proportion of research has covered contributing factors that increase the risk of adolescent pregnancy, such as socio-economic deprivation, parental/ family change and being born to adolescent parents (Howard, 2008). Literature has also described the outcomes of adolescent parenting which predominantly explain the potential for an intergenerational cycle of adolescent pregnancy. This is characterised by long- term benefit receipt, lack of education, crime and violence (Holtz, McElroy, & Sanders, 1999; Meade, Kershaw, & Ickovics, 2008). Conversely, there have more recently been attempts to cover the positive outcomes which can result from becoming a teen parent, such as new skills, an increased confidence and self- esteem (Collins, 2010). More importantly, it can give the opportunity for these youth to start over from the adversity and negative life events that they may have experienced themselves as children (Tuffin, Rouch, & Frewin, 2010). Such literature suggests that teen parenting may provide a focus for initiatives that support young parents towards successful futures.

Much international indigenous research on parenting has revealed experiences of marginalisation within the health care system, such as that of Browne and Fiske's (2001) work on the First Nations Women of Canada. This revealed examples of individual and institutional discrimination, and disadvantages due to race, gender and class. One participant described how she took her child to hospital due to a worsening nappy rash after the medication prescribed by their local doctor did not help. The child was taken off her by hospital staff and taken into state care because they assumed the child was being subjected to neglect and violence. This occurred without checking any medical history or contacting the child's doctor for information. Browne and Fiske (2001) state that mainstream health care and health research can help in constructing colonised

representations of indigenous people as' bad' parents, disorganised, and dependent. This fosters uneven power relationships which can be shown through paternalism and dependency on public health care. Arguably, this is further fuelled by uneven media coverage on poor parenting in 'minority' groups.

Negative health care experiences of indigenous parents are echoed in studies focusing on the Aboriginal people of Australia (Watson, Hodson, Johnson, & Kemp, 2002). Like many other indigenous groups, Aboriginal people have high rates of adolescent pregnancy (Senior, & Chenhall, 2008), and once again, little research has been done to identify their experiences with the public health care system. A recent study by Downey and Stout (2011) analysed the experiences of young Aboriginal mothers during and after pregnancy. Most participants commended staff on their patience, support and advice. It appeared that these were all characteristics in hospital workers which mothers valued while giving birth. Regardless of this, the significant amount of negative feedback that participants gave due to racism and ageism indicates that there is still much to improve on. One participant stated

> *"Like me, I'm half. You can't tell because I look like my dad. My mom is Aboriginal and my dad's not. I think that's why I was treated nice. I really think so because my sisters, they have different dads, and their dads are Aboriginal so they're full. And they're always treated bad. It depends on who you get but you don't see a lot of Aboriginal nurses working. Once in a while you will; they are actually the nicer once, always. They're always nice." (p. 40)*

Interviews with the participants suggest that there needs to be more sharing of health related information by health professionals during labour and birth. A number of the young women saw their doctors as detached and were confused and frustrated by conflicting information they received from nurses. The report advises that health care workers need to be better educated on how to provide young Aboriginal people with support and advice. However, it is difficult to state with certainty whether these experiences were in relation to age and ethnicity combined, as a number of articles concerning Aboriginal parents suggest that their ethnicity alone can lead to inadequate health care.

Another Australian study on Aboriginal parents (Watson et al, 2002) found similar experiences reported by mothers giving birth, which inidcates that ethnicity alone can lead to being provided with poorer health care. Insufficient information and support that was

given to them often resulted in miscommunication, loneliness and frustration, where mothers felt hesitant to ask questions. One mother signed a form that she could not read properly, which was asking for her permission to be sterilised during caesarean section. What can be perceived as miscommunication and lack of education in this case, can also be seen as an example of racism because she did not have the written English skills needed. A particular point was made that health care workers need to be more properly educated in working with those of different cultural and spiritual beliefs. This is reiterated in spite of the fact that it was indigenous people who were being cared for, whose needs and beliefs should already be understood and respected.

Regardless of ethnicity, adolescent parents are a marginalised group in society. International research such as that of Yardley's (2008) discusses how teenage mothers are typically represented as a "homogenous group of immature, irresponsible, single, benefit-dependent, unfit parents" (p. 671.). Consequently, teen mothers report feeling stigmatised, particularly in their use of public services such as clinics and hospitals (Yardley, 2008). Yardley's study interviewed various young mothers in England, one of whom stated that

> *"a few times when I've been into the clinic […], I go with my mum. And the nurses and that, they talk to my mum rather than to me, they treat me as if I'm a child" (p. 676)*

How participants dealt with this stigma varied, ranging from disassociating themselves from the 'teen parents' group, to confronting those who discriminated against them. Participants made the point that how one deals with criticism is challenging, because actively responding to discrimination (e.g. verbally) may give support to preconceived ideas, such as adolescent mothers as immature or overdramatic. Conversely, a passive response may mean that these predetermined ideas that the critic has are not challenged, therefore making them more legitimate. This makes encounters with the public, and with public health care system to be difficult.

National studies on adolescent pregnancy and parenting

It is promising that, of the sparse national research that has been performed on adolescent pregnancy, a considerable amount of recent work has been qualitative studies which aim to understand New Zealand teenage parents' experiences (Dickinson, 2011; Collins, 2010; Rawiri, 2007; Tuffin, Rouch, & Frewin, 2010). In particular, the work of Tuffin and

colleagues has been useful in trying to unsettle stereotypes that are rife in New Zealand concerning young fathers. It focuses on how young dads are placed in an undesirable position, due to the difficulties they face in meeting specific societal expectations of being an acceptable father. These expectations include active participation with their children, stable relationship with the child's mother and most importantly, the traditional requirement of the father as 'breadwinner' for his family. Interestingly, the study identified a strong desire from participants to overcome stigma and defy stereotypes of being absent and neglectful, focusing on providing their child with resources and support to ensure a better childhood than they themselves may have experienced. Despite these desires and what positive steps these parents took, this is not well represented in literature concerning young parents.

Reports of experiencing difficulties as a young parent echo within other New Zealand studies (Collins, 2010) and this is supported by a discourse study by Breheny and Stephens (2007). This study aimed to understand New Zealand health professionals' constructions of adolescents and motherhood. It discussed how adolescent parents are portrayed within health professional literature as incompetent parents, and this is revealed in interviews with medical professionals through what Breheny and Stephens describe as the 'development discourse' and the 'motherhood discourse'. The motherhood discourse involves prescribed behaviours and characteristics that are deemed appropriate in order to be competent and legitimate parents. The most crucial aspect of the discourse is love for the child. This is a paradoxical situation for an adolescent mother, as one midwife describes their positive reactions to pregnancy as 'immature' and 'naïve':

> *"The young women tend to get all clucky if they want to carry on with the pregnancy […] and no one seems to take on board that this is going to be you know years of broken sleep…"(p.121)*

However, if the mother appears to be serious in her role as a parent, this can be interpreted as uncaring. Participants consistently made comparisons between adolescent mothers and "good" mothers. They gave examples such as being on a budget but spending money on expensive toys, suggesting the affection but not the skills and abilities to qualify as a good parent. Their behaviour is interpreted through a set of predetermined judgments, not only in relation to whether they conform to narrow notions of a 'good' parent but also by being judged whatever their behaviour, often placing the parent in a no win situation. Any behaviour which does not fit within these narrow boundaries of the motherhood discourse

can be used as evidence of their incompetence. It appears that within this discourse, 'bad' mother and adolescent mother are synonymous. It would be interesting to understand a health care worker's opinion of an older mother breaking the boundaries of this discourse, like spending money on expensive toys.

Breheny and Stephens (2007) also discuss the 'development discourse' that employs the logic that with aging comes maturity and thus capability as a parent. Like the motherhood discourse, this puts adolescent parents in a challenging position. According to this theory, adolescents have an apparent set of shared characteristics which fit within the stage of 'adolescence'. This includes an inability to think ahead and putting their own needs first. Participants reported feeling that adolescence was a crucial time for maturing- a maturing, however, that is different from what a young person can gain from becoming a parent. The article challenges this idea as

> *"the development through the stage of adolescence is a process of simply adding years to the young women's age, rather than negotiating particular life stages and skills" (p. 115)*

The development discourse suggests that in relation to preconceived ideas of adolescent parenting, maturing only comes with time, overlooking the possibility that each individual matures at different rates, and that life experiences can be influential in maturing. This shows that the stages and phases framing of maturity is clearly an accepted idea within the public health system, and this is supported by undeniable societal and biological developments during adolesence (Improving the Transitions report, 2011). However, accepting this theory does not fully justify the stance that all adolescents are irresponsible and selfish, therefore making them unfit parents. In spite of how disputable this perspective may be, the study indicates that this is a belief that is held by public health care workers. Browne and Fiske (2001) argue that the encounters which marginalised people have with public health care workers are vital, as they can be reflective of institutional values. This theory can also be applied in relation to young parents to support the stance that institutional discrimination is prevalent with adolescent parents in New Zealand.

Some national research has touched on adolescent mothers' tendency to not follow public health care procedures (Breheny & Stephens, 2007), accrediting this as characteristic of a 'typical' adolescent, who has poor time management, is self-centred and unreliable.

However, in light of the previous research, demonstrating that behaviour is interpreted through predetermined notions, it is worth questioning these interpretations. An international study by Hanna (2001) exploring the struggles of teenage motherhood found that a significant issue for mothers was interacting with health professionals. This problem of not following standard health care procedures, such as making regular appointments was offset by participants feeling that nurses were 'authoritative' and 'bossy'. The unique circumstances that young mothers were in meant that, while they wanted to be treated like any other mother, they expected staff to recognise that they also had additional needs and they needed to be offered information and advice in a way that was not patronising. Because these needs were not met, they felt that avoiding using health care services was easier than actively challenging it. Rather than attributing it to issues of the adolescent's character and making negative judgements of young parents, it may equally be indicative of a health system that is not safe for them. It also shows that the public health care system prefers to simplify the fact that all young parents are different, by categorising each into this same reductive category, not doing much to acknowledge both individual difference between adolescent parents, and patterns of institutional discrimination.

Considering that adolescent mothers are viewed within the public health care system as not meeting appropriate standards as parents (Breheny & Stephens, 2007), it is not surprising that these parents report feeling under surveillance within this setting (Breheny & Stephens, 2007; Yardley, 2008; Hanna, 2001. De Jong (as cited in Breheny & Stephens, 2007) explained that young mothers reported feeling watched by health professionals , dreading consequences such as having their child taken off them if there was reason to believe they were unfit parents. According to Hanna (2001) this issue of surveillance is reported to be more prevalent concerning financial support from government, where seeking or receiving assistance comes with extensive public scrutiny. It is clear that how a young parent is perceived by society is flexible depending on circumstance. In situations where the parent receives government support, she/he should be classified as an adult, making their struggles less legitmate as they are just as much a parent as any other. However, in most other situations, they are simply children having children. Because young parents are supposedly children themselves, still naïve and immature (Breheny & Stephens, 2007), public surveillance is considered justified. While fear of surveillance is deemed to be a problem that needs to be attended to, it reaches beyond the health system. This is

because it requires changing the societal and institutional attitudes towards adolescent parents as incapable and a government dependant.

Services and support

Predictably, with childbirth comes contact with the public health care system, and as discussed, both international and national qualitative and quantitative research have described discrepancies in providing and accessing health services among minority populations including Maori. A recent national study was conducted by Arlidge et al (2009) on whanau/ families experiences when admitting their injured children to hospital. While many parents commended staff, crucial issues were raised such as poor communication and information, discomfort with a foreign environment, and issues of cultural miscommunication. Maori and Pacific parents felt particularly marginalised within the hospital setting and did not feel fully able to access services and information that were of a high standard. One Pacific mother stated

> *"I started getting a bit paranoid because I think I was thinking I wonder if these Palagi* (New Zealand European) *nurses are looking at me going 'I wonder if this is one of those cases where they've, where the mother's broken the arm" (p. 176)*

This mirrors the experiences of First Nations mothers previously discussed (Browne & Fiske, 2001), where indigenous people were constructed as being 'bad' parents, who were neglectful and violent. For the study by Alridge et al (2009), this theory of Browne and Fiske's is demonstrated through Maori and Pacific parents' reports of feeling judged as incapable parents based on their ethnicity. Therefore, this suggests that simply being a Maori parent can lead to public health care experiences of marginalisation and discrimination.

Kiro (2011) explains that Maori parents prosper when they have more support, which means that they and their children are more likely to overcome barriers to succeess. Because Maori parenting has become impacted on by the national and international context, Maori too face problems associated with changing family structure, urbanisation and increased participation of both parents in the work force (Kiro, 2011). It is worth noting that this also means a longer working life for grandparents, so parents may rely less on them for support. The breakdown of the traditional whanau structure of extended family

living in close proximity has meant that Maori parents do not have access to the same kind of whanau support that their parents and grandparents may have received. However, Abel et al (2001) identify whanau support as crucial and note that Maori/ Pacific Island families are more likely than any other major ethnic group to reside with extended family members, who participants reported to be of significant support.

A recent study explored young Maori mothers' experiences with social support during and after pregnancy (Rawiri, 2007). The stories and situations of each participant were different, which suggests that there may not be one type of 'solution' to best meet the needs of young Maori parents. However, there were some commonalities. Stress, depression and violence were common themes, and social support from friends and whanau was strongly identified as essential to the mother and child's wellbeing. In particular, the support that was offered from teen parenting units was unsurpassed; so much so that some felt they would not have been able to continue in their education if it were not for the units.

Various teen parenting units such as the Taonga teen parenting unit in Auckland have been established to educate and nurture young Maori parents and their children guided by the theory of Kaupapa Maori, as this organisation is run by Maori, for Maori. The TAONGA Education Centre Charitable Trust's presentation at the Auckland Community Hubs Forum (2011) reports that whanau is treasured, and this is no different for young parents and their children. The organization holds a ceremony where each child is offered a pounamu, symbolic of their pledge to do their best to care for and love the child. Students are educated through strategies that are culturally appropriate (e.g. learning of Te Whakakoha Rangatiratanga/respectful relationships with others and the land, Kaitiakitanga/ responsible leaderships and passing on of knowledge and gifts. This approach is responsive to the needs of the parent and child, where they are both valued.

When considering the marginalised position that both Maori parents and adolescent parents have in society and thus in health care and education systems, it is clear that the experiences and particular circumstances of young Maori parents need to be understood.

Access to information

Access to relevant information is crucial to any parent, because with knowledge comes opportunities for growth and development. In spite of this, obtaining needed information

from health and social service providers is identified as an issue for young Maori parents (Rawiri, 2007). Participants felt that they did not have sufficient access to the information that they needed for parenting. In particular, they had to overcome obstacles in order to understand what kind of support was available to them, including financial support. This barrier in obtaining information is mirrored in the study by Aldridge et al (2009) where Maori parents in particular frequently discussed how they did not want to ask staff for information because they appeared to be busy, and did not want to disturb them with their questions and concerns. One parent stated that

> *"There was actually no one, they were all busy, they had how many patients to one nurse, they were so busy you couldn't ask them, is she gonna be ok, or that kind of stuff" (p. 174).*

In comparison to Pakeha parents who felt they had adequate information concerning their child, Maori felt they lacked information in all areas, and often felt frustrated by this. This raises the question of why Maori and Pacific parents felt as if they were unable to approach staff, when Pakeha should also face the same issue of preoccupied staff who are low in numbers. The study identified that Maori parents in particular felt hesitant to ask staff for help, pehaps indicating need for social desirability. There is also the potential for negative reactions from busy staff if parents asked for support.

The article notes that language is a tool that is used differently by different cultures, and that written material for cultures with a strong oral tradition such as Maori or Pacific may not be the most appropriate. As one parent described

> *"Sometimes they give you a pamphlet, you don't have time to read it, and you need someone to say it out loud. Like there are services available for you and your child, you know. But they should have some people like these based in the hospital that can inform people about these services can help them".*

It is logical that the public health care system take different approaches in providing care to patients based on what is most appropriate for that culture. The literature highlights that this needs to be addressed for Maori.

Discussion

Adolescent pregnancy is an interesting matter, because the ability to fall pregnant implies strong reproductive health which is widely valued in western society. However, from what work has been done to understand dominant views of adolescent pregnancy, it appears that pregnancy at a younger age sits outside of what is acceptable. This is in spite of the fact that a woman is most fertile as a young adult. Adolescent pregnancy is perceived as a problem to be resolved. This is considered through a western lens which begs the question of whether this is how Maori perceive it. The potential for differences in values between Maori and Pakeha may be significant when considering adolescent pregnancy as an aspect of good health, therefore more work is needed to better understand Maori's perception of this.

With adolescent pregnancy comes growth of Maori as a population. Maori are considered to be a fast growing ethnic group in New Zealand, which can be partly explained by higher levels of young pregnancy (stats.govt.nz). While the trend of high levels of adolescent pregnancy among Maori has been problematized, in terms of population growth, it can have positive benefits to Maori as a group. New Zealand is a country that is governed by democracy, which means that resources are allocated partly by population basis. As discussed, Maori lack in resources in comparison to their non- Maori counterparts. An increase in population logically means more resources, which can facilitate growth and success.

The building of Maori as a population through adolescent pregnancy can also be extended to the possibility of adolescent pregnancy building stronger whanau relationships. It has previously been discussed that whanau relationships have shown to be important, especially where sexual health of the child is concerned. Closeness of age between parent and child may possibly lead to intergenerational dependence, which can be seen as a successful outcome. Intergenerational dependence is positive as interconnectedness may lead to strengthening Maori as a whole.

What is clear from the work that has been done on young Maori and on Maori as adolescent parents is that there is no 'one-fits all' solution to support them as youth and as adolescent parents. This is shown In Rawiri's study (2007), as the experiences of each participant were different. Cunningham (2011) explains that Maori youth are a diverse and culturally eclectic group. It is therefore difficult to determine 'what works' to prevent adolescent pregnancy,

especially with reports which indicate that adolescent pregnancy is not necessarily or always a 'problem'. There are possibly many different ways to help young Maori into their roles as parents and more research is needed to understand this. The way in which the parent and child is wanted and celebrated in settings such as the teen parenting units discussed in this review provides a considerable contrast to the ways in which adolescent pregnancy and parenting is regarded in dominant discourse. Certainly the differences between Maori and non- Maori socio-economically, in health and culturally mean that there needs to be specific steps taken to support young Maori

From the research that has been done concerning the wellbeing of young Maori, strong, communicative relationships have shown to be vital. Some research has touched on the importance of parent- child/ child- whanau relationships where sexuality is concerned (Kiro, 2011; Clark, Robinson, Crengle, & Watson, 2006). It has been found that those young Maori who are sexually active and report consistent use of contraception are more likely to report getting enough time with a parent. Kiro (2011) also discusses how the ability for young Maori to overcome hardships is facilitated by whanau support. The potential correlation between adolescent pregnancy in young Maori and relationships with parents is yet to be tested, but considering what has already been found, it is possible that this is significant. If this were true, implementing better strategies to strengthen these relationships is likely to be helpful where adolescent parenting is concerned. There are current government strategies which include focusing on Whanau Ora (2009) , emphasising the need to build on whanau relationships and to work with parents as part of their wider connections. This benefits both individuals and families as a whole. It stresses the need to build on existing whanau structures while strengthening the connection between whanau and provider.

Rawiri's study (2007) indicated how vital social support is for young Maori parents. Whanau should be considered more when examining the abilty of young Maori as capable parents. Cunningham (2011) discusses how strong whanau have structures and support systems which enable their youth to grow and develop. Although not all whanau today fits the traditional extended whanau structure, for many young Maori parents, the support from whanau is a clear advantage in helping them to develop as parents. . In addition, there may be a range of other whanau structures, not necessarily based on whakapapa connections that could foster these same supports and provide advantages.

Maori adolescent pregnancy is therefore complex, in spite of the negative, simplified, reoccurring representations we may see. How to support young Maori as youth and also as parents requires further revision, as there is diversity in every case. Creating safe, supportive environments for young Maori may help in allowing them to make informed, healthy decisions concerning their sexual health. From all that is uncertain on how to best help this vulnerable group, it is clear that young Maori are unique, and have potential that requires specific actions in order to be realised. While it is wrong to take a western perspective in viewing all Maori adolescent pregnancies as unwanted, we must understand that there is more to this group than what we bear witness to in dominant health research.

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