

A pregnant woman with long dark hair, wearing a black and white checkered off-the-shoulder dress, is smiling and gently holding her belly with both hands. The background is a plain, light color.

Empowering Voices:

Evaluating the Whanganui Best Start Model of Care through Hapū Māmā Perspectives

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Background

The Whanganui *Best Start Model of Care* was developed by the Health and Research Collaborative (HARC) to strengthen early pregnancy care for Māori women and their whānau (family) across general practice. This model was created through an iterative, three-stage process that brought together the voices of hapū māmā, clinical teams, and wider community services. The model was designed within a Kaupapa Māori framework, with development led by the Innovation and Research team from Te Oranganui Trust—an iwi-owned health service—in partnership with local primary care practices and HARC.

Module 1—the ‘Hapū Māmā Village’—laid the foundation for the model through hui with hapū māmā and their whānau. Designed by Māori, alongside these māmā, this phase created a culturally-based process that explored experiences and expectations of early pregnancy care. Insights were captured in the Village Insights Report (Healthy Families Whanganui, 2024), which guided the Best Start Model of Care. Where possible, māmā-informed recommendations were incorporated directly into the clinical practice design; however, a number of other recommendations identified broader health system changes needed to better support Māori whānau beyond the scope of the project.

Module 2 (Clinical Team) focused on service design within primary care practices. Using the Best Start pregnancy tool, developed by the National Hauora Coalition (Jardine, 2022), clinicians from a Very Low Cost Access (VCLA) clinic trialled early pregnancy assessments to identify both health risks and social needs. This work highlighted the roles, knowledge, and skills required to deliver effective, culturally safe care. Data were analysed by ethnicity to identify equity patterns, while common clinical issues, training needs, and implementation enablers were identified. Recommendations were then shared and tested across additional practices, including an iwi provider and two group general practices, to refine the model for different primary care contexts.

Module 3 (Wrap-Around Care) extended the model by mapping the community and health resources needed to support hapū māmā and their whānau beyond the clinic setting. Referrals made through pregnancy assessments were reviewed to understand the types of supports accessed and the agencies involved. This reinforced the importance of integrated, wrap-around care that links primary care with midwifery, community providers, and whānau supports to ensure positive pregnancy experiences and outcomes.

Together, these three stages created a flexible, culturally grounded model of early pregnancy care that was accessible through primary care and responsive to the voices of hapū māmā. The current evaluation was designed to explore how this model was experienced by māmā, with a focus on its cultural acceptability, and to identify ways it could be refined and strengthened for wider implementation across Aotearoa.

For a more detailed account of the initial activation project ‘**Early Pregnancy Assessment in Primary Care: Equity-focused Implementation of Best Start**’, the report can be found at: <https://www.harc.org.nz/research-project/best-start-early-pregnancy-assessment>.

The Project

Terminology

Best Start Tool

An electronic early pregnancy assessment tool integrated into the Patient Management System, guiding the provision of quality care for pregnant women.

Best Start Model of Care

A wrap-around, culturally responsive, holistic approach that integrates comprehensive support services, continuous care coordination, and community engagement to enhance early pregnancy care and improve maternal and infant health outcomes.

Early Pregnancy Assessment

Use of the Best Start tool, within the Best Start Model of Care, to identify health and social risks that could impact on pregnancy outcomes.

Early Pregnancy Care

Implementation of actions identified during early pregnancy assessment, within the model of care, such as tailored support, follow-up appointments, and specific interventions to address identified health and social needs.

Hapū Māmā

Pregnant Māori women.

Key Features of the Whanganui Best Start Model of Care

A number of important features of the Whanganui Best Start Model of Care were developed in an attempt to provide hapū māmā with access to wrap-around care throughout their pregnancy journey, particularly during early pregnancy (0 – 12 weeks gestation). These included:

- Regular clinical governance;
- Peer review meetings;
- Peer education, audit and data feedback;
- Best Start lead nurse for task and recall list management;
- Unpressured, protected time slots for nurse appointments;
- Alertness to pregnancy indicators in patient contacts including enrolments, consultations, and inbox reports;
- Agreement on coding and classification processes;
- Active engagement of the wellbeing teams—Health Improvement Practitioners (HIPs) and Health Coaches—through use of ‘warm-handovers’; and
- Follow up care integrated with midwives including the availability of a Best Start clinical summary.

Introduction

Pregnancy care in Aotearoa New Zealand is marked by both opportunity and inequity. Māori wāhine continue to experience disproportionate barriers to early and culturally safe maternity care, with ongoing impacts on both maternal and infant outcomes (Lawton et al., 2013; Tupara & Tahere, 2020). For hapū māmā in the Whanganui region, these inequities have historically included later engagement with maternity services, challenges in transitioning from general practice to midwifery care, and higher rates of pregnancy-related risk factors such as smoking, alcohol use, and maternal mental health concerns (Makowharemahihi et al., 2014; Ministry of Health, 2019).

Despite this, the Whanganui rohe (region) also demonstrates a rich foundation of community strength. Kaupapa Māori approaches such as the recently established antenatal education pathway offered through Te Whare Piringa—a co-designed whānau centric, mātauranga Māori support service offered to whānau through their hapūtanga journey (Healthy Families Whanganui Rangitikei Ruapehu, n.d.)—Hapū Wānanga, the Early Pregnancy Assessment Approach developed by the Whanganui Regional Health Network, and culturally grounded smoking cessation programmes have highlighted the power of local, whānau-centred initiatives to enable positive change (Gifford et al., 2015; Hawaikirangi, 2021). These approaches reflect an asset-based perspective, recognising the resilience and leadership of hapū māmā, whānau, and iwi health providers as key drivers of improved outcomes.

The *Best Start Model of Care* was developed in Whanganui as a locally grounded response to these needs. Drawing on insights from the *Hapū Māmā Village* hui, led by the Research & Initiative arm of Te Oranganui Trust (Healthy Families Whanganui, 2024), and shaped by clinician feedback, the model sought to ensure that early pregnancy assessments were consistently delivered in primary care. Its aim was to identify health and social risks early, engage the wider primary care team, and strengthen integration with midwives and community providers to ensure coordinated, supportive responses (Gifford et al., 2015; Walker et al., 2019). Tested across four diverse practices, including iwi and VLCA clinics, the model embedded Kaupapa Māori principles and community voices at its core.

The current evaluation builds on this developmental work by exploring the cultural acceptability of the Best Start Model as experienced by hapū māmā. Using qualitative interviews, the study focuses on the perspectives of Māori women and their whānau to understand what aspects of the model felt safe, empowering, and useful, and what could be improved. By centring hapū māmā and whānau experiences, the evaluation aims to refine the Best Start Model so that it is responsive, adaptable, and able to be scaled across primary care practices in Whanganui and beyond.

Purpose

The purpose of this study was to evaluate the Best Start Model of Care, in order to enhance its value, by exploring the experiences and feedback of hapū māmā who received early pregnancy care through a Very Low Cost Access (VLCA) clinic or an iwi-owned clinic in

Whanganui. By centring the voices of Māori women, the study aimed to understand the aspects of the model that were culturally acceptable, effective, and supportive, as well as the areas that required refinement. These findings will be used to guide the iterative development of a flexible, adaptable model that will strengthen continuity of care across primary care practices, supporting equitable outcomes for Māori māmā and pēpi (babies), and provide insights to inform wider implementation across Aotearoa New Zealand.

Aims

1. To evaluate how early pregnancy care can better align with the needs and expectations of hapū māmā, ensuring services are responsive and supportive.
2. To refine and strengthen the Best Start Model of Care, drawing directly on the insights and experiences of hapū māmā who have engaged in a Best Start assessment.
3. To optimise the Best Start Model of Care so it can serve as a framework for delivering equitable, culturally safe, and effective early pregnancy care for hapū māmā, with potential for adaptation across Aotearoa New Zealand.

Objectives

1. To describe the experiences of hapū māmā who have engaged with the Best Start tool and Best Start Model of Care.
2. To identify the elements of the Best Start Model of Care that are acceptable, effective, and culturally responsive, drawing directly on hapū māmā feedback.
3. To refine the Best Start Model of Care by incorporating participant insights to strengthen its responsiveness to the needs of Māori women and their whānau.
4. To investigate potential adaptations to the Best Start Model of Care that would support its implementation, continuity, and adaptability across a wider range of primary care practices in Aotearoa.

Methods

This study employed a qualitative approach, using semi-structured interviews to comprehensively understand the Best Start Model of Care from a hapū māmā and whānau perspective.

Semi-Structured Interviews

Semi-structured interviews were carried out with hapū māmā who had participated in a Best Start assessment in one of two research practices—a Very Low Cost Access (VLCA) practice and an iwi Māori practice—within the last year. Both of these practices were involved in the initial development of the Best Start Model of Care. The semi-structured interview guide was developed collaboratively with a senior Kaupapa Māori researcher to ensure questions were relevant, culturally safe, and grounded in principles of manaakitanga, whanaungatanga, and

rangatiratanga. Ethics approval was obtained through the Health and Disability Ethics Committee (HDEC).

Recruitment was led by kaimahi (staff) from each practice. All wāhine Māori who had engaged with the Best Start tool in the past year were sent a text invitation, which linked to a short video on the HARC website featuring a well-known Māori nurse from one of the practices. The video explained the research and encouraged wāhine to consider taking part. From this page, participants could register their interest directly with the research team. A second text reminder was sent one week later, inviting wāhine and their whānau to a 'kai and kōrero' hui at Te Whare Piringa. This hui provided an opportunity to learn more about the project, ask questions, and voluntary sign-up for those who wished to participate. Whānau involvement was encouraged throughout.

Despite these efforts, uptake was lower than anticipated. A final text reminder was sent, and kaimahi from each practice worked with clinicians to engage eligible māmā, in an opportunistic manner, at routine appointments. This approach was conducted in a non-coercive way, and wāhine were assured that their choice would not affect their care. In total, nine hapū māmā participated across the two practices—eight identified as Māori and one as a Pacific Islander.

Participants received a koha of \$60 (supermarket voucher of their choice) to acknowledge their time, expertise, and costs. Interviews were conducted by an experienced member of the research team trained in cultural safety, either in the participant's home or at Te Whare Piringa. Whānau were welcome to attend, and participants could bring their pēpi or children.

At the beginning of each interview, the participant information sheet was reviewed in person, and participants had the opportunity to ask questions. All participants provided written consent, including consent for audio-recording. Interviews were transcribed by a member of the research team, with transcripts de-identified and securely stored. Participants were emailed a password-protected copy of their transcript to review, with the option to make corrections before analysis.

Transcripts were analysed using a reflexive thematic approach (Braun & Clarke, 2021). Coding was carried out in NVivo, and themes were developed individually by two members of the research team, followed by iterative discussions to reach consensus. Interpretations were reviewed by a senior Māori colleague to ensure cultural appropriateness and accuracy. This process aimed to honour the voices of hapū māmā, privileging their lived experiences as central to the evaluation.

Results

The following section presents key themes that emerged from interviews with hapū māmā who received a Best Start assessment at either a VLCA or iwi provider general practice in Whanganui. The findings are drawn from reflexive thematic analysis and reflect both shared and diverse experiences across participants. Direct quotes are included to highlight māmā voices and ensure their lived realities are central to the evaluation. Given the small sample

size, that Whanganui is a small town, and many services are interconnected, where quotes are important, but could potentially lead to identification of the participant, generalised statements are used instead.

The results are presented in nine sections. This includes: 1) Identification of pregnancy; 2) Introduction to Best Start; 3) Best Start appointment/assessment; 4) Barriers to care; 5) Enablers of Care; 6) Best Start Wrap-Around Care; 7) Māmā-Led Insights; 8) Overall appraisal of the current Best Start assessment; and 9) Tailoring of the Best Start assessment and Model of Care.

Identification of Pregnancy by Health Services

Participants described a variety of ways their pregnancies were confirmed or identified within the health system. These pathways influenced how and when māmā were offered a Best Start assessment, reflecting both intentional and opportunistic entry points into care.

Some māmā attended their general practice specifically to confirm their pregnancy:

“So, when I first found out, I found out at home, then I went to the GP and they basically did the same tests that I'd done at home. Sent me to get my bloods done. Then once it was confirmed, they brought me in.” [KI002]

“I didn't really know what to do when I found out that I was pregnant. I didn't know. Do I just call the doctors and tell them I'm pregnant? Which is pretty much what I did. I just rang them, told them I was pregnant, and then they got me in.” [KI004]

Others were already aware they were hapū and mentioned this during unrelated visits—for other health-related issues. These interactions allowed for opportunistic identification, which enabled early engagement and planning for care.

They did some bloods and organised an appointment for a best start to come back and further talk about the pregnancy because I was just there for a check-up, because I thought I had gastro. [KI001]

I think it might have been one of my health issues that I had gone in there [for], but I also needed bloods and that's when they kind of brought it up. Well, we do have a Best Start. that, yeah we normally do with our pregnant mums and that just kind of goes over everything. And I was like, oh yeah, okay then. [KI006]

These opportunistic moments—where clinicians responded to casual disclosures—were particularly valuable for initiating early antenatal discussions with māmā who may not have otherwise sought pregnancy care at that point, highlighting the importance of flexible, responsive care models in general practice settings.

In addition to general practice, some participants engaged with other parts of the health system, such as the Emergency Department (ED) or Whanganui Accident & Medical (WAM).

While these services sometimes served as an initial point of contact regarding pregnancy, they did not always result in clear or timely follow-up.

One māmā described how her pregnancy was initially missed through secondary care, despite expressing concerns:

- KI001: So, I went into the [Secondary Care Service] with severe pain and they did blood and stuff, and they said I wasn't pregnant and did a scan. There was no baby and they put me through...
- Partner: Oh, radiation.
- KI001: And then maybe three weeks later, I was like super sick; spewing, thought I had a tummy bug. And then when I went to [Health Centre], then I ended up being pregnant.
- Interviewer: How was that for you, finding out that way?
- KI001: Pretty awkward. Yeah. To be honest, because I took a pregnancy before I went [to Secondary Care Service] and it said I was. They said I wasn't. And then to go back later on—a few weeks later—to find out, I am. It was just a bit... Not the best way.

This experience highlights a number of important things. Firstly, it demonstrates a missed opportunity for accurate and safe assessment and points to the need for consistent early pregnancy detection protocols across settings. In addition, it poses a question around whether or not, and if so, how potential misdiagnoses are managed and what processes are followed to feed this back to the service in question to ensure that similar presentations in the future have a better outcome. Additionally, it highlights a potential power differential between clinicians and māmā, where māmā's voice (e.g., that she has taken a pregnancy test and it was positive) is dismissed or overridden by clinician mindsets.

Finally, in some instances, pregnancy identification occurred through inter-service communication (e.g., between WAM and the Health Centre), highlighting the role of information flow in linking care. In these cases, information about pregnancy was included in discharge summaries and then detected by someone from the māmā's health centre and actively followed up. While this method of proactive detection of pregnancies by primary care services is an important form of identification, there are two areas that could be strengthened. Firstly, it would be of benefit if the external services who have identified the pregnancy advocate for māmā by proactively ensuring that their medical centre is made aware of the pregnancy. Secondly, there is a need to inform the māmā how the pregnancy was detected and why it would be beneficial to attend the health centre for a Best Start. For example, in one case, a māmā was unaware she had even received a Best Start appointment and only pieced this together during the interview:

- Interviewer: It just sounds to me like they knew you were pregnant. Had you been into WAM at all before?
- KI003: I might have mentioned it...
- Interviewer: Because one of the ways this program is supposed to be beneficial is if pregnancy is picked up an ED or WAM or somewhere else.

KI003: Did I go in to WAM before I went into...? I think I took (Child) into WAM. Yeah, and it might have been.
Interviewer: So, would you have been obviously pregnant at the time?
KI003: No, but I did tell them that I was pregnant.
Interviewer: Ah. That's probably be what's happened.
KI003: Yeah. That'll be what's happened.

These findings illustrate the diverse and sometimes fragmented ways in which pregnancy was identified across settings, reinforcing the value of both self-initiated and opportunistic identification. Consistent early engagement—whether through planned or incidental encounters—enabled timely connection to the Best Start process and highlighted the importance of integrated communication between services.

These findings reinforce the importance of equipping general practice teams with the training and flexibility to identify pregnancy not only during formal confirmation appointments but also through opportunistic interactions. Among the nine māmā interviewed, five (56%) presented specifically for confirmation of their pregnancy, while the remaining four (44%) were identified through other contact points, including routine consultations, Emergency Department or Whanganui Accident and Medical (WAM) visits, and administrative follow-up. This highlights the pivotal role of primary care services in early antenatal engagement—particularly when clinicians are responsive to cues and supported by clear inter-service communication pathways. Implementing structured prompts or brief check-in questions during unrelated visits could further strengthen early detection and ensure equitable access to wrap-around support.

Of note, as the pregnancy journey progressed beyond initial identification, māmā experiences highlighted that timely and coordinated access to midwifery care was a critical next step in maintaining continuity and confidence during early pregnancy.

Introduction to Best Start

Awareness and Understanding

Once a pregnancy was identified, māmā were invited to participate in an appointment for the Best Start assessment. For some, this process was clearly explained and presented as part of a supportive, strengths-based pathway toward improved care coordination during pregnancy.

“She invited us back the following week for a Best Start. She said it was a new thing that they're trying out to make the system a little bit easier.” [KI001]

Others, however, were less aware of the purpose of the programme or unsure whether the appointment was optional or routine.

“They just said, ‘Have you thought about doing the Best Start?’ I was like, I don't even know what that is” [KI005].

“The first [pregnancy] I was definitely keen. I can't remember if it was an option, the first time. I can't remember if it was an option the second time either, but I just said yes because it was it definitely good to refresh.” [KI004]

Another participant recalled being told: “You can come in for a Best Start appointment and we'll go over a few things... injections and things like that... keep an eye on [your] health,” [KI006], but was not initially aware this was a named programme.

One māmā reported confusion about whether she had had a Best Start assessment at all. She discussed a pre-enrolment appointment during which she may have completed elements of the Best Start process but was not told that this was what it was:

KI003: They called it a pre-patient interview to sign me up at the practice...
Interviewer: So, they didn't know you were pregnant when you had to do that?
KI003: No. And they only did me. They didn't do anyone else in the family. I wonder if that was when they did it [Best Start]? Yes, it's just not very clear. [KI003].

In this case, conflicting advice from the nurse and the participant's midwife also undermined trust, and she described feeling frustrated and misled.

“She asked a whole of questions and then she started giving advice against what my midwife had given, because I already made contact with my midwife. So, I didn't listen to her... I didn't need to take any of the things she was telling me to take. I got a prescription that I didn't need. I spoke to my midwife about it afterwards, and she was like, “No, well, you don't actually need any of that stuff because you're already doing all that with the plan that we've got in place.” And then they charged me for the appointment. Which I got told I there wasn't a charge for... Yeah, it's honestly just terrible.” [KI003]

Across all experiences, the way Best Start was introduced shaped māmā expectations and engagement. When offered with clear explanation and a relational, caring tone, the process was generally well-received. In contrast, when the purpose or content of Best Start was vague or inconsistently communicated, māmā were more likely to feel confused or disengaged. This highlights the importance of consistent framing and informed introduction of the programme, grounded in whakawhanaungatanga—relationship and connection—and clear communication.

Best Start Assessment

Acceptability of the Best Start assessment, by māmā, varied depending on their overall experience of the appointment. This section outlines these experiences, including relevance and usefulness of the questions, quality of practitioner engagement, duration and structure of the Best Start assessment, the impact of specific questions, and the role of the māmā's previous history and experiences with health care.

Overview of Appointment Experience

Māmā shared a wide range of experiences of the Best Start appointment, from feeling well-supported and informed, to feeling overwhelmed or uncertain.

Experienced as a Checklist

For many, the Best Start assessment was experienced as a checklist, involving a large number of questions covering their pregnancy, living situation, and past experiences.

“I remember getting asked a whole lot of questions. And then her offering different services for me throughout the pregnancy and then showing me how to find a midwife and where to go next for that. But other than that, yeah, it was just, you know, a bunch of questions”. [KI001]

“They just ask you the questions and they click all the boxes and the screens right there in front of you... They work on their computer screen and it’s just right there and she was just clicking it, whatever I said.” [KI006]

This māmā highlighted a problem that had occurred as a result of a checklist format, stating that sometimes her answers did not fit into the boxes provided. This resulted in the nurse having to adapt and find spaces within the questionnaire where she could write her answers to ensure they were captured, which prolonged the time taken to complete the questionnaire.

“There were a few things that, if I can remember rightly, that she kind of just had to like jot in something, because it wasn't really an answer for her like, I didn't have much of an answer, but we needed to put something to move to the next [question].” [KI006]

Some māmā found the appointment helpful, especially after a long gap since their last pregnancy.

“The questions were like, most of them were pretty straightforward, like, you know—do you have violence in the house and stuff like that, how's your house? And yeah, especially after [number of years] gap, like, it was just good to kind of have like a refresh.” [KI006]

This māmā also appreciated the practical support offered:

They were kind of like oh, we've got this and that, like Plunket, things like that... which I found really, really helpful for us, yeah, with that big age gap. [KI006]

However, not all experiences were positive. For some, the appointment brought up feelings of discomfort or mistrust due to past experiences with the health system. One māmā explained:

“It was hard for me, like I said, because they judged me and all medical places have judged me for my past..., so it was quite hard for me to even try and open up about it” [KI005].

Additionally, the checklist nature of the tool was perceived by some as a box-ticking exercise or too similar to their experiences with some government agencies. Māmā who saw the Best Start from this perspective were more likely to feel suspicious about the purpose of the assessment, limiting the amount of information they were comfortable sharing.

Yeah, it kinda reminded me of, and I guess it's a little bit different with them, but like a WINZ application... So, there was a little bit of, like, I'm not sure I can actually tell you something. [KI002]

Length of Best Start Appointment

Length of the appointment also shaped how māmā felt about the process. One participant acknowledged the value of the session but admitted that the duration created a barrier to follow-up:

"I'll be completely honest, it was that it took that long that it kind of put me off, going back and asking questions again. You're kind of thinking, like, oh, I just went through all that do I have to do it again if I ask a question? I'll be honest." [KI001]

Despite this, however, this māmā reported that, while it was long, "it was enjoyable. She made sure I had everything I needed" [KI001].

Fatigue and morning sickness further complicated the experience for some. One māmā described feeling too unwell to engage fully:

Interviewer: When you think about it, were you actually able to remember what services that that the doctor did kind of suggest or...?

KI002: I'll be completely honest no. So, none of them.

Interviewer: You don't remember them?

KI002: No, because I was so sick, it was kind of like, I was kind of just happy to get out of there by the end of it because I just really wanted to use their bathroom more than anything.

This māmā added, "I found, yeah, being sick and then sitting there for a whole hour was a struggle to concentrate, especially when my stomach just wanted to do other things" [KI002].

Despite the challenges, most māmā acknowledged the relevance of the questions and the need for the assessment to be comprehensive. As one put it:

"I don't see there being much way of shortening it only because the questions are relevant. And some of them do need expanding on for certain people." [KI001]

Relevance and Usefulness of Questions

Participants' experiences of the Best Start questions were mixed, reflecting both the usefulness of the information gathered and the way it was delivered. For some, the questions

felt relevant and helpful, particularly when linked to personal medical history or general health information that would inform care moving forward.

One māmā reflected positively on being asked about her previous pregnancies, noting:

“They asked about my deliveries with my other kids and if I had any health issues in the family... straightforward questions that you expect to be asked, because it gives them insight on how things went the last the last time. So, they know for this time... There’s kind of a pattern with me going overdue.” [KI001]

For others, information about health and nutrition was particularly useful. One participant shared:

“When I think of my Best Start... the main ones that I really gained from it is the dos and don’ts in regards to eating and drinking. That’s probably what I would say is very important.” [KI004]

One māmā had recently moved to Whanganui from the Pacific Islands. She described how much she had appreciated the Best Start assessment, given that the New Zealand system was so different than what she was used to. Having the opportunity to ask questions and learn about the opportunities in New Zealand—such as free midwifery care—had been emotionally overwhelming for her.

I think for me, it’s overwhelming because we don’t get this kind of care back home and like, I think pretty blessed to be here to experience this here in New Zealand... I thought, why not? Just answer a few questions and maybe get to know more about why they have this test and why we don’t have it back [home]. [KI007]

A significant and concerning reflection came from a participant who had felt judged by the person taking the assessment. She described the questions as overly focused on her past, rather than her current wellbeing or pregnancy. She described the way in which the nurse had started her Best Start appointment, the negative and triggering way she had worded her questions—stating “why would you say that?!” [KI005], and the lack of empathy or compassion that she was shown throughout the assessment. This had resulted in disconnection from the process and the decision not to disclose anything to the nurse, which may have put the māmā—or her pēpi—at risk. When asked what she would have valued in this situation, she responded:

“How’s your pregnancy going? Is everything going well?’ Stuff like that.” [KI005]

These varying responses highlight the importance of sensitivity and individualisation in questioning—ensuring that māmā feel both respected and supported during the Best Start process. Questions perceived as judgmental or irrelevant may undermine trust, while those that feel affirming and useful can support engagement and continuity of care. These findings point to the importance of whakawhanaungatanga, and manaakitanga (i.e., creating a safe and welcoming space) if the Best Start Wrap-Around Model is going to be experienced as culturally acceptable to Māori hapū māmā.

Quality of Practitioner Engagement

Māmā consistently spoke of the importance of the way in which the nurse engaged with them during the Best Start assessment, citing the benefits of whakawhanaungatanga, proactive and open-minded practitioners, appropriate provision of information around the Best Start tool, and nurse competence conducting the Best Start assessment.

Whakawhanaungatanga and Relational Care

Relational connection—whakawhanaungatanga—was a central component of positive experiences. One māmā said:

“She was so good. I'm one that, I don't connect well with people that don't connect well with me. And I really felt like she really cared... she came up with conversation within the survey and stuff as well.” [KI002]

Another reflected on how warmth, personality, and follow-up created a sense of trust.

“Like, you know, they're not just there to do their job... Like you're not just going in there for that and then 'see you later' kind of thing... I felt like a few of them... would kind of follow-up just to make sure that everything was okay. Like that, you know, knowing that she would do that made me feel comfortable, like, ever seeing her again... It's all those little things that make it a little bit easier for that person.” [KI006]

In contrast, the absence of whakawhanaungatanga during the appointment led to reduced engagement and confidence within the process.

“...You'd expect... whakawhanaungatanga or whatever. I couldn't believe it... I even said, what's your name? It's shocking, eh. It's really tragic, honestly. It's bad... She was training this lady too... I was like, so confused. Yeah, it was very weird” [KI003].

These experiences highlight the value of relational care during the Best Start assessment—when genuine connection was made beyond the clinical process of a formal checklist, māmā felt acknowledged, safe, and supported.

Proactive and Open-Minded Practitioners

For some māmā, having a proactive practitioner was crucial to feeling supported throughout the Best Start assessment. This was particularly evident when the nurse had previously confirmed the pregnancy or provided past care. One participant recalled that when it was clear that she needed guidance around her pregnancy, the nurse quickly got the Best Start process underway:

“I [did] that big survey, for starters... It was pretty big. But the person who I had kind of already connected with me and knew a lot of the questions, the answers to a lot of the questions, so to kind of save me with the boring stuff... She kind of [did] some of it.” [KI002]

These existing relationships helped make the process smoother and more personalised. Participants also described the nurse's role in making the logistics of the appointments easier:

KI001: Oh, no. [Nurse] made it really easy. So straightforward, yeah.
Partner: No, I thought they're pretty good eh? But it could have just been the nurse, but I thought, yeah, they're actually pretty good."

Some māmā also appreciated being supported around when and how to disclose their pregnancy, particularly when this was provided without a sense of coercion to make a specific decision. One māmā, who was being careful about who knew of her pregnancy, explained:

"They encouraged me to let people know. So, I had that support... we just wanted to wait till we felt it was right." [KI004]

Open-minded, non-judgemental care was especially meaningful for younger māmā or those making complex decisions. One participant shared:

"I think the biggest help was, it sounds cliché, but just that they were, the person I had was like real open, gave me all the options whether I want to keep a baby or not continue with my pregnancy... So real, non-judgemental. Yeah. Just laid the options out—these are the choices." [KI002]

This approach helped build trust, enabling māmā to feel heard and empowered in their pregnancy-related decisions.

Information Provision and Informed Participation

The provision of clear explanations around various aspects of the Best Start assessment—such as the purpose of the Best Start assessment, the types of questions that would be discussed, and the likely length of the appointment—were a vital aspect of whakawhanaungatanga. For many māmā, this was their first experience with the Best Start assessment and some required the nurse to take extra time to explain the purpose and process of the Best Start assessment in a way that made sense for them—so they could truly understand what they were being asked to take part in, and make an informed decision about their involvement.

The [Best Start] was more detailed, more informative in terms of the questions that I asked them. How [Nurse] answered them was pretty good... I think it was very informative for me... the way she presented the questions to me. It made me like comfortable enough to share... I was more open to share because she set a good environment. She explained what the test was about... So yeah, it was really good. [KI008]

"Just the follow-up... making sure at the appointment, like you're feeling comfortable within what's being discussed. And that you understand it... [so you're] not just walking out and being like, oh, I should have questioned that..." [005]

In addition to this, the opportunity to opt in or out of the process contributed to a sense of autonomy:

“I think I had a pretty good experience, other than the fact that I was tired, but that was just 'cause I was pregnant... I think, the good thing was my nurse was quite specific, like ‘we’re doing this’. You can opt into it, or you can opt out.” [KI002]

Even when māmā felt fatigued or were experiencing morning sickness, clear communication helped ensure they remained informed and engaged.

Competent Practitioners

Having a competent practitioner was highlighted as an important aspect of relational care. For māmā, competence extended beyond clinical skill to include good communication, willingness to follow-up with a doctor if they were unsure about how the patient’s medical conditions may impact on the pregnancy, and good knowledge of the tool to allow for engagement rather than concentrating on the screen. One māmā described the appointment as “triggering” and when asked what had led to this response, she replied:

I'm not sure. I think it was that whole, the fact that she was just very clinical, didn't even introduce herself. And it was very robotic. [KI003]

In contrast, some māmā shared that their nurse’s gentle and open way of communicating made them feel comfortable and supported.

“I know that there can be some nurses that would just sit there and read every single question to a T. And that would be boring for me. Whereas she came up with conversation within the survey and stuff as well.” [KI002]

Finally, the nurse’s thoroughness and willingness to check details helped build confidence in the care being provided.

“She went and asked the doctor a few things... it was good that she went and got a second opinion.” [KI006]

Preferred Practitioners

For many māmā, the practitioner’s cultural identity, gender, and life experience shaped their sense of safety and comfort. One māmā said:

“The doctor that I had... she was Māori... she did have a good understanding. I just remember her saying something about how as Māori we love, like kaimoana and stuff... it was good to have her have that understanding as well.” [KI004]

Another participant appreciated that both of her nurses, across two pregnancies, were Māori, which had contributed to her feeling more comfortable opening up in the assessment.

“From like a cultural point of view, I felt comfortable” [KI004].

Practitioners who were female—especially those who were also mothers—were seen as more relatable and trustworthy.

“That’s what us māmās want to feel safe and to go to a clinic like that... We rather feel comfortable to open up to someone that’s, like, a female... a female for me is definitely a big thing for me... it has to be a female” [KI005].

Interviewer: Okay, so was your nurse practitioner a mum?

KI005: Yes, she was... That made me feel more comfortable.

One participant suggested that younger nurses were more welcoming and easier to relate to, contrasting this with a perceived attitude of older staff.

“The nurses... they were welcoming, like I had, I think a few of them were quite young, so like it was nice... You can get some older ones that may be not so welcoming and you kind of, well, I don’t want to say too much.” [KI006].

Presence of Nursing Students

A few māmā mentioned that there had been a nursing student present during their Best Start assessment. Experiences with the students varied, with some māmā suggesting it had added to their discomfort during the appointment and others suggesting it had added a little light relief. The need for whakawhanaungatanga was even more apparent in assessments that included a second clinician (e.g., a nursing student). In situations where this was lacking, māmā were less comfortable and less engaged in the process than other māmā:

“It was really awkward and uncomfortable... Neither of them [introduced themselves]... You’d expect... whakawhanaungatanga or whatever. I couldn’t believe it... I even said, what’s your name? It’s shocking eh. It’s really tragic, honestly. It’s bad... She was training this lady too... I was like, so confused. Yeah, it was very weird” [KI003].

For others, however, having a nursing student present was experienced more positively:

KI001: I always say yes to students, because if you don’t get the practice, how are you meant to learn?

Partner: She was actually pretty good... I just liked how she looked after my missus”.

Of note, when students were actively engaged in the assessment and were given the opportunity to ask questions during the appointment—to further their own understanding of the tool—māmā felt more comfortable with them being there:

“I found it a lot more easier because she was asking the questions I wasn't really wanting to ask... She would, like laugh at some things just like, ease the lighten in the mood.” [KI001]

These accounts highlight the importance of respectful communication, clear roles, and active participation when involving students in sensitive assessments.

Duration and Structure of the Best Start Assessment

Māmā and their whānau varied in their opinions around the length of the Best Start assessment. Some of the participants felt the appointment was too lengthy.

“It was long. I just sat there and turned on the phone. It was long.” [001 Partner]

The length of the assessment was particularly frustrating for māmā who, prior to the Best Start appointment, had not been given clear information about the purpose of the assessment and the likely timeframe. Many māmā discussed having to fit their medical appointments around work and children, so the lack of specificity around how long the appointment was going to take led to frustration and decreased engagement with the Best Start process.

KI003: Well, yeah, because what I would have expected would be a half an hour appointment ended up being an hour and a half longer because I had to wait for half an hour before I even got into the appointment or whatever it was. And then the appointment was really long.

Interviewer: So, did you not know it was going to be long?

KI003: No, I didn't know it was going to be that long... So, I think, knowing that would be good when I booked it in because I had work.

Although the Best Start assessment process could be lengthy, the sense of connection with a responsive and familiar nurse made it more manageable for many māmā. This was especially true when there was an existing relationship—such as a nurse who had previously confirmed the pregnancy or supported the māmā with other health needs. This relational continuity helped reduce the burden of the long process.

“I didn't feel like it was too long. Probably a little bit longer with the other health issues than her just checking in with the doctor and stuff like that. But apart from that, like, they were pretty much straight, easy questions.” [KI006]

Another participant reflected on the value of clear communication:

“Oh, no. [Nurse] made it really easy. So straightforward, yeah” [001].

Comments about the structure of the Best Start assessment mainly centred on the length of the appointment, with some māmā comparing it to similar questionnaires with midwives or other clinicians during previous pregnancies.

KI001: With my first pregnancy, my midwife asked a lot of those types of questions that I was asked in the Best Start, but it was over the first three appointments at the start of my pregnancy. So, like, for me, I found it a lot easier and she expanded on every single little thing, so I didn't have to go back and ask

questions. And I kind of thought that was a really cool thing because this time around I was like, it got a bit draining after 40 minutes.

Partner: Yeah, but the midwife you had then, she had like 30 years experience.

Some māmā described the assessment as a computer-based process, led by the nurse who entered their responses by selecting from predefined options. While this was generally straightforward, a few participants pointed out limitations in the format—particularly when their answers did not quite match the available tick-box options. In these instances, the nurse would need to record their responses manually in alternate sections, highlighting the rigid nature of the system and the need for flexibility to reflect more nuanced answers.

So they answer all the they just ask you the questions and they click all the boxes and the screens right there in front of you. Yeah. So, they work on their computer screen and it's just right there and she was just clicking it, whatever I said... There were a few things that, if I can remember rightly, that she kind of just had to like jot in something, because it wasn't really an answer for her like, I didn't have much of an answer, but we needed to put something... The longest part was probably her trying to jot in the gaps and then, yeah, seeing the doctors about my other health issues. [KI006]

Impact of Specific Questions

Participants' experiences of the Best Start questionnaire varied widely depending on the nature and delivery of specific questions. While many māmā found the content appropriate and understood the reasoning behind each topic, others described moments of discomfort or emotional impact—particularly when questions touched on sensitive areas such as family environment, past trauma, or mental health. The following sections outline the range of responses, from those who experienced minimal impact to those who found certain questions challenging or triggering.

Minimal Impact

For many māmā, the Best Start assessment questions were not experienced as intrusive or upsetting. Several felt the topics covered were both appropriate and expected, including those related to smoking, mental health, and housing. One participant reflected positively on the smoking-related questions, noting:

KI001: She kind of extended her speech on smoking and the health issues... She says but you don't have to [quit].

Partner: And I was, nah I'm alright"

Others appreciated the opportunity to discuss mental health, saying, "I really liked all the questions, especially mental health, that was really good" [001], and "[The questions] were fine... I think I'm just in a very good and safe situation" [004]. These types of questions were really important for the māmā from the Pacific Islands, as they opened up space to learn how and where to access mental health and wellbeing support if she needed it:

“I think it was really good when she said that if you’re getting overwhelmed, you’re stressing and you feel like you need to, [Health Centre] has... that wellbeing thing.” [KI008]

In general, participants found the assessment to be affirming and easy to engage with, noting that while some questions were sensitive, they understood why they were being asked:

“It doesn't make me feel uncomfortable... Maybe if I was experiencing something relative to the question, then maybe I would have felt a bit uncomfortable, but I felt completely fine to answer.” [KI004]

For these māmā, the structure and tone of the appointment provided a comfortable and safe environment to share their experiences.

Some Impact

A smaller group of participants described experiencing some discomfort or confusion around certain questions—particularly those related to living conditions or household makeup. One māmā shared:

“When they asked about my living situation... in my head, I'm thinking, why do you need to know that?” [KI002]

The sense of intrusion was amplified by concerns around family privacy:

“My family... they don't like being in on forms and stuff.” [KI002]

Another participant described being caught off guard by questions about housing quality:

“I Googled it when they asked us... They’re asking is your house warm? Is it damp?... I thought that was really weird. That’s something I remember because I didn’t expect that... Kind of caught me off guard a little... When she said a Best Start, like to do a pregnancy, I didn’t expect that kind of question to be in it.” [KI001]

While some of these questions initially raised confusion or defensiveness, participants often reflected afterwards that they could understand their purpose. One participant noted, “It does make sense, especially within New Zealand” [KI001], and another acknowledged, “I have people around me if I do get deep” [KI002], recognising the questions as a potential prompt for identifying supports.

High Emotional Impact

A few participants described aspects of the assessment as distressing or even triggering. Importantly, this kind of emotional reaction to a question appeared to be the result of a lack of whakawhanaungatanga or relational connection. One participant recalled:

“I remember coming back [home]... I was just like really quite, almost disgruntled. I think I was a bit triggered, to be honest.” [KI003]

The clinical and impersonal tone was particularly problematic:

“She was just very clinical, didn’t even introduce herself... very robotic” [KI003].

Questions about vaccination and past trauma exacerbated discomfort, particularly when participants felt judged or pressured:

“She tried to tell me why she thinks I should have [vaccinations]... I said, ‘I’ve already had this discussion.’” [KI003]

Others identified how the questions touched on deeply personal or historical trauma:

“That was a big one for me... I [grew] up with literally nothing.” [KI005]

Mental health-related questions also evoked strong reactions for a small number of māmā:

“I shut off... I don’t like talking about my past... I’ll just turn around and just be very blunt about it nicely, but bluntly, I’ll just go, look, I am not here to talk about this. I’ve had counselling in the past. It’s never worked.” [KI005]

For these māmā, the structure and delivery of the assessment had unintended emotional impacts that may need to be acknowledged in future implementation.

[Helpful or Empowering Questions](#)

Participants generally found the majority of the Best Start questions helpful and relevant, particularly those that supported their learning, encouraged reflection, or affirmed their wellbeing. Questions that focused on practical aspects of pregnancy—such as nutrition, mental health, and baby development—were remembered most positively. Māmā appreciated when questions were clear, purposeful, and tied to their needs, rather than overly repetitive or administrative.

For some, the guidance on healthy habits was especially useful. One participant explained:

“The questions that stick out most for me... it’s the main ones that I really gained from... the dos and don’ts in regards to eating and drinking. That’s probably what I would say is very important.” [KI004]

Others valued when the focus turned toward their baby’s progress and environment:

“There was some good things like about the housing and, you know, about asking about my baby and how’s the baby’s scans were and stuff like that. That’s the things I do like to hear.” [KI006]

Questions related to mental health were also highlighted as meaningful:

“Yeah, I really liked all the questions, especially mental health, that was really good.” [KI001]

However, participants also noted some gaps, such as not being asked about their level of access to appointments or services (e.g., whether or not they had transport) or not ensuring that māmā knew that it was not compulsory to attend a Best Start assessment.

Interviewer: Did they ask you about transport or anything in that Best Start appointment?
KI005: No.

“I think, so the first time I was definitely keen. I can’t remember if it was an option the second time either, but I just said yes because it was good to refresh.” [KI004]

Overall, māmā described the most helpful questions as those that connected directly to their day-to-day realities and supported both their physical and emotional wellbeing. The opportunity to discuss these topics in a caring, non-judgemental environment helped make the process feel purposeful rather than procedural.

Prior Experience and Comparisons

Māmā who had previously participated in Best Start or had multiple pregnancies compared their current experience with earlier ones. For some, the process felt familiar and helpful as a “refresher,” especially after long gaps between pregnancies.

“Yeah, it was just good to kind of have like a refresh... especially after that ** year gap, like, it was just good to kind of have like a refresh kind of, yeah, just to make sure that you’re on the straight and narrow.” [KI006]

However, not all repeat experiences were positive. A small number felt that their previous knowledge was not recognised:

“Because I was working at the time too, my time was kind of like, squished in... I sort of thought, why am I doing this stuff? Like, why am I going to get this prescription? Like, that’s another thing, a task to do, that I didn’t sign up for.” [KI003]

For māmā coming from another country (e.g., the Pacific Islands), experiences of pregnancy and birthing were very different.

“We just go in and they fill out a card... and they basically check... your blood pressure... We get a small card, that’s our card, when is our next clinic date. So we don’t have a midwife, like how we do here. There’s no midwives. You’re only privileged to get a midwife if you pay for it when you deliver in your labour. So when you get into labour, then the midwife is there. Otherwise one will be there with you in the public hospitals.” [KI008]

Despite multi-gravida, the hugely different maternity systems between a māmā’s home country and New Zealand highlighted the importance of having the Best Start as an entry

point to learning about what is available and what to expect throughout their pregnancy journey.

“She was telling me that we provide midwives that you go and see and they can come to your house. It’s like, ‘really? Do we have to pay for this?’” [KI008]

“When she asked me about, do you have a midwife, like, I was caught off guard... Because I was like, I have no idea, because in both my births in [the Pacific Islands], the midwife was in the delivery room already there. So I was really new to the whole structure and so I was confused and said, ‘can you just explain a little bit more about what do you mean, if I had a midwife?’” [KI008]

Insights such as this highlight how important it is not to assume that māmā who have had other children will know what to expect during their current pregnancy, especially if they have moved to New Zealand from another country.

This variation highlights how parity (first-time vs experienced māmā) shapes expectations and perceptions of value. In many cases, first-time māmā tended to see Best Start as informative and reassuring, while experienced māmā wanted it to build on existing knowledge rather than repeat it. This was not always the case, however, demonstrating the importance of ascertaining where each māmā is at, through the whakawhanaungatanga process, and tailoring the Best Start assessment to meet both need and expectations, while still ensuring safety, current support systems, and other important areas are also covered.

Barriers to Care

Māmā identified a range of factors that limited their ability to fully engage with or benefit from the Best Start assessment. These included both service-level barriers and individual-level challenges, such as the impact of previous experiences and the availability of personal support.

Health-Service Related Barriers

Across interviews, māmā identified several service-related barriers that influenced how effectively they could engage with and benefit from the Best Start process. These barriers were often linked to the structure and delivery of appointments rather than to the content itself. Challenges included a lack of socialisation to New Zealand health services, difficulties remembering or acting on information received, experiences of perceived or actual judgement, and ongoing mistrust of health and social services.

SOCIALISATION TO NEW ZEALAND HEALTH SERVICES

For māmā coming from a different country, it was identified that knowledge of maternity processes was limited, as discussed above. However, this lack of knowledge was not purely at the maternity level but generalised across all health services. For example, it was apparent that the māmā who had recently moved to New Zealand had extremely limited understanding of the New Zealand primary care system and had not received any socialisation around how

to access supports in different scenarios or what to do if she was in another region and needed pregnancy-related or other medical care.

I know that [Health Centre] says that they're available to support us. Like our medical care. But what if I have gone away to another town, or another city, and I need urgent care?.. I wouldn't know if they would treat me because I don't belong to, because that's what I see here. That you have to belong to a certain medical centre to go and visit. Whereas back home, you can go to any medical centre. They will see you... But over here, they are kind of strict with 'you have to go to your GP, whoever is your GP', and what if I've gone out to another town and I urgently need care and the closest is another medical private medical? How would I know? [KI008]

Despite having established some strong relationships with people from church and her workplace, it appeared that this sort of information was not something she discussed with others.

"So, like, if I didn't have you tell me that information right now, where would, who would have told me that information?.. I'm not really that type of person to just ask random people. So, what would, what service, like is there a number I could call apart from, because when we call after, at the GP, it just goes to voicemail." [KI008]

This highlights potential cultural differences around how people from different ethnicities may need to access health information. As this māmā suggested, for hapū māmā, the Best Start assessment is the perfect opportunity to explore what is already known about the health system and where there might be gaps.

"Or if they included in the Best Test that you are in a state of emergency and you know that this is your GP but they can't help you at this time, these other, like the information you gave me [E.g., WAM & ED], I think it should be part of this because the care is different back home and yeah. Because she didn't tell me that information, what you're telling me now. Just in case of emergency." [KI008]

Overall, this māmā's experience highlights an overall gap in health service provision for people who immigrate to New Zealand. It demonstrates the need for a systematic way to provide education to new immigrants around how the health system works, what to expect from the health system, and how to navigate it depending on the situation.

RECALL AND RETENTION OF INFORMATION

While the Best Start assessment aimed to provide helpful guidance and information, many māmā reported challenges in retaining what was discussed. Some found the information handed out too generic or disconnected from the personalised support offered during the appointment. One participant noted, "*It just... referred to those [online resources]*" [KI001], rather than acting as a reminder of the services actually discussed.

Physical discomfort (e.g., morning sickness), stress, or feeling overwhelmed during the appointment also impacted the ability to absorb information. As one māmā explained:

“I was so sick... I was just happy to get out of there by the end of it... it was a struggle to concentrate” [KI001].

Others described the difficulty of processing information in the moment, only to reflect later and realise what had been missed:

“Things don’t hit me until after I’ve done it and I’ve processed it” [KI002].

Several participants said they could not recall what services were recommended, even when they had followed through on the referrals. One reflected:

“If they did [suggest something else], I didn’t take it in” [KI002].

Māmā suggested that the information might have been more useful if written down or discussed with a support person:

Interviewer: “Is there anything they could do in that appointment that might help you remember the important things?”

KI002: “I don't know, for remembering, but mine was probably taking mum, because when I thought about it later, we'd debrief it type thing.”

When asked what might help with recall, māmā suggested written summaries, take-home resources tailored to their needs, or even small memory aids (e.g., to put on the fridge) to support delayed processing. As one suggested:

“It'd be nice just to like be able to go back and be like, oh, that's right. This is what we went through. Oh, I can ring this number” [KI001].

Participants also highlighted the risk of information overload—especially for first-time māmā—when too many topics were covered in one session.

“The only thing that really sticks out... was the do’s and don’ts of food, and I know they actually went over other stuff.” [KI004]

Overall, these findings suggest that retention could be improved through more tangible, personalised materials and by acknowledging the cognitive load māmā may be under during a Best Start assessment.

ACTUAL OR PERCEIVED JUDGEMENT

A key message that emerged from one participant’s kōrero was the deep and enduring impact of perceived judgement during healthcare encounters, particularly linked to previous parenting challenges. This māmā shared that some of the first questions asked during her Best Start appointment were critical and triggering:

“That’s what puts me right off... I wonder why people don’t turn up ever again or they shut themselves off and they don’t feel safe because they just came out with that.” [KI005]

The framing of early conversations in this way not only heightened distress but undermined trust in the service as a safe and supportive space. This māmā explained what she had hoped for instead:

“They should be asking you questions of ‘how is your health? How is your well-being? How is your mental health? And how is your state of mind?’” [KI005]

This sense of being pre-judged based on historical records or assumptions shaped her broader experience of care across multiple settings:

“All medical places have judged me... so it was quite hard for me to even try and open up.” [KI005]

When asked whether she had considered changing health providers after these experiences, the response reflected a common protective strategy:

“No. I completely close myself off.” [KI005]

This narrative illustrates how perceived judgement can significantly impact on engagement with care, even when support is needed. For māmā who have experienced multi-system involvement, unchecked wording choices can reactivate trauma, reinforce mistrust, and contribute to disengagement. These findings emphasise the need for trauma-informed, mana-enhancing communication approaches that are based on curiosity, safety, and respect—particularly in early antenatal conversations.

MISTRUST OF SERVICES

For some māmā, level of engagement with the Best Start assessment was shaped by a pre-existing mistrust of healthcare and social systems. This mistrust was often rooted in past experiences of judgement, loss, or unwanted intervention. One participant recalled being hesitant even when the assessment was initially offered:

“They just said, have you thought about doing the Best Start? I was like, I don't even know what that is... I told them not to get their hopes up about it, though.” [KI005]

Questions perceived as intrusive, such as those about household composition, could evoke a defensive reaction, particularly if the Best Start was delivered in a checklist format, as opposed to a conversational/relational format.

“So, like when they asked about my living situation... in my head, I'm thinking, why do you need to know that?... It kinda reminded me of... a WINZ application... My family... they don't like being on forms and stuff.” [KI002]

“So, there was a little bit of, like, I'm not sure I can actually tell you something... I would be honest. But then I also like, yeah, I don't know. It's hard to explain.” [KI002]

For some māmā, medical services were associated with trauma or loss, reinforcing self-protective behaviours:

“I closed myself off for a bit.” [KI005]

Even when required to engage with services due to existing medical conditions, participants described withholding information to protect themselves and their whānau:

“I've got a baby doctor there... She's a nice lady, but um yeah. She's still tries to push me to ask for certain information, but I won't give it. Yeah, so I'm still closed off with [Medical Centre]. Like, if I turn up to appointments, I will, but if they ask me certain questions, I'll close myself off. To protect myself and my family.” [KI005]

CONFIDENTIALITY CONCERNS

Many of the concerns about trust were directly tied to perceived or actual breaches of confidentiality. Some participants had experienced personal information that they had shared with one clinician being passed on to other clinicians without consent, resulting in long-lasting impacts on their willingness to open up.

“They say that they can be trusted and it's confidential, but then it ends up somewhere else to someone else... There was a lot of things that I was hiding from them because I wasn't quite sure if I could [be honest] or not.” [KI005]

For māmā who had experienced system-level judgement, the need for genuine relational safety was critical:

“That's what us mamas want—to feel safe to go to a clinic like that. They say that it's confidential and then we can feel safe to open up...” [KI005]

Interviewer: So, your midwife, is she someone that you would trust?

KI005: I've only got a hospital midwife. So, yeah, no.

Judgement and a lack of empathy from previous providers often exacerbated these concerns:

“They just straight off the bat, judged me there and then on spot... They didn't offer me nothing...” [005]

These experiences created a lasting wariness toward disclosing personal information in clinical settings, especially when providers had not taken the time to build rapport or explain the purpose of their questions.

UNCONSENTED DATA SHARING BETWEEN SERVICES

A key contributor to mistrust was the experience of information being shared between services without māmā's knowledge or consent. This created a sense of vulnerability and reinforced participants' reluctance to disclose personal information. One participant described being blindsided by providers who had prior knowledge of her health history without her knowledge or permission:

“It just came out of nowhere... I got my walls up because of it. I'm just too scared to do anything or go for help for anything. Just in case I get judged for it.” [KI005]

The feeling of surveillance, particularly across different parts of the health system, made it difficult for some māmā to feel safe:

“There must be a system they can go to and still look at it... if I only met the person once or twice and they bring that up, it's like, well, that's not what I'm here for.” [KI005]

This theme highlights the critical importance of transparent communication and informed consent when sharing data across services.

Personal Barriers

In addition to the structural and service-level challenges, māmā also described a range of personal circumstances that shaped their ability to fully engage with the Best Start process. These included feeling unwell or overwhelmed during appointments, past negative experiences with services, and varying levels of support from whānau. For some, prior trauma or engagement with multiple health-related teams made it harder to trust providers or speak openly. For others, cognitive load, emotional stress, or simply being in survival mode reduced their capacity to take in or act on information. These insights point to the importance of flexible, relationship-based care that adapts to the real-world context māmā are navigating.

IMPACT OF PAST

For some māmā, childhood trauma, previous medical history, and negative experiences with previous health providers had a lasting influence on their current interactions with health and other support services. One māmā described how her history had contributed to mistrust and emotional vulnerability. In addition, she highlighted how repeated reminders of her past, by providers—especially when it seemed disconnected from current circumstances—was experienced as undermining.

“They're just bringing up stuff from the past... you shouldn't be bringing that up” [KI005].

These experiences meant that even when services were offered with good intentions, they could evoke fear, shame, or self-protection, particularly when confidentiality was not clearly explained:

“So when they say it’s confidential... my understanding is usually what comes with that should be, but they keep bringing up my [past]...” [KI005]

Although clinicians were aware of her history, it was clear that her previous experiences with healthcare and a lack of genuine relationships between providers and this māmā had had such a significant impact on her that she barely engaged. For māmā in this position, such disengagement and lack of positive healthcare relationships leads to increased risk—for both māmā and pēpi—due to a lack of structured emotional support in place to safeguard her mental health and wellbeing.

Interviewer: “But they didn't offer you any help?”

KI005: “Oh, no. They just straight off the bat, judged me, there and then on spot. Didn't ask me ‘oh do you need any [counselling]? Do you need any help with maybe when you’re really, really stressed’... This is why I don't feel very safe around medical people.”

PREVIOUS PREGNANCIES

For those who had parented before, the expectations and assumptions around experience could be both helpful and burdensome. Some māmā noted that they had made an effort to read and learn about how the baby was developing and things to be aware about during their first pregnancy but less so in later pregnancies.

“My first pregnancy I did read that book [education supplied by the medical service]... the second one I didn’t.” [KI004]

Others described how their confidence from previous pregnancies did not necessarily translate into their current experience, especially if the new pēpi had different needs or physical and emotional exhaustion made things harder:

“I breastfed my other children until they were almost two... I only breastfed him for like six, eight weeks... I couldn’t do it... I got quite upset about it. I just felt like... why can’t I do this?” [KI006]

This important insight—the belief that ease of previous pregnancies would translate to the current pregnancy—was raised by a few māmā who later experienced unexpected challenges with their pregnancy or new baby, changing circumstances, or diminished personal capacity.

“That’s what we think. Like, we’ve got this... and then sometimes we get slapped in the face. No, you can’t. It’s not going to work like that this time.” [KI006]

The need for this to be acknowledged, perhaps as part of the Best Start assessment, or in hapū wānanga/antenatal classes, was raised.

LOW LEVELS OF PERSONAL SUPPORT

Māmā's access to personal support during pregnancy varied. For those with limited social support, this was attributed to emotional or physical distance from whānau, a recent relocation to Whanganui, or a personal choice to keep the pregnancy private at that time.

“And we did keep our first pregnancy a secret for quite a while. We didn't really tell our families until like 15 months. So, it was good to have [Best Start]... especially from a medical point of view, to have that information, because I wasn't talking to anyone at the time about it.” [KI004]

For some participants, limited access to strong whānau or social support networks made it harder to process or act on the information provided during the Best Start appointment. While other māmā described relying on trusted people to attend and help recall details from appointments, those with fewer supports were more likely to internalise struggles or disengage.

Interviewer: And I think that's one of the ideas of Best Start is that actually, it just normalises it and says one of the parts of pregnancies can be this.

Partner: Yeah that's the best part about it.

KI001: Because I find with this pregnancy, especially after my second one, oh, I'm kind of just like, uh I'm a bit over trying. I'd rather just do the journey and get excited at the end. But that's just how things have unfolded with having to find the support myself and, you know, it's just been a struggle.

Even when support was available, in theory, it was not always accessible in practice or aligned with what māmā needed emotionally. For those who were disconnected from family, the absence of consistent, non-judgemental support created further barriers to engaging fully with health services. In addition, participants who had recently moved to Whanganui reported feeling isolated as they had not yet established local connections or support networks for themselves or their whānau.

Interviewer: Is there anything in the best start around that? Like how long you've lived here, whether you have support systems already here?

KI001: Yep, they did ask those questions and I think I said we have families support, but we don't here. We don't really know the what's out there. The system, as such. Yeah.

Interviewer: But then you can't remember what they suggested because it wasn't written down.

KI001: Pretty much.

BARRIERS TO MIDWIFERY SERVICES

Access to midwifery care was a significant barrier for some māmā. Problems clustered around four interrelated areas: choice and continuity, availability and capacity, gaps in system navigation and referrals, and differences between rural and urban services. These barriers affected confidence, timeliness of care, and the overall sense of support during pregnancy.

Choice and continuity

The ability to choose a midwife, or keep the same midwife if it was not the first pregnancy, mattered to māmā. Where choice was limited, people felt uneasy or left to rely on informal networks to secure continuity:

“People around me would, like, reassure me ‘if you're not comfortable, you just find another one. You know, you don't have to stick with that one’”. [KI004]

When there was a choice between midwives, due to midwife availability and capacity, it improved confidence:

“I messaged a midwife and she said, ‘yeah, I can fit you in.’ I was like, cool... Best midwife I've had.” [KI006]

But several participants described the stress of not knowing whether a midwife would be available when they needed one or not being able to find one.

Availability and capacity

Many māmā experienced long waits, phone tag, or midwives being fully booked—sometimes at critical times in pregnancy—leaving them anxious and unsupported:

“I searched up the midwives, I messaged her, and I kind of just went with her... everyone that I kind of looked online was kind of not available for those months. I was kind of like, oh.” [KI006]

“I rang about six different midwives and we couldn't find one... I ended up going with my aunty [in a different region] because... my work had a lot of travel.” [KI003]

The sense of a chaotic or over-subscribed system was captured here:

“They told us to ring the other number at the hospital... I'm a little hoha, but... they've all said that they're all too busy.” [KI001]

System navigation and referral gaps

Participants described unclear referral pathways and inconsistent support from primary care when a midwife could not be found. This added to frustration and risk of falling through gaps:

“I rang [Health Service] for a check-up and they told me I have to ring the hospital [midwives]. So, I rang the hospital and they told me, no, you need to go ring these midwives... I just told you they said no, so why are you not helping me?” [KI001]

Several māmā suggested that Best Start could include practical help to secure midwifery care rather than leaving the search entirely to the māmā.

Rural versus urban differences

Participants who had experience of both rural and urban services contrasted prompt, continuous midwifery care in smaller towns with the more fragmented provision in Whanganui. Small-town services were described as easier to access and more relationship-based:

“When I was in [rural region]... you get given the number for the midwife clinic and it starts from there... it was a hundred times better than [Whanganui].” [KI003]

By contrast, urban capacity limits and cross-district restrictions (for scans and appointments) created additional travel, cost, and delay:

“They sent us to Palmy to get one done... then they tried to charge us \$180 for the scan.” [KI003]

Implications

Barriers to midwifery access reduced choice, delayed continuity of care, and increased stress for pregnant māmā:

“Yeah, even being a third time mum, I'm getting to that stage where you get the diabetes checks and all that checked. I don't even have a midwife to do that, so even for a third time, I'm getting a bit antsy about it... Because you know a first time, Mum, oh, I would be so upset. Being a third time mum, that just made me angry. I can totally see, because some people would just be like, oh, I'm never ringing back there again because that was horrible. That's how I felt. That's how I felt.” [KI001]

Practical steps that could mitigate these barriers include: clearer, actively supported referral pathways from primary care to midwifery services; including midwife-finding support within the Best Start process; and addressing capacity pressures so continuity and timely access are more reliably available.

LIMITED ACCESS TO HAPŪ WĀNANGA/ANTENATAL CLASSES

Several māmā described challenges accessing antenatal or hapū wānanga classes, despite valuing their importance for connection, learning, and preparation. Limited availability of classes—both in terms of timing and promotion—meant that opportunities were easily missed.

For some, the issue was simply not being informed that such classes existed:

Interviewer: You haven't been offered [antenatal classes] here?

Partner: No. We've done one when we first had our [child in a different region]... They sort of made it like, we didn't have to do it, but they sort of like told us that it would be a good idea, because we were first time parents. They told us they're

like, you know, there's a lot of things that come with it and it could be stressful, but this will be a way to like help you fellas deal with whatever's going on.

Interviewer: Okay, so by not having access to a midwife, you don't have access to being told anything about antenatal classes?

KI001: We're pretty good now. Yeah, since the other day we've been learning quite a lot about [Health Service] and all the different services they offer. Because yeah, beforehand we didn't know they did any of that...

Partner: Yeah, I reckon that needs to be in [the Best Start assessment].

Others found out about options later through community connections rather than through formal care pathways:

“We were just lucky we came to that [kai and kōrero hui]... that’s when we found out about everything that was available here.” [KI001]

Work schedules and fixed class times further limited attendance, particularly for those working nights or irregular hours:

“It didn’t work in with the times that I was working... it would have been good to go to, but I’ll miss out and just go to work.” [KI006]

Even experienced parents highlighted how refresher classes would have been helpful when pregnancies differed from previous ones:

“The antenatals would have been cool... just having all those classes to go over everything again would have been nice. Everything was so much different this time around.” [KI006]

Māmā and whānau expressed that greater flexibility—such as evening, weekend, or alternative delivery formats—along with better promotion through primary care or Best Start assessments, could improve access and participation.

These insights highlight a key function of the Best Start assessment—identifying māmā who have limited support, whether from whānau or from appropriate services, during their pregnancy journey. Once support needs are recognised, there is a need for clinicians to actively seek opportunities to connect māmā with additional supports where appropriate.

In summary, Māmā described a range of factors that limited their ability to engage with or benefit fully from the Best Start assessment. These included both service-level barriers—such as limited healthcare socialisation, information overload, judgement, mistrust, and lack of access to midwives and hapū wānanga/antenatal classes—and personal-level barriers—such as past trauma, lack of support, emotional distress. Taken together, these findings highlight how service design and practitioner approach has the ability to support engagement, particularly for those navigating complex personal histories or competing demands.

Enablers of Care

While there were identified barriers to engaging with the Best Start assessment or wider maternity care, māmā also described meaningful supports that enhanced their sense of connection, safety, and access to services. Enablers included strong whānau ties, culturally aligned services, peer learning environments, and positive midwifery experiences. These findings highlight key opportunities for services to strengthen and extend what is already working well.

Role of Whakapapa, Whānau, and Community

Connections through whakapapa, whānau, and community played a vital role in supporting engagement with services. In several cases, māmā noted that a familiar face within a clinic or being referred by a whānau member gave them confidence to attend, particularly when navigating unfamiliar services. For one participant, having a friend working at her general practice strongly supported her to engage with primary care:

“He was the one that was calling me saying that we have this and that... He was the one that was sorting out my things” [KI002].

Māmā strongly acknowledged the benefits of knowing staff at a service, or recognising faces once they arrived, reporting that it helped reduce anxiety and promote connection:

“I already knew of this place [Te Whare Piringa], because my cousin is [Staff], but I'd never actually connected in. They got me to do the prenatal classes... And then, not long after I had started in here, [Familiar Person] started and I used to work with [them] as well. So I was like, a lot of people that I'm familiar with rather than going into a big strange place” [KI002].

In one case, a hapū māmā found herself attending antenatal education alongside her nurse, who was also pregnant:

“And then I found out that she was actually hapū herself. So, she ended up doing hapū māmā with me. It's a small world... It was actually pretty cool having a nurse in the space as well.” [KI002]

In addition, for some māmā, shared whakapapa, such as having a Māori nurse or being cared for by Māori providers, made a significant difference in comfort and cultural safety:

“Both of my nurses, the first time around in this time around were both Māori. From like a cultural point of view, I felt comfortable” [KI004].

Hapū Wānanga: Peer Learning and Cultural Grounding

The hapū wānanga facilitated by Te Oranganui at Te Whare Piringa were consistently praised for their relational, interactive approach. Rather than using a textbook approach to

pregnancy, the wānanga provided space to learn from other māmā and share lived experiences in a safe and validating environment:

What's been awesome has been like that Te Whare Piringa being open. The hapūtanga wānanga was awesome. [KI003]

"It wasn't a space where you just learned from the one person... It was more learning off people's lived experiences rather than from a book. I'd probably recommend it for anyone" [KI002].

Māmā noted that these wānanga helped normalise a range of pregnancy and parenting experiences, reduced isolation, and promoted whakawhanaungatanga among participants. This was particularly important for those new to Whanganui or parenting without a large support network.

"You're surrounded by other mothers... I reckon yeah, it'll be pretty good" [KI001].

Warm Facilitation into Kaupapa Māori Services

An important incidental finding, as a result of this study, was the benefit of having hui (meetings) or appointments (in this case māmā interviews) at Te Whare Piringa. This was consistently highlighted throughout the study. During the recruitment phase, eligible hapū māmā and their whānau were invited to attend a 'kai and kōrero' morning, held at Te Whare Piringa, to learn about the project. While this was not well attended, all of the māmā who did attend later reported that they linked into the services provided by this Kaupapa Māori-based facility, as a result of attending the hui.

"Yeah, we were just lucky we come to that [kai and kōrero hui], because after that, then I talked to [Attendee] and she told us about everything that was available here." [KI001]

"For the last two weeks [the fortnight following the kai and kōrero], I went down to the Mums and bubs. Yeah. But, before that, I didn't. Oh, I did the wahakura wānanga, which was kind of through them. But other than that, I hadn't ever come in here. But they've always been very like open, because I'm doing baby alone basically. They're always like, "bring her in. I'll look after her. You can have a nap." It's like, next week I'm getting the mirimiri done. And I'll message them, "can I leave baby with you while I go in and get it done?" and they're like, "yeah, of course." [KI002]

In addition, the majority of the Best Start Evaluation interviews were held at Te Whare Wānānga, as māmā were given the option to meet there or to have the kōrero in their own space. For some māmā, having the Best Start appointment at Te Whare Piringa, in a non-medicalised, community-based setting, created a low-stress environment where they could be gently introduced to kaimahi and kaupapa (purpose) of Te Whare Piringa, which in turn facilitated future engagement. This initial experience helped reduce barriers to accessing wrap-around support by making māmā feel more at ease and informed about what was available to them and their whānau. When they arrived at their Best Start Evaluation kōrero, they were met by a kaimahi, who chatted to them both before and after their interview. This

served as an important first step in building trust and whanaungatanga between māmā and the wider support team within Te Whare Piringa. This finding demonstrates the potential for the Best Start to function as more than a screening tool. By developing pathways where māmā are indirectly introduced to support systems, such as Te Whare Piringa, in a low-stress, casual way, it provides a gateway to access culturally grounded care.

Further supporting this approach, māmā who had not yet visited Te Whare Piringa—either through the ‘kai and kōrero’ hui or during their Best Start assessment—said that although the service was mentioned to them, they would be unlikely to attend on their own due to anxiety about going somewhere unfamiliar without support.

“Yeah, she did tell me about that place. Like, how they help out young mothers and they, um. Because she told me to actually go have a look on their Instagram page. And I was having a look, and, yeah, it looks pretty cool. It's just that I'm not really a people's person...” [KI009]

Prioritised Acute Appointments during Pregnancy

Māmā emphasised the importance of being able to access acute or same-day appointments during pregnancy—particularly when unexpected symptoms, uncertainty, or stress arose. For many, responsiveness from practice staff signalled care, safety, and respect. As one māmā reflected,

“If it's not going to work with me, then I'll try the next day or, you know, or just ring and be like, ‘do you have an appointment for this time?’ to try and make it work for me and my job?” [KI006]

This sense of flexibility and willingness to prioritise hapū māmā helped reduce anxiety and encouraged timely engagement with care. For others, however, difficulties booking appointments or uncertainty about where to go in urgent situations created barriers. One māmā described her confusion about accessing care when away from her enrolled practice:

“I know that [Health Centre] says that they're available to support us. Like our medical care. But what if I have gone away to another town, or another city, and I need urgent care?... I wouldn't know if they would treat me because I don't belong to [that practice]... What if I've gone out to another town and I urgently need care and the closest is another medical [centre]? How would I know?” [KI008]

It was suggested that the Best Start process itself could better prepare māmā for such scenarios:

“If they included in the Best [Start] test that you are in a state of emergency and you know that this is your GP but they can't help you at this time, these other, like the information you gave me [e.g., WAM & ED], I think it should be part of this... Just in case of emergency.” [KI008]

These insights highlight that timely access to acute care is not only about appointment availability but also about communication, clarity, and reassurance. For māmā, being seen promptly—especially in moments of uncertainty—helps foster trust and a sense of being genuinely cared for. Embedding clear, consistent processes for prioritising acute appointments, alongside transparent guidance for urgent or after-hours care, would further strengthen the Whanganui Best Start Model of Care’s commitment to equity, responsiveness, and relational wellbeing.

Ensuring that hapū māmā can access timely, prioritised appointments within general practice is only one part of the continuum of early pregnancy care—equally vital is the ability to secure consistent midwifery support and continuity throughout the journey.

Midwifery Support: Choice and Continuity

Although access to midwifery care was a challenge for some, those who found a supportive, culturally responsive midwife described this as a key enabler of care. Choice and continuity emerged as essential components:

“She kind of, yeah, it was like she was a family member. Like, that's how she kind of slotted in with us. And that's what we kind of wanted. Yeah, she was great... Best midwife I've had.” [KI006]

Māmā who did not have a choice about their midwife were more concerned about the care they would receive than those who were able to find a midwife they were happy with.

“People around me would, like, reassure me: ‘If you're not comfortable, you just find another one.’” [KI004]

Having the ability to choose a midwife—or receive help to find one—was linked to feeling empowered and respected. In cases where friends, partners, or health providers helped facilitate these connections, māmā felt more in control of their care. For some māmā, the Best Start assessment played an important enabling role in accessing midwifery care. Nurses who took initiative to identify and share information about available midwives made the process easier and less stressful for māmā.

The first time around... the second time around I just went with the same midwife. First time around, it's a bit like, I just searched up on the website. Oh, actually because my first appointment, she was like, start looking for a midwife. And then I think it was my second appointment, she was like, okay, so she actually ended up going online for me and having a look and then writing down some numbers just for me to message. [KI004]

Wrap-Around Care: Value and Experience of the Best Start Model

The purpose of the Best Start assessment is to serve as the first step in a more holistic approach to care. This includes providing education, identifying areas of support need, and

connecting māmā with services and people that will tautoko (support) them during pregnancy.

Value of the Best Start Tool

Māmā described the Best Start assessment as a valuable entry point into wrap-around care — a space where they could ask questions, receive guidance, and feel that someone was walking alongside them in early pregnancy. For many, it filled an important gap when midwifery care was delayed or unavailable. The tool provided practical health information and reassurance at a time when uncertainty was high. One māmā noted that, without a midwife:

“It kind of just gives you information that you maybe didn’t think was important... you do find out maybe stuff that you didn’t think you needed to know.” (KI004)

A Bridge Between Services

Several participants contrasted their Best Start experience with earlier pregnancies, reflecting that this model represented a clear improvement in coordination and early support. Those who had moved from other regions highlighted the difference:

“I’ve never come across any kind of appointment like this at the doctor’s... I was just midwife and that was it. So, when going through that and talking to them about everything, it was actually really nice.” (KI004)

Having a structured, early pregnancy assessment within primary care ensured some māmā were linked sooner to midwives, social and mental health services, and community resources. For many, this strengthened their confidence in navigating the system and reduced the likelihood of “falling through the cracks.” However, a few noted that connections sometimes relied on the initiative of individual staff, suggesting the need for clearer and more consistent referral pathways.

Supporting Continuity and Relational Care

A key strength of the model was continuity. When māmā saw the same nurse or practitioner across multiple visits, trust and comfort developed quickly:

“She made space in her appointments for us to follow up with her... it felt like she made time for us. She didn’t just send us off to someone else.” [KI001]

Another participant described how the nurse’s ongoing involvement “*saved me with the boring stuff — she already knew a lot of my answers.*” [KI002]

This sense of being remembered and cared for by name was often described as the difference between a transactional visit and a genuinely supportive relationship. Māmā who experienced multiple providers or repeated questions found the process tiring, reinforcing the importance of continuity within wrap-around models.

Holistic and Responsive Care

The holistic nature of Best Start was particularly valued. Questions about mental health, living conditions, nutrition, and safety were perceived as both relevant and reassuring for the majority of māmā:

“I really liked all the questions, especially mental health — that was really good. Each pregnancy is so different.” [KI001]

Others appreciated the emotional validation and normalisation that came with these discussions:

“It’s okay to be like that... if it gets worse, you can see someone about it. Don’t hide away.” (006)

These moments of reassurance often opened the door for more honest kōrero about wellbeing. Some māmā were referred to Health Improvement Practitioners (HIPs) or counselling, while others preferred to reflect or seek support later. The flexibility to respond at their own pace was seen as respectful and mana-enhancing.

Gaps and Areas for Strengthening

Despite the strong foundations, several areas for improvement were identified. Some māmā noted that follow-up actions — such as referrals or information discussed — were not always written down or easy to recall later. Others described receiving resource packs containing outdated materials, which reduced confidence in the information provided.

“I just got this bag... it had heaps of expired little things... an expired voucher and a couple of pamphlets and a book on pregnancy.” [KI001]

Additionally, while many experienced compassionate care, a few highlighted inconsistencies in communication between services, especially when juggling multiple appointments or complex medical conditions. For māmā navigating medication changes or hospital appointments, a single coordinating contact or navigator role was suggested to “*tie it all together.*” [KI003]

The Role of Best Start Nurses in Medical, Mental Health and Care Coordination

Participants’ experiences reflected the central role that nurses play in providing oversight across multiple domains of care during pregnancy. In several cases, it was the nurse who recognised potential health or social concerns and proactively initiated follow-up or referrals.

For others, nurses played a crucial role in organising care — including sourcing available midwives, linking māmā into community services, and introducing them to programmes such as hapū wānanga. One participant shared that they only learned about these supports after

attending a project hui and how this had broadened their awareness around other maternity-related community resources:

“Yeah, we were just lucky we come to that [Project Hui]... [Attendee] told us about everything that was available here... Since the other day we’ve been learning quite a lot about [Medical Service] and all the different services they offer. Beforehand, we didn’t know they did any of that.” [KI001]

However, issues were also raised around access to information and services. Some māmā noted that without a midwife, they were unaware of antenatal class options altogether — revealing a potential gap in system-wide oversight. Others highlighted that while classes were mentioned, practical barriers such as incompatible timing or lack of clear follow-up meant they missed out:

“They had said... we can send you out to the maternity classes... but I was still working... it didn’t work in with the times... it would have been good to go.” [KI006]

The nurse’s role in providing timely, accessible, and pregnancy-related service information was therefore critical.

Resources and education provided by nurses were also highly valued. In hindsight, some participants reflected that more detailed information—particularly around specific services available for hapū māmā (e.g., hapū wānanga/antenatal classes or mirimiri—traditional Māori massage available through Te Whare Piringa—could have helped to reduce isolation, promote community, and provide more detailed information to help manage expectations and reduce distress:

“They had just told me what was going to happen... but I didn’t know the intensity of it... that’s where the antenatal classes would have been good.” [KI006]

Across accounts, the importance of nurses as trusted, relational, and proactive organisers of care was clear — especially in situations where other care pathways (such as midwifery) were fragmented or absent. Strengthening this role through consistent information-sharing, follow-up systems, and scheduling flexibility could further enhance outcomes and reduce missed opportunities for support.

Mental Health Oversight and Support Through the Best Start Model of Care

Te taha hinengaro (mental and emotional wellbeing) was widely recognised by māmā as a critical aspect of pregnancy care, and many described the Best Start process as one of the few opportunities where these conversations were initiated in a safe, structured way. The inclusion of mental health-related questions helped normalise kōrero about emotions and wellbeing during pregnancy. One māmā reflected:

“I really liked all the questions, especially mental health — that was really good... because each pregnancy is so different.” [KI001]

For some, this conversation prompted reflection on earlier experiences of depression or anxiety, creating space for awareness and early identification. As one participant described,

“The way things happened with [my first child’s] birth, it did make me go a bit depressed... but my aftercare provider picked it up and gave me all the services for help.” [KI001]

KI001: “I know something that I've seen in the people around me that have had kids, and they're expecting kids, the mental health side is a big...

Partner: Big, big, big thing.

KI001: Like, some people around us, they did really well with the first child, but the mental health has gone a bit downwards with the second, third, fourth, fifth, you know, carry on, kind of thing.

Partner: Yeah, it’s just everyone doesn't like asking for help. Everyone doesn't like admitting when you have a problem.”

The model’s integrated approach—with the option of referral to a Health Improvement Practitioner (HIP) or other in-house support—was viewed positively. Māmā appreciated being told that help existed and that seeking it was normal:

“They were asking, ‘do you want help? We have this person, we have that person’... they referred me to someone at the GP.” [KI002]

Even when māmā chose not to take up these offers, knowing that mental health support was available was reassuring. The approach was perceived as mana-enhancing and non-judgmental, offering choice rather than pressure:

“It’s kind of giving them reassurance that I’m in a good situation... I don’t mind those kinds of questions.” [KI004]

However, a few participants described variable follow-up and limited practical guidance if they began to struggle with their mental health and wellbeing. As one explained,

And then the other thing would be, yeah, probably mental health logistics in terms of the support and understanding there might be a service that they could refer to to support you with that. 003

KI005: They keep bringing up my mental health... It's all coming back to when I was younger. And coming back to me still to this time.

Interviewer: Was that mental health stuff around your pregnancies?

KI005: No.

Interviewer: Have they gone into with you what you should do if you start to feel like that again?

KI005: No

Environmental stressors, such as unstable housing or exposure to unsafe surroundings, also impacted mental wellbeing. While some māmā had strong support from HIPs or partners, others described ongoing stress:

“Some days around this [housing] complex,... that’s stress as it is for me... I need to get out of here because of my mental-health state of mind.” [KI005]

Importantly, many valued the relational aspect of care—being able to speak honestly without judgment:

Just laying it out on the table was nice. Just so then it was like out there, like. And yeah, because my partner used to say, why are crying for? And I just used to, oh, well, I don't know. Like, I don't know. [KI006]

Of note, however, the number of appointments māmā were required to attend during their pregnancy had an impact on whether or not they were able to connect with extra agencies for support.

Interviewer: “Do you see your HIP very often?”

KI005: “No, because I'm so busy with all my midwife appointments and baby scans and blood tests.”

Summary

Overall, the Best Start framework provided a vital entry point for early discussion of perinatal mental health, particularly through its holistic, hauora-aligned design. Māmā appreciated the empathy and openness of staff, the normalisation of mental-health kōrero, and the offer of practical supports. Future refinements could focus on ensuring consistent follow-up for those identified as at risk, improving coordination between HIPs and maternity teams, and maintaining strong, trusting relationships that encourage ongoing engagement and self-referral.

Implications for Practice

These findings highlight the importance of integrating mental health support as a routine and culturally affirming aspect of antenatal care. Embedding te taha hinengaro assessment within early pregnancy encounters, such as the Best Start, can facilitate early identification, reduce stigma, and normalise conversations about distress. To build on this foundation, services should ensure clear and timely follow-up pathways for those at higher risk, including consistent referral processes to HIPs and counselling providers. Strengthening whanaungatanga between nurses and māmā is also critical, especially for those with prior trauma or reluctance to engage with formal mental health services. A flexible, relationship-based model that enables self-referral, peer support, and wraparound care—while actively acknowledging the social determinants of wellbeing—has the potential to enhance outcomes for hapū māmā and their whānau.

Medical Oversight and Addressing Medical Needs

Medical oversight played a crucial role in identifying and responding to physical health needs during pregnancy, with many māmā appreciating the responsiveness and continuity of care

provided by the nurses and practitioners involved. For example, one participant described how their nurse promptly prescribed folic acid and anti-nausea medications, and when those weren't effective, provided practical home remedies to try instead. This flexible and caring approach helped build trust and responsiveness into the care pathway:

“She tried different nausea pills... they all didn't work, but she just gave me some home remedies to try and went from there.” [KI001]

It was also noted that the Best Start conversation enabled early detection of physical health issues such as iron deficiency, particularly for those with dietary restrictions during pregnancy:

“I can't eat red meat and I struggle to take in iron... [it] was picked up in your Best Start? Yes.” [KI001]

The model of care also functioned as a key referral point for those with complex health needs, including individuals on high-risk medications. One participant shared that their medication regime required careful adjustment during pregnancy to avoid potential risks to the pēpi:

I have been back to [Health Service], yep. I have, because I'm under high medications. But because I'm pregnant, they've got to wean me off them... [KI005]

While some appreciated that these issues were recognised and documented, others highlighted a gap in follow-up support:

Interviewer: “Have they put in support for you around that?”
KI005: “Yeah, no, they haven't.”

Participants also appreciated how nurse practitioners coordinated with doctors to ensure appropriate medical management:

“You see the nurse practitioner... she just had to follow up with the doctor... That's so valuable when you've got other health things going on.” [KI006]

However, a recurring theme was the desire for more structured support after health issues were identified. While early detection and documentation were strengths of the system, follow-up pathways were sometimes unclear or absent, especially for those with existing health challenges that intersected with their pregnancy.

Overall, these experiences reflect the value of integrated medical oversight within a wrap-around care model, while also highlighting the need for improved continuity and resourced pathways to support follow-through once physical health concerns are raised.

Practical Oversight and Organisation of Care

Organisation of care emerged as both a key strength and a persistent challenge within the current model. Many māmā valued nurses who proactively coordinated appointments or

adjusted schedules to make care more manageable. For those living rurally or juggling multiple commitments, such consideration was particularly appreciated:

“They didn’t want me to have to come back in again. So, they actually went out of their way to try and make it easy.” [KI002]

However, the complexity of multiple, overlapping appointments — often across hospital and community settings — created stress and sometimes led to missed care. One māmā explained how the sheer number of appointments became overwhelming:

“It’ll just be appointments nearly every day... and then I just discharge myself because I can’t handle it.” [KI005]

Although the use of reminders such as texts and letters was common, inconsistent communication between services sometimes resulted in confusion or duplication. As one participant noted:

“We turn up to the hospital... and they said it’s been rescheduled. Why didn’t you guys tell us?” [KI005]

The lack of a single person or system to “tie it all together” was a recurring theme, suggesting a gap in the coordination of wrap-around care.

Despite these challenges, there were examples of proactive and relational care that aligned closely with Kaupapa Māori principles. Nurses who offered flexibility and continuity—or who shared lived experiences, such as being hapū themselves—were seen as approachable and understanding:

“It was actually pretty cool having a nurse in the space as well.” [KI002]

Māmā also valued when practical barriers were recognised and addressed, such as through taxi chits to reduce transport stress, or opportunistic scheduling of multiple appointments in a single visit. These small but meaningful adjustments helped reduce the load of navigating a complex maternity system and supported greater engagement with care.

Resources Provided

Resources offered through Best Start were mixed in quality and usefulness. While some māmā recalled being asked helpful background questions (e.g. whānau support, safety), others felt the follow-up was lacking. One participant described receiving an information pack with expired creams and outdated vouchers, which undermined its credibility and utility. Pamphlets were provided but often generic, duplicating information easily found online rather than reinforcing personal discussions with the nurse. Participants expressed that if important service information had been discussed during the appointment, they would have benefitted from receiving personalised, written summaries or referrals. The lack of tangible take-home resources meant that many forgot what had been suggested or didn’t follow through.

Māmā described mixed experiences with the information and resources received through Best Start. While many appreciated being asked helpful background questions (e.g., whānau support and safety), several felt that the practical take-home resources were limited or outdated. One participant explained:

“We have family support, but we don’t here. We don’t really know what’s out there... you can’t remember what they suggested because it wasn’t written down.” [KI001]

Several māmā received resource packs but some felt disappointed by their quality or relevance:

“I just got this bag and it had heaps of expired little things... like an expired bio-oil cream and an expired voucher. I didn’t really find that very helpful.” [KI001]

Information pamphlets were typically generic and not connected to the kōrero that took place during the assessment:

“It was about the different do’s and don’ts in pregnancy... different services you can use... but they weren’t reminders of services you discussed with your nurse.” [KI001]

Others reflected that while key wellbeing questions were asked—such as about safety, relationships, and living situations—these did not always translate into meaningful follow-up or potential referrals for community support:

“They obviously asked all of those basic questions... I guess maybe because my answers were all fine, they didn’t offer that. Maybe if my answers had been different, they would have.” [KI004]

Overall, while the Best Start process enabled useful screening, participants highlighted the need for consistent, personalised, and current resources—particularly written summaries of local supports that reinforce what was discussed in appointments.

Access to Appointments

Access to appointments was generally described as positive when nurses took time to schedule appointments around work, childcare, or travel constraints.

“[The nurse] made it really easy. So straightforward. She was really good. She was really accommodating. I gave her times that suited us while the kids are in kindy, and she just found an appointment within those times.” [KI001]

Some called to confirm in advance and followed up after the visit; for example, to ensure that māmā had accessed their prescriptions or other pregnancy-related things.

“She rang back and asked me to pop in and she’s done it herself... because the receptionist told us to leave. She checked that I’d got my script for the nausea pills and iron tablets.” [KI001]

Participants valued back-to-back appointments and advanced notice, which reduced stress and made it easier to plan transport.

“It was simple, like having the appointments back-to-back rather than different days... and they told me in advance, not just ‘we’re open today, want to come?’ and I have to scramble for a ride.” [KI002]

However, where access broke down (e.g. requiring a repeat prescription but being told by each service to access this from a midwife from a different service), participants sometimes experienced frustration or loss of trust.

“Yeah, everyone's booked out from [Month], which is where I kind of need that midwife support... I rang [Health Service] for a check-up and they told me I have to ring the hospital. So, I rang the hospital and they told me, ‘no, you need to go ring these midwives. I'll send you a list because we can't help you unless they say no’, and I'm like, well I just told you they said no, so why are you not helping me?” [KI001]

In contrast, others found the process straightforward and well-supported, especially where the nurse checked in before and after visits. Flexibility and proactive communication were highly valued, particularly when balancing pregnancy with work or childcare responsibilities:

These examples demonstrate how relational, flexible, and well-organised care made a tangible difference in access and continuity. However, the few instances of miscommunication between clinical and administrative staff also highlight where clearer processes could further enhance the experience for hapū māmā.

The Importance of Self-Agency

Many māmā demonstrated strong self-agency—the confidence and determination to make informed choices about their own care and that of their pēpi. Many entered the Best Start process already engaged in learning, asking questions, and advocating for themselves, even when navigating complex or unfamiliar health systems. This proactive stance was reflected in comments such as:

“It goes very fast, I think. Especially if you actually want to be there. If you didn't want to be there and you didn't want this best start appointment, it would probably feel like it was dragging. But I wanted to be there, I wanted to know what they had to say.” [KI004]

Some māmā, especially those with previous pregnancy experience, did not feel an immediate need for referrals or external support. While they valued the information provided, they preferred to determine their own care pathways, either independently or alongside whānau.

“If I really did need help right there and then, I would be fine with that, but if it was something I just wanted to look into, I’d rather do it on my own and think about it.” [KI001]

Māmā spoke about researching information independently, comparing advice from different professionals, and making their own judgments about what felt right for them and their whānau.

KI001: “I remember the living situation.”

Partner: “Same.”

KI001: “At first, I kind of thought that was real weird.”

Partner: “Because I Googled it. I Googled, when they asked us “Is your house alright? Is it damp? Yeah, I was, yeah that that’s an out of it question, ok.”

“I felt like I got what I needed to from them from the appointment. I didn't leave them with all of these other questions. You don't really get all of these other questions until further in your pregnancy, you experience other stuff, which is when I start to use Google.” [KI004]

“There was a nurse there... and she asked a whole lot of questions and then she started giving advice against what my midwife had given... So, I didn't listen to her because her advice was, she was telling me to take vitamin D, this that the other... I spoke to my midwife about it afterwards, and she was like, “No, well, you don't actually need any of that stuff because you’re already doing all that with the plan that we've got in place.” [KI003]

These findings show that māmā are not passive recipients of care but active decision-makers who bring knowledge, resourcefulness, and resilience to the Best Start process. Supporting this agency through open communication, shared decision-making, and validation of māmā expertise strengthens partnership, enhances trust, and ensures care remains aligned with the values of manaakitanga and whanaungatanga—reflecting a wider strength of the approach.

Continuity of Care

Continuity—both relational and informational—was consistently identified as central to the model’s success. Earlier findings around midwifery access and trusted practitioner relationships illustrate how ongoing connection reduces stress and ensures seamless navigation between services. Embedding structured follow-up systems and stable provider relationships remains a key opportunity for improvement.

Māmā Pregnancy-Related Reactions, Reflections, & Shifts in Perspective

Participants reflected on diverse experiences surrounding the discovery of pregnancy and the evolving sense of agency and preparedness across pregnancies. These reflections shaped how, when, and why they engaged with care.

For some, discovering they were hapū was unexpected or unclear. One māmā described the confusion she experienced after receiving mixed results from different services:

“I took a pregnancy [test] before I went into [Secondary Care Service] and it said I was. The [Secondary Care Service] said I wasn’t. And then to go back later on... I am. It was just a bit... not the best way.” [KI001]

Others delayed disclosure or engagement with care due to minimal physical symptoms or a desire for privacy.

“Both pregnancies, I did leave it quite late... I didn’t really feel pregnant and I didn’t feel like I needed to seek that medical [care] because I kind of just felt fine.” [KI004]

For māmā who had previously struggled with fertility or had been actively trying, the confirmation of pregnancy brought surprise and a rapid emotional shift:

“I was trying for so many years and it never worked. And in such a sudden bang it worked. I was like, okay. Alright.” [KI005]

Some māmā were not aware they were pregnant until blood tests were done for other reasons or whānau commented on it.

KI005: “It was actually my partner that noticed it. I didn’t even know I was pregnant.”
Partner: “One of the cats... just started sitting on her stomach a lot... I was like, oh, that’s usually a sign.”

Others described complex emotional reactions based on their family situations. One noted:

“When we found out... my partner’s youngest had just started school. So, it was kind of like, oh, well, we’ve got to do that.” [KI006]

Several māmā shared how pregnancy became “real” only after engaging a midwife, particularly in the early stages when it had not yet been shared with others:

“Maybe just it becomes real after you get a midwife... once you get a midwife, it’s like, you’re pregnant. Even though the bloods obviously tell you you are.” [KI004]

The experiences of multigravida māmā highlighted how perceptions and approaches often shift between pregnancies. One described a heightened sense of responsibility and caution the first time around, compared with a more relaxed approach in her second pregnancy:

“On my first one... I felt like I had to do this, otherwise something’s going to happen... That first time round, I just cut out everything to make sure that everything was okay for baby... I don’t know what it is. You’re just a lot more relaxed the second time round.” [KI004]

This shift was also reflected in how resources were used:

“My first pregnancy I did read that book... the second one I didn’t. Because the first-time round, I’m just like, all excited. What’s growing today?” [KI004]

One māmā also described the challenge of balancing work and wellbeing, having pushed herself to continue working until late in pregnancy:

“I always told myself I'd work right up... I've got this, I'll work right up. I think I ended up stopping at like 36 weeks. I was like, nah, I need the time for myself. I feel like... you put more stress on yourself... if I don't stop now, I'm going to be... actually have no time for myself before the baby comes.” [KI006]

She continued by discussing her insights after she had stopped working, with a sense of regret that instead of focusing on whānau and her own needs, she had prioritised work. This māmā had not been able to access hapū whānau or antenatal classes and was poignantly aware of how, perhaps, if she had been involved in some form of antenatal community group, she might have been more aware of the high expectations she was placing on herself and the alternatives.

“I feel like if I just didn't worry about work as much as I did, and kind of put me and my family first and just said, ‘no, that's it!’ and just put a stop right to it, because I feel like I had to kind of not let my clients down. So, a little bit, they kind of came first... So, and I, yeah, I wish I didn't in a way. Now that I see it on maternity leave... If I had just been like, hey, look, I've got this [appointment]. I'm going to be taking the day off, or I'm taking this much time off, and then I'll be back. Yeah. But at that time, I just thought, no I need to go to work and I'll just try and get that appointment. And if it's not going to work with me, then I'll try the next day or, you know, or just ring and be like, ‘do you have an appointment for this time?’ to try and make it work for me and my job? Yeah, instead of just being like, ‘no, I've got this [appointment] and it needs to be attended to’... Yeah, a bigger picture now.” [KI006]

The need for trustworthy, non-judgemental information and reassurance was also emphasised. As one māmā explained:

“When you search on Google... it's just always going to tell you you shouldn't do something... So, to have [someone to talk to] is... yeah, I think it's really good.” [KI004]

Together, these reflections highlight that pregnancy is experienced in unique, shifting, and context-specific ways. First-time and returning māmā bring different levels of knowledge, confidence, and support needs. These findings point to the importance of early antenatal care approaches like Best Start being both adaptable and relational—offering māmā space to come to terms with their pregnancy, connect to appropriate support in their own time, and feel genuinely heard and supported, regardless of whether it is their first or fifth pregnancy.

Māmā-Led Insights & Suggestions For Improving The Best Start

Continued Face-To-Face Format

Some māmā highlighted the value of kanohi ki te kanohi (face-to-face) appointments for Best Start. This format conveyed a sense of importance and validation:

“So, the fact that they do it face to face tells you that it's actually really important.” [KI004]

Participants felt that in-person delivery provided better engagement and understanding compared to phone or online options:

“Yeah, I'm not interested in, like, over the phone stuff... I would have felt it wasn't important.” [KI004]

Alternative or Supportive Formats

While face-to-face was valued, many māmā emphasised the need for alternative or flexible formats—particularly to reduce information overload or better suit neurodiverse or time-constrained needs. Suggestions included completing parts of the questionnaire independently prior to the appointment, splitting the appointment across two sessions, or providing visual or video-based content:

“It would be nice just to have different options... here we go again... For me, to be honest, I would have liked to fill out some of the paperwork my own. Only because, well my living arrangement is the same as last time. Could have just shortened the time.” [KI001]

“Even just break it down into two appointments... It's the hour of thinking and answering questions and it does get a bit hoha.” [KI001]

“Put it in a movie... These are the services you can get. Oh, it would be all good.” [KI001 Partner]

Online options were also suggested, particularly for those already familiar with the content:

“I would have preferred if it was online and I could do it myself at home... I was drained. Socially drained. Mentally drained.” [KI002]

However, several māmā indicated that these alternatives should be optional rather than standardised, given the diversity of needs and preferences:

“I think it should be given the options... so you feel like you know what's going on.” [KI001]

Support for Practical Needs

Participants advocated for more tangible follow-up supports tied to their specific needs—especially around finding a midwife or navigating other services:

“If the Best Start included helping and supporting finding a midwife... that would lessen the awkwardness.” [KI001]

Others noted the benefit of tailoring the environment or interaction to reduce discomfort or whakamā (shame):

“Maybe ask the māmā, are you comfortable? Are you warm? Do you need anything?.. If they don't feel safe going to a medical place, maybe they come to their house.” [KI005]

Practitioner Continuity and Approach

Trust and continuity of care emerged as central to a positive experience. Māmā wanted to see the same practitioner throughout, with a respectful and welcoming approach:

“I'd have the same person, the same carer... explain that there might be some sensitive questions in here.” [KI003]

This was particularly important when discussing sensitive issues like mental health, housing, or past trauma:

“Don't overly push people... that's how they close themselves off.” [KI005]

Resources and Reminders

There was a strong desire for written or digital follow-up materials summarising key services and supports discussed during the appointment:

“It would be nice just to like be able to go back and be like, oh, that's right... I can ring this number.” [KI001]

“Even having like a pamphlet... so you can actually read through and remember what the services were.” [KI001]

“A little follow-up text. That'd be easy.” [KI003]

Simple, accessible formats were preferred over flashy brochures:

“A piece of paper would be fine... just a reminder that could be helpful.” [KI001]

Ongoing Value Across Pregnancies

While first-time māmā felt the Best Start process was especially beneficial, many also found value in repeating the process with subsequent pregnancies—either as a refresh or because each pregnancy can bring different challenges:

KI004: “New things come up...”

Interviewer: “So even if you got asked in future pregnancies, you think you would say yes?”

KI004: “Yeah.”

Others acknowledged the role of Best Start in normalising mental health conversations and creating a safe space for disclosure:

“It’s just nice to get the information out there... before it gets too late.” [KI006]

“The mental health side is a big... big, big, big thing.” [KI001 Partner]

Overall Appraisal of the Best Start

Most māmā reflected positively on their experience of the Best Start assessment, often rating it highly due to the nurse's relational approach and the feeling of being cared for. Several rated their experience an 8 or 9 out of 10, emphasising how they “didn’t feel like [they] left there with a bunch of questions unanswered” and that they “got what [they] needed to from it” [KI004]. The interpersonal connection with the nurse was a central factor:

“She was so good... I really felt like she really cared. I know that there can be some nurses that would just sit there and read every single question to a T... whereas she came up with conversation within the survey.” [KI002]

Others described the session as “pretty straightforward,” “welcoming,” and akin to a “refresher” of existing information [KI006]. Some noted the value of receiving early support before they had access to a midwife, particularly in the first trimester, describing the timing as appropriate and useful. However, a small number of māmā had more neutral or mixed experiences, with one noting discomfort and rating the session a “3.5 to 4” due to how some questions were asked [KI006], and another suggesting the process could be made clearer upfront:

“Because you’re pregnant, we have a Best Start questionnaire... Would you like to come in and have that?” [KI003]

Overall, the assessment was seen as worthwhile, especially when delivered with warmth, flexibility, and clarity:

“I would recommend Māmā's to do it. Yeah, if they get the opportunity.” [KI006]

Discussion

The findings from this evaluation offer important insights into māmā’s experiences of the Best Start assessment in two community-based, equity-focused primary care settings. Overall, māmā described the Best Start assessment as a valuable opportunity for early connection, support, and reflection—especially when delivered through trusted, relational practitioners. Key enablers included whakawhanaungatanga, clear communication, and coordinated follow-up. Barriers arose when care felt rushed, transactional, or insufficiently explained. These insights collectively demonstrate that culturally-grounded, relationship-based approaches are essential for achieving equitable, holistic pregnancy care. However, the results also highlight the variability in implementation, communication, and accessibility, suggesting that there is need for further development and refinement of the assessment process.

Early Identification and Pregnancy Confirmation

For many māmā, the Best Start assessment was their first structured appointment following the confirmation of pregnancy. The assessment played a central role in not only identifying health and social needs early, but also in acting as a gateway to antenatal support at a time when few had a midwife assigned. This early contact was especially valuable for first-time māmā and for those without strong existing ties to maternity services. However, inconsistent pathways for identifying pregnant patients in practice systems meant that some māmā missed out on timely engagement with the assessment, highlighting the need for clearer processes and proactive outreach.

While not explicitly raised by māmā, the research highlighted that the current system for confirming pregnancy may be unnecessarily prolonged and burdensome. Several māmā described attending an initial appointment solely to inform their general practice of their pregnancy or to have it formally confirmed. These appointments typically involved a urine test and a referral for a blood test, primarily so that the clinician could “make sure” they were pregnant. However, most māmā had already confirmed their pregnancy through at least one home pregnancy test prior to attending.

This additional appointment placed an avoidable financial and logistical burden on māmā, particularly as it was followed by a separate, funded Best Start appointment. Attending two separate appointments created an extra step in what could be a streamlined process. A more efficient approach could involve merging the confirmation and Best Start assessments into a single, free appointment. Māmā who present to the practice for pregnancy confirmation could be directly scheduled into a Best Start time slot. This appointment could incorporate the urine test and blood test referral alongside the Best Start assessment itself.

Many māmā reported feeling overwhelmed by the volume of pregnancy-related appointments required, especially when managing other children or employment. Streamlining these early appointments could help reduce this burden. However, implementing this approach would require Best Start assessments to be delivered by nurses with strong communication skills, cultural competence, and the ability to quickly build trust and connection (whakawhanaungatanga). Without prior rapport, nurses would need to be especially attuned to the needs of māmā to ensure that the assessment remains a positive and supportive experience.

Best Clinicians and Optimal Locations for Delivering the Best Start Assessment

Determining who should deliver the Best Start assessment, and where it is best conducted, are central considerations in ensuring that the model remains both effective and culturally acceptable. Findings from this evaluation indicate that while the assessment can technically be completed by any appropriately trained clinician, its success depends less on clinical role and more on the individual’s communication style, relational approach, and cultural competence. Māmā consistently valued nurses who demonstrated warmth, empathy, and active listening—qualities that align with manaakitanga and whakawhanaungatanga. Those practitioners who could quickly build trust, adapt their communication, and take time to connect were most effective in creating a safe and mana-enhancing space for discussion.

The evidence therefore supports nurse-led delivery as the preferred model, provided that nurses receive ongoing training in cultural safety, trauma-informed care, and strengths-based communication. Health Improvement Practitioners (HIPs) and Health Coaches (HCs) also play an important complementary role, particularly when they are integrated into the assessment process through warm handovers or joint sessions. In some cases, clinicians with established relationships—such as practice nurses known to the māmā or kaimahi from community-based services—may be best positioned to lead or co-facilitate the assessment, ensuring relational continuity and a sense of familiarity.

Equally important is the setting in which the assessment takes place. While general practice settings are effective for opportunistic identification and integration with other health services, they may not always offer the most culturally safe or comfortable environment. Māmā who completed their Best Start Evaluation interviews within the community-based, Kaupapa Māori setting of Te Whare Piringa emphasised the value of kōrero in this relaxed setting. These spaces, grounded in tikanga and wairuatanga, provided a calm, non-clinical atmosphere that supported open kōrero and strengthened engagement. Flexibility of location—offering options such as home visits, Te Whare Piringa, or general practice clinics—allows māmā to choose where they feel most comfortable, which is particularly important for those with prior negative experiences in clinical settings or barriers such as transport and childcare.

In summary, the findings suggest that the *best clinicians* are those who combine clinical expertise with relational skill and cultural humility, and the *best locations* are those that uphold choice, comfort, and cultural alignment. Embedding flexibility into both who delivers and where the Best Start assessment occurs will ensure that it remains consistent with the principles of equity, partnership, and whānau-centred care.

Understanding and Informed Participation

Experiences of being introduced to the Best Start assessment varied widely. Some māmā described being invited into the appointment with clear explanations and the option to decline, while others were not aware that they were participating in a formal assessment. The lack of informed participation—the ability of māmā to fully understand the purpose, content, and voluntary nature of the Best Start assessment—was more common among younger māmā and those for whom English was not their first language. For these groups, the role of the nurse was critical in breaking down the purpose of the appointment, explaining the process step-by-step, and checking for understanding. Without this scaffolding, some māmā were left feeling unsure, or even mistrustful, of the purpose behind some of the questions.

The Experience of the Best Start Assessment

While most māmā appreciated the holistic nature of the questions and the opportunity to discuss potential support opportunities, the format of the Best Start tool as a questionnaire had the potential to be experienced as a rigid checklist. How the tool was used varied between clinicians. Two main approaches to the delivery of the Best Start were identified: 1) the use of the tool as a 'checklist' or 'box-ticking' approach, and 2) the use of the tool as a guide to

understanding the areas where Māmā might need more information or support. Māmā who experienced the Best Start as being asked a “bunch of questions” that were “clicked through” on the screen, were less likely to engage in the process than māmā who experienced the assessment in a more conversational, relational format. Use of the Best Start as a checklist was perceived as onerous and, at times, intrusive. In addition, when answers did not fit easily into predefined boxes, the flow of the assessment was interrupted. Some felt reminded of compliance-driven processes used by government agencies, which could contribute to feelings of suspicion or caution about disclosing personal information. However, these effects were often mitigated when nurses used the tool in a flexible, conversational way, embedding whakawhanaungatanga and manaakitanga into the interaction.

Barriers and Enablers of Care

The nurse delivering the Best Start assessment was often the most significant determinant of whether the experience was positive, supportive, and empowering. Where nurses took time to build rapport, adapted their communication style, and offered warmth and empathy, māmā consistently reported feeling comfortable, heard, and cared for. Practical barriers such as transport, cost, or difficulty making appointments were also identified, particularly for māmā without access to regular support.

Wrap-around Support and Follow-up

Māmā appreciated the support they received around accessing a midwife, hapū wānanga, and mental health (e.g., increasing awareness of the potential to access HIPs within the service). In addition, when clinicians followed up after the Best Start appointment (e.g., to check that she had been able to secure a midwife), māmā described feeling genuinely cared for. However, there were inconsistencies in how this support was communicated or actioned. A small number of māmā described receiving no follow-up, being bounced between services (e.g., when trying to access a midwife), or being unsure how to navigate a system that kept referring them to other agencies. Strengthening the referral process, ensuring clear documentation, and maintaining shared understanding among providers would enhance the continuity and effectiveness of care.

Overarching Components of Care

Across all interviews, māmā highlighted three overarching components that shaped how they experienced the Best Start assessment and their wider engagement with primary care. While each component of the model contributed differently, the areas of communication, manaaki and whakawhanaungatanga, and alternative formats stood out as the most influential in determining whether the process felt supportive, empowering, and culturally safe. These elements were central to how māmā judged the *cultural acceptability* of the Whanganui Best Start Model of Care—whether it upheld values of respect, inclusion, and mana-enhancing practice, or whether it felt transactional and detached. Together, these themes cut across all stages of care, reflecting not just how services were delivered, but how they were received, understood, and felt. They emphasise that the strength of the Best Start Model lies not only

in its systems and structures, but in the quality of relationships, responsiveness, and flexibility shown in everyday practice.

Communication

An important aspect of communication within the Best Start assessment was the presence—or absence—of informed participation: the ability of māmā to fully understand the purpose, content, and voluntary nature of the Best Start assessment, both before agreeing to take part and throughout the assessment itself. Informed participation requires clear, culturally appropriate communication by the nurse or practitioner, allowing space for questions, checking for comprehension, and ensuring māmā feel confident and safe in choosing to engage.

For many māmā, the experience of communication was the single greatest factor shaping whether the assessment felt empowering or intimidating. When nurses explained the process clearly, invited questions, and used a conversational approach, māmā felt respected and supported. Conversely, when the process felt rushed, overly clinical, or “like ticking boxes,” trust and engagement diminished. Effective communication was strongest where practitioners recognised that māmā came with differing levels of prior knowledge, health literacy, and confidence navigating services, and adjusted their approach accordingly.

Manaaki and Whakawhanaungatanga

As described earlier, whakawhanaungatanga was central to positive Best Start experiences, forming the foundation for trust, openness, and emotional safety. Embedding this principle across all stages of care—from first contact to follow-up—ensures that the cultural value of manaakitanga remains integral to clinical practice.

Alternative Formats

While the face-to-face format of the Best Start assessment was valued for its relational benefits, many māmā expressed the need for alternative or flexible formats that better reflected their diverse circumstances. Māmā suggestions were not about replacing the face-to-face approach but about creating choice. Māmā emphasised that alternative formats should be optional and culturally appropriate, ensuring that every participant can engage in a way that fits their needs and comfort level. Offering flexible pathways—such as digital forms, recorded video explanations, or printed guides—would uphold equity by removing participation barriers while preserving the mana-enhancing, relational intent of the Best Start process.

While the preceding sections highlight the service-level and practitioner components that shaped māmā experiences of the Best Start assessment and model of care, the kōrero also revealed another important dimension: the strengths that māmā themselves bring to the process. These strengths—grounded in resilience, whānau support, and a deep sense of responsibility for their own wellbeing and that of their pēpi—are central to understanding why the Best Start Model of Care works for many whānau. Recognising these inherent

capabilities shifts the focus from viewing māmā as recipients of care to acknowledging them as active partners and drivers of their own health journeys.

Acknowledgement of Māmā-Based Strengths and Contributions to the Best Start Process

Although the primary aim of the evaluation was to understand how the Whanganui Best Start Model of Care was designed, implemented, and experienced in practice, the voices of hapū māmā also revealed significant strengths that they themselves bring to the assessment process. These strengths—rooted in self-advocacy, cultural identity, whānau connection, and a desire for knowledge—are central to the success and sustainability of the Best Start approach.

Many māmā entered the Best Start assessment with a strong sense of agency and determination to do what was best for themselves and their pēpi. Even in the face of uncertainty or barriers to accessing services, they demonstrated persistence in seeking care, asking questions, and following up on referrals. This willingness to engage, even when systems were confusing or inconsistent, reflects deep motivation and resilience. For some, the appointment was an opportunity to voice concerns or clarify information they had gathered from their own research, showing a proactive orientation toward learning and decision-making in pregnancy care.

A recurring theme was the importance of whānau as a source of strength. Māmā frequently described being guided by partners, parents, siblings, or friends who encouraged them to seek help or who shared their own pregnancy experiences. This relational support enhanced confidence and reinforced the sense that Best Start care was a shared journey rather than an individual one. Māmā who felt able to bring whānau into the conversation—either literally or through shared decision-making—described feeling more empowered and connected throughout the process.

Cultural identity and community connection also emerged as powerful assets. Māmā who engaged with Kaupapa Māori spaces such as Te Whare Piringa or hapū wānanga described feeling affirmed and “seen” in those environments, which strengthened their confidence to advocate for themselves in other health settings. Their reflections show that cultural belonging operates as both a protective and enabling factor, amplifying engagement when services align with Māori values of manaakitanga, whanaungatanga, and wairuatanga (spiritual wellbeing).

Collectively, these findings highlight that hapū māmā are not passive participants but active partners in achieving equitable and culturally responsive care. Their openness, self-awareness, and willingness to engage form the foundation upon which the Whanganui Best Start Model of Care can continue to grow. Recognising and intentionally building upon these māmā-based strengths will be essential to evolving the programme beyond a service-delivery model toward one that genuinely honours partnership, empowerment, and collective wellbeing.

The recognition of māmā-based strengths within the Best Start process provides a foundation for strengthening both engagement and outcomes. To ensure these strengths are not only

acknowledged but actively woven into the model, practitioners must approach each Best Start encounter as a partnership rather than a process. This begins with taking time to understand each māmā's unique circumstances, aspirations, and sources of strength—whether these lie in her whānau connections, cultural identity, lived experience, or self-determination. Practitioners can actively draw on these assets by asking open, mana-enhancing questions that invite māmā to share what already supports their wellbeing, and by affirming these contributions as valid foundations for care. Embedding these strengths within the assessment and follow-up process shifts the dynamic from service provision to co-creation, where solutions are shaped collaboratively and respect māmā expertise. This approach also requires flexibility in practice—allowing for whānau inclusion, shared decision-making, and ongoing reflection on how clinical processes can better align with Māori models of wellbeing. By grounding care in the recognition of māmā capability and leadership, the Best Start Model can continue to evolve beyond a service-delivery framework toward one that truly honours partnership, empowerment, and collective wellbeing.

Together, these findings suggest that the ongoing success of the Best Start Model depends as much on recognising and nurturing the strengths that māmā bring as it does on refining systems and clinical processes. When the model is grounded in authentic partnership and shared leadership with māmā and their whānau, it becomes not only more culturally acceptable, but also more sustainable—reflecting a model of care that grows from within the community it serves.

Overall Acceptability of the Best Start Model of Care and Clinical Implications

In summary, the Whanganui Best Start Model of Care was largely perceived as acceptable, valuable, and supportive by hapū māmā. Most participants rated their Best Start appointment positively and viewed it as an opportunity to have questions answered early, receive reassurance, and strengthen their connection with primary care services. The model's proactive and holistic approach—particularly the early identification of pregnancy, the unpressured time allowed for discussion, and the inclusion of wellbeing pathways—was recognised as a key strength. These aspects were consistent with the values of manaakitanga, whanaungatanga, and tino rangatiratanga, supporting a sense of trust and partnership between māmā and practitioners.

However, the degree of acceptability varied depending on how well the assessment was delivered in practice. Where communication was clear, relational, and culturally attuned, the assessment process was described as empowering and mana-enhancing. In contrast, when the interaction felt procedural or lacked warmth, māmā were less likely to feel engaged or to view the process as meaningful. The findings demonstrate that the acceptability of the model is not determined solely by its structure, but by how effectively its guiding principles are embodied in day-to-day practice.

From a clinical perspective, these findings carry significant implications. First, relationship-based communication and cultural responsiveness must remain at the centre of care delivery. Ongoing education and reflective practice for nurses and clinicians are essential to strengthen skills in whakawhanaungatanga, informed communication, and trauma-aware engagement. Second, continuity and integration between services—particularly between nurses, HIPs/HCs,

and midwives—require further development to ensure that māmā receive seamless wrap-around support rather than fragmented or duplicated care. Third, there is an opportunity to increase flexibility and choice in how the assessment is offered, through alternative formats that better meet the needs of neurodiverse, rural, or time-constrained māmā, while retaining the relational strengths of face-to-face contact.

At a systems level, the findings suggest that the Whanganui Best Start Model of Care has achieved much of what it set out to do—creating an early, structured, and holistic entry point to antenatal care that reflects local needs and values. However, for the model to fully realise its potential as a culturally acceptable and equitable approach, clinical governance must continue to evolve from a service-centred framework to a truly māmā- and whānau-centred model of practice. Strengthening consistency, communication, and inter-service connection will ensure that all māmā—not only those who encounter the “right” practitioner—experience care that is relational, responsive, and grounded in Kaupapa Māori values.

Evidence of the Best Start Model Providing Full Wrap-Around Care

The Whanganui Best Start Model of Care was designed to embed culturally responsive, wrap-around support for hapū māmā through multiple clinical and relational components. These included: 1) Regular clinical governance; 2) Peer review meetings; 3) Peer education, audit, and data feedback; 4) Best Start lead nurse for task and recall list management; 5) Unpressured, protected time slots for nurse appointments; Alertness to pregnancy indicators in patient contacts including enrolments, consultations, and inbox reports; 6) Agreement on coding and classification processes; 7) Active engagement of the wellbeing teams—HIPs and Health Coaches—through use of ‘warm-handovers’; and 8) Follow-up care integrated with midwives including the availability of a Best Start clinical summary. The voices of māmā in this evaluation provide valuable insight into how each of these features was, or was not, reflected in practice.

Regular clinical governance and **peer review meetings** were not directly visible to participants, as they are internal structures that were operating behind the scenes. However, māmā experiences varied considerably between practices and practitioners—some describing warm, relational, and well-coordinated care, while others experienced confusion, inconsistent communication, or judgment. This variation points to a need for stronger governance oversight and peer reflection to ensure a consistent, culturally safe approach across all providers. Similarly, **peer education, audit, and data feedback** were not evident from māmā perspectives, with differences in practitioner competence, communication style, and use of the Best Start tool indicating uneven training and reflective learning across clinicians and practices.

The role of a **Best Start lead nurse for task and recall management** was partially evident. Several māmā described being followed up and feeling cared for after their initial assessment, suggesting that nurse-led coordination was effective where established relationships existed. However, this was not universal, with others reporting little or no contact following their appointment. **Unpressured, protected time slots** were a positive aspect when clearly communicated—māmā valued having time and space to talk without feeling rushed. Yet when the appointment length was unexpected or poorly explained, some experienced

frustration or disengagement, particularly when balancing work and family commitments. This highlights the importance of managing expectations and maintaining flexibility while upholding the intent of providing unhurried, relational care.

There was strong evidence of **alertness to pregnancy indicators** in routine contacts. Several māmā described opportunistic identification of pregnancy during unrelated visits—such as attending for blood tests or other health concerns—which led to early engagement in antenatal care. This proactive approach aligns well with the model’s goals and was one of the clearest examples of the system working effectively. As would be expected, **agreement on coding and classification processes** was largely invisible to participants; however, in some cases, unclear documentation or inconsistent naming of the Best Start appointment led to confusion about whether the process had even occurred. Greater transparency and consistency in communication and recordkeeping would help strengthen trust and continuity.

Engagement of **Health Improvement Practitioners (HIPs)** and **Health Coaches (HCs)** through warm handovers did not occur for any of the māmā involved in the research. Although the role of HIPs and HCs in supporting mental health and wellbeing were sometimes discussed during the Best Start assessment, few māmā recalled being directly connected to these supports, suggesting that warm handovers are not currently occurring and that the value of wellbeing team involvement is not yet being recognised.

Similarly, **follow-up care integrated with midwives** varied considerably. While some māmā experienced strong continuity and collaborative care between their nurse and midwife, others reported conflicting advice or a lack of communication between providers. This inconsistency reduced confidence in the process and highlights the need for more formalised, transparent pathways for information-sharing and continuity across services.

Overall, the findings suggest that while the structural elements of the Best Start Model are largely functioning at a systems level, they are not yet fully visible or consistently experienced by hapū māmā. Interviews showed that proactive pregnancy identification and unpressured, relational engagement were strong features, aligning closely with Kaupapa Māori values of manaakitanga and whanaungatanga. Māmā appreciated being invited to access wellbeing teams and, in some cases, receiving clear follow-up care—indicating that these system-driven aspects are effective and valued. However, other components such as clinical governance, wellbeing integration, and coordination with midwives require strengthening to ensure a seamless and empowering experience. While the model has delivered meaningful improvements through proactive service-level actions, its focus remains primarily on organisational processes rather than on visibly māmā- and whānau-centred wrap-around support. Greater emphasis on relational, whānau-level engagement will be needed for the Best Start Model to fully achieve its intended impact across all settings.

Building on these findings, it is clear that while the system-level foundations of Best Start are strong, several key components of wrap-around care—particularly those that rely on inter-service coordination and direct support for māmā—require further attention. This was most evident in areas such as access to midwives and hapū wānanga, where the experiences of māmā highlighted ongoing gaps in navigation and continuity of care.

Strong evidence of this feature was found. Māmā described opportunistic identification of pregnancy during unrelated visits—such as coming in for blood tests, illness, or other health concerns—which allowed earlier connection to care and faster initiation of wrap-around support. Clinicians’ alertness to pregnancy cues was one of the clearest examples of the Best Start system working effectively, reflecting proactive engagement and commitment to early intervention.

These findings reinforce the importance of equipping general practice teams with the training and flexibility to identify pregnancy not only during formal confirmation appointments but also through opportunistic interactions. Among the eight māmā interviewed, four (50%) presented specifically for confirmation of their pregnancy, while the remaining four (50%) were identified through other contact points, including routine consultations, Emergency Department or Whanganui Accident and Medical (WAM) visits, and administrative follow-up. This highlights the pivotal role of primary care services in early antenatal engagement—particularly when clinicians are responsive to cues and supported by clear inter-service communication pathways. Embedding structured prompts or brief check-in questions during unrelated visits could further strengthen early detection and ensure equitable access to wrap-around support.

[Access to Midwives](#)

The ability for māmā to find a midwife varied significantly and there appeared to be no consistency or predictive factors underlying which māmā had acquired a midwife quickly and with ease and those who struggled to find one. A few māmā were still without a midwife when interviewed, despite their active attempts to secure one. The only consistent factor raised by māmā was when their baby was due, with many māmā declined midwifery services because none of the midwives had availability over the time that they were due to deliver. In one case, a māmā was informed that there would be a midwife starting early next year that would have capacity to add her to her caseload and that, until then, she could be supported by another midwife in that group. While it is positive that midwives are attempting to support māmā on an interim basis, to stop them from ‘falling through the cracks’, this was not an ideal situation for māmā, who preferred having the same midwife throughout their pregnancy. The possibility of having to swap to another midwife later in their care led to anxiety around how that might work and whether or not they would have time to develop a sense of trust with the new midwife.

Some māmā reported receiving information about how to find contact details for local midwives, with a few shown how and where to find the link on the internet. In addition, a few māmā received follow-up texts from their nurse checking in to see if they had found one. There were no accounts, however, of nurses actively supporting contact with midwives, by calling them at point-of-care, during the Best Start assessment. It is likely that, for some māmā, proactive contact with midwives during the Best Start appointment would have reduced the burden and confusion while trying to access one on their own. In order to provide full wrap-around care, there is a need for the clinician to support māmā, at whatever level they wish to receive support, to secure a midwife.

These challenges were particularly pronounced for māmā who had recently moved to Whanganui, many of whom were navigating both a new community and a new health system at the same time.

Mobility and Recent Relocation to Whanganui

A notable proportion of māmā interviewed had moved to Whanganui within the previous 12–18 months, highlighting the region’s changing population dynamics and the resulting implications for continuity of care. Many of these māmā described arriving in Whanganui with limited local connections and little knowledge of available maternity or primary health services. For some, this created uncertainty about where to begin seeking care and who to approach for pregnancy confirmation or support.

Those who successfully accessed the Best Start assessment often did so through opportunistic contact with general practices or word-of-mouth recommendations, rather than through established referral pathways. This finding suggests that new arrivals may face a higher risk of delayed engagement unless proactive outreach, early identification, and clear information about local maternity options are provided.

Conversely, māmā who had connected with community-based services such as Te Whare Piringa or who were supported by whānau already living in Whanganui described feeling welcomed and quickly linked into care. These examples reinforce the value of community anchors and culturally grounded spaces in supporting newcomers to establish trust, find belonging, and navigate the local health system.

Strengthening collaboration between general practice teams, community providers, and settlement networks—local systems, organisations, and informal supports that help people who have recently moved into a community—could help ensure that newly arrived māmā are consistently identified and supported early in their pregnancy journey. Recognising mobility as an important determinant of access is essential for maintaining equity within the Whanganui Best Start Model of Care.

Access to Hapū Wānanga/Antenatal Classes

Regardless of length of time living in Whanganui, few māmā who participated in a Best Start assessment linked their attendance at hapū wānanga or antenatal classes to information received during their appointment. In fact, none of the māmā reported enrolling in these courses as a direct result of the Best Start discussion. While some māmā recalled being told about available options, they often forgot the details afterward or were unclear about how to access them. Others remembered receiving information about upcoming hapū wānanga sessions but were unable to attend due to conflicting work shifts. Although many māmā had been informed about hapū wānanga, few felt they were given a strong sense of its purpose—such as gaining a deeper understanding of pregnancy, labour, birth, and newborn care, and building a support network with peers and experienced māmā. Several māmā reflected that, in hindsight, they would have prioritised attending if they had better understood the benefits and long-term value of participating.

Māmā insights, both from those who had accessed hapū wānanga through community contacts and those who had not attended one, clearly demonstrate the vital role of these courses—particularly hapū wānanga, which are based on Māori matauranga. This needs to be more explicit during the Best Start assessment. In addition, the way in which the information is provided and the level of nurse support needed to find and apply to a suitable course, needs to be individualised for each māmā, depending on their needs.

[Engagement with Te Whare Piringa](#)

Te Whare Piringa is a highly promising, yet currently underutilised, Kaupapa Māori-based community resource. It offers a wide range of supports, including full-time on-site kaimahi; weekly māmā and pēpi groups—one of which is specifically tailored for young māmā; regular hapū wānanga; free mirimiri (massage) for hapū māmā; access to midwife and nurse appointments; and private rooms for resting, breastfeeding, or taking time out. One of the service’s strongest features is its grounding in Kaupapa Māori values, creating a calm, non-clinical environment centred on whakawhanaungatanga and manaaki.

The drop-in model allows māmā to engage with the service at times that suit them, rather than needing to fit around appointment-based systems typical of medical care. Interviews conducted on-site highlighted the positive impact of this model, with a large majority of māmā going on to engage further with Te Whare Piringa after their interview. For young māmā, single māmā, and those new to Whanganui—who often lacked established support networks—this immediate connection to a community-based service was especially valuable. The presence of two lead kaimahi who share the role and offer continuity of care further strengthens the service. This was shown to support engagement and attendance during the Best Start process, reinforcing the importance of trusted relationships in early pregnancy care.

[Evidence of Key Features of Model Of Care Apparent Through Māmā Insights](#)

[Early Identification of Hapū Māmā](#)

Earlier findings highlighted the value of both self-initiated and opportunistic identification within primary care settings. Ensuring consistent processes across point of contact—from general practice to urgent care—supports early connection to wrap-around care and strengthens continuity between services. This reinforces early pregnancy identification as a primary means of achieving equity in access and care within the Best Start Model of Care.

[Equity-Focused Universal Care for All Māmā](#)

Equity-focused universal care for all māmā was strongly supported by the report findings. The model’s design aims to offer wrap-around, accessible services for all pregnant people. The report demonstrates attention to reducing barriers to care (e.g., free appointments, flexible locations) and prioritises access for priority groups. There is clear emphasis on equity for Māori, young māmā, and those without existing support. The involvement of kaupapa Māori organisations like Te Whare Piringa further strengthens this equity focus.

Opportunistic Assessment within Primary Care Settings

The use of opportunistic assessment within the primary care setting was supported through māmā insights. The assessment is routinely offered in general practice settings, and nurses are using opportunistic encounters to engage māmā. The report validates this model but suggests that location flexibility (e.g., offering assessments at Te Whare Piringa or in māmā's homes) could further reduce barriers and improve cultural alignment. In addition, the model could benefit from more structured options for where and when opportunistic assessments take place.

Nurse-Led Screening and Support, Delivered in a Flexible, Culturally-Aligned Way

Nurse-led delivery is working well, particularly when there is an existing relationship between nurses and māmā. Māmā valued relational, respectful care. However, the effectiveness was inconsistent depending on nurse communication style, cultural competency, and workload. Flexibility was sometimes lacking (e.g., fixed appointment times or locations). There was a clear need for ensuring nurses are trained in whakawhanaungatanga and cultural safety to improve delivery consistency.

Whānau-Centred Approach and Connections to Community and Hapū-Based Supports

There is evidence that the model promotes whānau-centred care, but connections to supports like hapū wānanga, Te Whare Piringa, and Plunket were not always well activated. Many māmā forgot the options discussed during the appointment or were unsure how to access services. This can be improved with clearer communication, tailored follow-up, and practical support (e.g., warm handovers, scheduled introductions) to strengthen these pathways.

Systematic Follow-Up of Identified Needs

Systemic follow-up of identified needs was partially supported; however, it was inconsistently implemented. While nurses do follow up on some identified needs, the report indicates this follow-up is variable and often dependent on workload, documentation, or personal initiative. Māmā frequently did not recall or receive proactive follow-up on issues raised during their appointment, highlighting the need for strengthening systematic processes and accountability for follow-up.

Embedding of Equity Principles, Cultural Safety, and Strengths-Based Practice

The focus on equity principles, cultural safety, and strengths-based practice was strongly supported in the design of the Best Start Model of Care; however, there was mixed evidence in implementation. The kaupapa and values underlying the model align well with equity and cultural safety principles. Many māmā experienced respectful, non-judgemental care, especially when seen by familiar nurses or when assessments occurred in culturally safe spaces like Te Whare Piringa. However, experiences varied, and some māmā described feeling

dismissed, unheard, or overwhelmed. Embedding training, cultural alignment, and workforce support is essential to strengthen this consistently.

Summary of Key Features

The evaluation found that the key features of the Whanganui Best Start Model of Care are largely supported by the experiences of hapū māmā who took part in this research. Early identification, equity-focused universal care, and nurse-led screening within primary care settings are functioning well, with most māmā being offered the assessment early in pregnancy. The model's Kaupapa Māori foundation and whānau-centred intent are clear strengths, particularly when assessments are conducted by familiar nurses or in culturally aligned spaces such as Te Whare Piringa. However, the evaluation also identified areas for improvement in terms of follow-up processes, cultural safety training, flexible delivery of care, and support to access community services like hapū wānanga. While the model is meeting its objectives in many respects, further refinement is needed to ensure consistency across sites and to implement equity-enhancing practices more deeply and systematically.

Recommendations

While māmā generally experienced the Best Start process as supportive and empowering, the following practical improvements could further strengthen its impact and value as an equity-enhancing model of care.

1. Streamline the Early Pregnancy Care Pathway

Combine the pregnancy confirmation appointment and Best Start assessment into a single funded appointment to reduce duplication, lower financial and logistical barriers, and support timely access to care. For this to be effective, the Best Start assessment must be delivered by nurses trained in whakawhanaungatanga and culturally safe engagement to ensure māmā feel comfortable, even without a prior relationship.

2. Strengthen Communication Through Relational, Respectful Engagement

Enhance the cultural safety and effectiveness of Best Start by embedding key relational principles in all interactions:

- **Whakawhanaungatanga first:** Build trust and meaningful connection before engaging in sensitive kōrero.
- **Socialise the purpose:** Clearly explain who is involved, why the assessment is done, and how information will be used.
- **Conversational approach:** Prioritise natural dialogue over a checklist-style delivery.
- **Use non-judgemental, strengths-based language:** Avoid triggering language around sensitive topics, such as, trauma, smoking, or drug use.
- **Centre māmā voice and expertise:** Listen without assumptions and support self-determination.

Implementing these approaches across all Best Start settings will promote equity, trust, and open engagement.

3. Offer Flexible, Māmā-Centred Options for Engaging With the Best Start Tool

Provide multiple, optional ways for māmā to complete the assessment, recognising differences in preference, cognitive load, and life circumstances. These options include:

- **Pre-appointment digital completion** (e.g. emailed PDF or form).
- **In-clinic tablet or iPad option.**
- **Staged completion** across multiple appointments.
- **Informative video** or resource introducing Best Start.

These formats can reduce overwhelm, improve accessibility for māmā with neurodiversity or trauma history, and support deeper, more meaningful engagement. Ensure a process is in place for nurses to review digital responses beforehand and to follow up where needed.

4. Offer Flexible, Culturally Responsive Locations for Best Start Assessments

Providing flexibility around where assessments take place—such as offering Te Whare Piringa or home-based options alongside general practice clinics—should become standard practice, supported by clear booking and documentation pathways. Flexible, culturally responsive locations help to:

- Reduce barriers such as cost, travel, and transport.
- Promote whānau involvement.
- Support comfort and cultural alignment.
- Decrease DNA rates.

Providing options recognises the diversity of māmā and their needs.

5. Strengthen Coordination and Follow-Up

Implement clearer systems to ensure key information (e.g. referrals, test results, service options—both within and between services) is documented, actioned, and followed up.

- **Designated Kaimahi or Coordinator:** Assign a designated kaimahi or coordinator for māmā with complex needs.
- **Proactive Support:** Proactively support midwife access where there are challenges.
- **Co-delivery Between Nurses and Wellbeing Team:** Prioritise warm handovers between nurses and wellbeing team members (HIPs, HCs, or kaimahi) through co-delivery or shared appointments.

These strategies reflect Māori models of wellbeing—such as *Te Whare Tapa Whā* (Durie, 1994)—by supporting balance across *te taha tinana* (physical), *te taha hinengaro* (mental and emotional), *te taha whānau* (family and social), and *te taha wairua* (spiritual) wellbeing. This

approach strengthens the wrap-around nature of Best Start care, ensuring that every māmā receives support that is relational, accessible, and grounded in Māori values.

6. Improve Resource Quality and Consistency

Ensure all māmā leave the assessment with:

- **Locally tailored, up-to-date information**—e.g. midwives, hapū wānanga, mental health supports.
- **Personalised handouts** based on identified needs, or a generic summary with key sections highlighted.
- **A “pregnancy pathway summary”** that māmā can keep and refer to across services.

These materials help reinforce what was discussed and can bridge communication between general practice, midwifery, and secondary services.

7. Tailor Best Start for Multigravida Māmā

For māmā who have previously been pregnant, offer a more flexible or "refresher" version of the assessment. This allows discussion of any changes in circumstance while acknowledging existing knowledge and keeping appointments efficient.

8. Enhance Cultural and Relational Continuity

Where possible, enable māmā to see the same nurse for follow-up appointments. Embed cultural safety by centring whakawhānau, mana-enhancing practices, and whānau-inclusive approaches across all points of care.

9. Strengthen Awareness of and Referral Pathways to Local Community Supports

Ensure every māmā is introduced to relevant local services—such as hapū wānanga or Māmā and Pēpi groups—during the Best Start process. Recommendations include:

- **Brief service introduction** within the appointment.
- **Tailored flyers, resource links, and enrolment assistance.**
- **Follow-up checks** to confirm service connection.

This ensures wrap-around care is accessible and integrated from early pregnancy.

10. Prioritise Acute Appointments during Pregnancy

Ensure that hapū māmā are consistently prioritised for acute or same-day appointments within all general practices and associated services:

- **Establish clear triage and recall pathways** to identify pregnancy status early and trigger prompt clinical responses when māmā present with acute needs.

- **Embed this approach with practice policies**, supported by staff training and regular audit.

Prioritising acute appointments in this way will help ensure that all māmā receive timely, reassuring, and culturally safe care, while reinforcing the Best Start model’s commitment to equity, early intervention, and wrap-around support.

11. Promote Supported, Low-Stress Access to Te Whare Piringa

Create and support systems that encourage māmā to engage with Te Whare Piringa early and meaningfully:

- **Offer Best Start appointments onsite**, especially for younger māmā, newcomers to Whanganui, or those without strong whānau networks.
- **Ensure access to HIPs or Health Coaches**—ideally full-time, but at minimum on scheduled days.
- **Consider inclusion of Plunket kaimahi** to support parenting and continuity.
- **Enable warm introductions** by nurses or kaimahi to reduce anxiety and build trust.
- **Strengthen general practice–community relationships** through regular check-ins, shared events, and co-training.

In addition, system-level efforts should be made to actively promote Te Whare Piringa as a referral option across services.

12. Improve Primary Care, Secondary Care, & Midwifery Services Connection

Address disconnection between services by:

- **Holding regular hui** (e.g. “kai and kōrero” style) to foster relationship-building and service awareness.
- **Developing shared referral pathways** that clarify who should lead care and how services can collaborate around each māmā’s needs.

This can reduce confusion and improve coordination for both providers and māmā.

13. Ensure Socialisation to Pregnancy-Related Healthcare

Proactively identify māmā with limited understanding of how pregnancy care works in Aotearoa—particularly young māmā and recent immigrants. Offer health-literacy conversations across multiple visits if needed, or hand this over to midwives where strong relationships exist, to avoid fragmentation and overwhelm.

14. Acknowledge Māmā-Based Strengths and Contributions

Actively recognise and build upon the inherent strengths that hapū māmā bring to the Best Start assessment.

- **Create training and practice guidelines** that emphasise partnership-based approaches that value māmā as co-contributors to their care, rather than recipients of services.
- **Support practitioners** to identify and draw on each māmā’s unique strengths—including self-advocacy, whānau connections, cultural identity, and personal aspirations—through mana-enhancing communication, open questioning, and shared decision-making.
- **Embed these strengths** within every stage of assessment and follow-up.

Active acknowledgement of māmā-based strengths and contributions will help shift the model from service delivery toward genuine partnership, empowerment, and collective wellbeing, ensuring the Best Start process continues to reflect Kaupapa Māori principles and community leadership.

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