THE ROLE OF THE MIDWIFE POLICY

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION

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1. Introduction

Ka Whangaia, Ka Tupu, Ka Puawai
That which is nurtured, blossoms, and grows.

The New Zealand Nurses Organisation (*NZNO*) Tōpūtanga Tapuhi Kaitiaki o Aotearoa seeks to articulate the Role of the Midwife policy for the purpose of informing and influencing government, ministry policy settings, funding decisions and the delivery of maternity care and services across the health sector.

The role of the midwife has evolved over time, and has been defined through educational preparation, regulatory standards, scope of practice, policy and public perception. NZNO's policy describes a future-focussed perspective, considering the challenges and current political climate in which midwifery exists.

The role of the midwife policy should be read in conjunction with other NZNO policies.

2. Definitions of Midwifery

The International Confederation of Midwives (ICM) definition and scope of practice provide a globally recognised foundation for understanding midwifery as a profession (refer Appendix One). In Aotearoa New Zealand, midwifery is delivered through a midwife led continuity of care model, in which midwives practise as distinct, autonomous, and accountable professionals[1].

This approach is consistent with international best practice and strengthens policy defensibility across clinical governance, legal, and interprofessional domains, while remaining firmly grounded in Aotearoa New Zealand's regulatory framework[2].

The ICM definition complements, but does not replace, the Midwifery Scope of Practice and Qualifications Notice 2026, which remains the legally binding scope for midwives practising in Aotearoa New Zealand[3].

The role of the midwife is enabled by their:

- Education and qualifications
- Scope of practice and standards of competence
- Use of codes of conduct and ethics
- Meeting the criteria for and holding an annual practising certificate including the continuing competence requirements, and
- Area, focus and sphere of midwifery practice.

Te Tatau o te Whare Kahu | Midwifery Council (*the Council*) describes Midwives *as registered health professionals whose expertise is providing care to women and their babies during pregnancy, labour and birth and the first six weeks after birth[4].*

[1] https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/
[2] https://midwiferycouncil.health.nz/Web/Web/I-am-a-registered-midwife/Scope-of-Practice.aspx
[3] https://gazette.govt.nz/notice/id/2025-gs6005
[4] https://www.midwiferycouncil.health.nz/Web/I-am-a-registered-midwife/Scope-of-Practice.aspx

3. Scope of Practice

A new Midwifery Scope of Practice and Qualifications Notice came into force on 1 February 2026, issued by the Council under the Health Practitioners Competence Assurance Act 2003.

It replaced all previous scope notices and consolidated changes that were first introduced in late 2024, then clarified following legal and regulatory scrutiny in 2025[5]. Importantly, this was neither a fundamental expansion nor contraction of what midwives do clinically.

It was a reframing and clarification of the role, with stronger emphasis on:

- Professional autonomy
- Cultural and te Tiriti o Waitangi obligations
- Inclusivity of gender diverse people, and
- Clearer language about responsibility and consultation.

4. Workforce Shortages and Sustainability

Workforce pressure remains the central issue for Aotearoa New Zealand midwives, despite some recent growth in absolute numbers.

The Midwifery Council of New Zealand, Workforce Survey 2025 (the Survey)[6]
The dataset on practising midwives found:

- 3,469 midwives held a practising certificate in 2025 (the highest number on record)
- 332 Māori midwives as *primary ethnicity* (9.6%), 524 midwives when counting *any Māori ethnicity* (15.1%) (The Survey allows up to three ethnicity responses per person. Therefore, totals are higher when using *any ethnicity* vs *primary ethnicity)*
- 69 Pacific midwives as *primary ethnicity* (2.0%), 138 midwives when counting *any Pacific ethnicity* (4.0%)
- Despite growth, there remains a significant workforce shortfall
- Around 32% of midwives work in caseload (Lead Maternity Carer / LMC) practice
- Around 52% work in core (employed) midwifery roles, and
- Increasing numbers of midwives are working part time, reflecting sustainability pressures.

These findings indicate that while workforce numbers are increasing, they are insufficient to meet demand and changing work patterns further exacerbate pressures on maternity services. Furthermore, these shortages directly undermine continuity of care, drive unsafe workloads, and reduce access to LMCs, particularly for Māori, Pacific, and rural whānau.

[5] https://gazette.govt.nz/notice/id/2025-gs6005
[6] Dixon, L., Greenslade-Yeats, J., Clemons, J. H., Ravenswood, K., & Mharapara, T. (2025). Balancing the joys and challenges of the continuity of care model: A study exploring the perspective of midwives and their family members.

5. Section 88, now Section 94

Section 88 (now Section 94)[7], ushered in changes to the funding and delivery of maternity services in Aotearoa New Zealand. This was in response to concerns that childbirth had become overly medicalised and removed from women's control. By the 1970s and 1980s, maternity care was largely hospital based and dominated by obstetricians, with midwives positioned within a nursing hierarchy and lacking professional autonomy[8][9].

The reform movement that followed was both professional and consumer driven. Feminist health activism, alongside midwifery advocacy, argued for a model that recognised childbirth as a normal life event and prioritised continuity of care, informed choice, and relational practice. This movement culminated in the Nurses Amendment Act 1990[10], which restored midwifery autonomy and enabled midwives to practise independently as primary maternity care providers[11]. This legislation laid the groundwork for what became the LMC model, in which a single practitioner, most often a midwife, takes responsibility for care across pregnancy, birth, and the postnatal period[12].

This model reflects a set of explicit objectives: continuity of care, partnership between the midwife and the woman, and the appropriate use of specialist services. It also aligns with international evidence suggesting that midwifery continuity of care models is associated with improved maternal experiences and reduced intervention rates for low-risk pregnancies. Aotearoa New Zealand's system is particularly notable because it has implemented this model at a national scale[13], something few other countries have achieved[14].

However, while the philosophical and clinical foundations of the system remain widely supported, its funding mechanism, originally established under Section 88 has become increasingly contested. The central issue is that the system relies heavily on self-employed midwives who are paid through a government set fee schedule. This arrangement limits the ability of midwives to negotiate remuneration or working conditions and requires them to absorb business costs within fixed payments. In effect, it combines high professional autonomy with constrained economic activity.

Recent legal developments have reframed this issue as one of structural inequity rather than simply workforce dissatisfaction. In 2026, the High Court found that the Crown had failed to ensure fair and reasonable remuneration for community midwives and that the funding model constituted gender-based discrimination. This finding situates the debate within

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[7] https://www.health.govt.nz/publications/primary-maternity-services-notice-2021
[8] Bryder, L. (2023). *The best country to give birth? Midwifery, homebirth and the politics of maternity in Aotearoa New Zealand, 1970–2022*. Auckland University Press
[9] Stojanovic, J. (2010). *Midwifery in New Zealand, 1904–1971*. Birthspirit Midwifery Journal, 2, 53–60.
[10] https://www.legislation.govt.nz/act/public/1990/107/en/latest/#LMS1194138
[11] Grigg C, Tracy S. New Zealand's unique maternity system. Women and Birth, 2012; 26, e59-e64
[12] https://www.midwife.org.nz/news/webinar-emancipating-midwifery-reflecting-on-30-years-of-midwifery-autonomy/
[13] Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S., Jones, L. V., Shennan, A. H., & Rayment-Jones, H. (2024). *Midwife continuity of care models versus other models of care for childbearing women*. Cochrane Database of Systematic Reviews, 2024(4), CD004667. https://doi.org/10.1002/14651858.CD004667.pub6
[14] New Zealand College of Midwives, n.d. *Webinar: Emancipating midwifery, reflecting on 30 years of midwifery autonomy*. Available at: https://www.midwife.org.nz/news/webinar-emancipating-midwifery-reflecting-on-30-years-of-midwifery-autonomy/

broader pay equity discussions, particularly those concerning the undervaluation of feminised professions that emphasise relational and continuity-based care[15][16].

A further tension lies in how the funding model shapes practice. Payments are structured in modules tied to stages of care, with a considerable proportion linked to labour and birth. This creates a disconnect between remuneration and workload, as much of the labour intensive work such as care coordination, travel, and ongoing availability is either undercompensated or invisible within the funding framework. From a design perspective, this misalignment raises questions about whether the funding model adequately incentivises and sustains the intended model of care[17].

These structural issues contribute directly to workforce challenges. Despite stable training numbers, New Zealand continues to experience shortages of practising midwives, particularly in community settings, with retention identified as a critical issue. The continuity of care model, while valued, requires extended periods of on call availability and unpredictable working hours, which can have significant impacts on midwives' wellbeing and work life balance. Empirical research has highlighted both the intrinsic rewards of relational continuity, and the strains associated with sustained on call work, suggesting that the model's sustainability depends on better structural support[18].

Evidence from Aotearoa New Zealand and international reviews demonstrates that misalignment across funding, workforce, and organisational policy settings directly undermines continuity of care, equity, and system performance[19][20].

Equity considerations further complicate the policy landscape. Analyses of maternity service utilisation indicate disparities in access to LMCs, particularly for Māori, Pacific communities, and those in rural and remote areas, raising concerns about whether the current model can deliver equitable outcomes without targeted investment and redesign[21].

Current reform discussions therefore focus less on altering the fundamental model and more on modernising its supporting infrastructure. There is broad consensus across stakeholders that the principles of continuity, partnership, and midwife led care should be retained. The challenge lies in aligning funding, contracting, and workforce supports with these principles.

Proposed reforms include developing payment systems that better reflect time, complexity, and on call responsibilities; introducing more flexible contracting arrangements; and strengthening team-based models to improve sustainability and resilience within the workforce.

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[15] https://www.rnz.co.nz/news/health/596243/it-s-just-not-right-community-midwives-call-for-overhaul-on-pay-contracts
[16] https://www.midwife.org.nz/wp-content/uploads/2024/09/College-of-Midwives_Case-Orientation-Document.pdf
[17] https://www.health.govt.nz/publications/primary-maternity-services-notice-2021
[18] https://openrepository.aut.ac.nz/server/api/core/bitstreams/909dda46-46f5-4dcf-aa85-1f2f5e3d05c5/content
[19] Health Research Council of New Zealand. *Sustainable LMC midwifery: Balancing work and whānau responsibilities.* (2021). https://www.hrc.govt.nz/resources/research-repository/sustainable-lmc-midwifery-balancing-work-and-whanau-responsibilities
[20] World Health Organization. *WHO calls for global expansion of midwifery models of care.* (18 June 2025). https://www.who.int/news/item/18-06-2025-who-calls-for-global-expansion-of-midwifery-models-of-care
[21] https://www.healthnz.govt.nz/publications/analysis-of-claims-under-the-primary-maternity-services-notice

6. A Relational and Privileged Practice

Midwifery is grounded in a relational philosophy often described as *being with woman*, reflecting the vital role of partnership, trust, and continuity in care. This concept emphasises that midwives do not simply provide clinical services but develop meaningful relationships with women and their whānau throughout pregnancy, birth, and the postnatal period. While this philosophy originated within a woman-centred framework, contemporary midwifery practice extends these principles to all people accessing maternity services, including transgender, non-binary, and gender-diverse people, ensuring care remains inclusive, respectful, and responsive to individual needs[22].

As such, midwives occupy a unique and privileged position, being invited into one of the most significant and vulnerable experiences in a women's life. This privilege is particularly evident during labour and birth, where midwives support both the physical process and the emotional transition to parenthood, fostering a sense of safety, autonomy, and empowerment[23].

A key component of this role is the midwife's involvement in supporting the early relationship between the mother and baby. Midwives facilitate critical bonding experiences such as skin to skin contact and breastfeeding, which are essential for attachment and long term wellbeing. Continuity of care models further strengthen this relationship by enabling midwives to develop trust and familiarity over time, contributing to improved maternal satisfaction and outcomes[24].

Research indicates that these relationships are central to the effectiveness of midwifery care, as they support holistic, woman centred practice that extends beyond purely biomedical outcomes[25].

However, the sustainability of this privileged and relational role is increasingly challenged by workforce and system pressures. Evidence from New Zealand shows that midwives working in continuity of care models experience significant demands, including long hours, on call responsibilities, and limited support, which can impact their wellbeing and ability to maintain these relationships[26].

As a result, there is growing concern that the relational foundations of midwifery may be compromised in under resourced systems, leading to more fragmented care. This highlights that the value of midwifery lies not only in clinical outcomes but also in its capacity to provide relational, holistic, and person-centred care, which requires adequate support to be sustained.

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[22] Guilliland, K., & Pairman, S. (2010). *The midwifery partnership: A model for practice* (2nd ed.). New Zealand College of Midwives.
[23] Pairman, S., Tracy, S., Thorogood, C., & Pincombe, J. (2015). *Midwifery: Preparation for practice* (3rd ed.). Elsevier.
[24] Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, (4).
[25] Pace, C. A., Crowther, S., & Lau, A. (2022). Midwife experiences of providing continuity of carer: A qualitative systematic review. *Women and Birth*, 35(3), e221–e232.
[26] Dixon, L., et al. (2025). *Balancing the joys and challenges of continuity of care: Midwives' experiences and wellbeing.*

Midwives in Aotearoa New Zealand make a distinct and internationally significant contribution to maternal, newborn, and whānau wellbeing through an autonomous, midwife led, continuity of care model that is grounded in partnership, equity, Te Tiriti o Waitangi, and the facilitation of physiological birth. This contribution is central, not supplementary to the maternity system and must be explicitly recognised and protected through policy, funding, and service design.

Evidence shows that this continuity is both clinically and relationally defined and is undermined when system fragmentation prevents midwives from retaining responsibility across settings[272829].

Facilitating physiological pregnancy and birth is a core function of the midwifery profession, although the way this is enacted varies across settings and roles. Midwives may contribute through continuity of care models, hospital based practice, specialist services, education, leadership, research, or policy. While continuity of care is a defining characteristic of Aotearoa New Zealand midwifery, not all midwives provide care across the entire childbearing continuum.

Regardless of practice setting, midwives apply their knowledge and skills to support physiological processes, promote evidence-based care, identify complications, and facilitate timely referral and collaboration when required. Midwives may practise in the home, community, hospital, or other maternity settings while remaining professionally responsible and accountable for the care they provide[303132].

Delivering culturally safe, te Tiriti o Waitangi care by practising in partnership with Māori, supporting tino rangatiratanga, and enabling culturally grounded models of care. Partnership, informed choice, and cultural safety are explicitly embedded in Aotearoa New Zealand midwifery standards and competencies and aligned with Te Tiriti o Waitangi obligations. Evidence shows that relational continuity is a key enabler of equity and that erosion of continuity disproportionately affects Māori whānau, compounding structural inequities[3334].

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[27] Midwifery Council of New Zealand. *Briefing to the Incoming Minister of Health.* https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Midwifery%20Council%20Briefing%20Paper.pdf

[28] Bradford, B.F., Wilson, A.N., Portela, A., et al. (2022). *Midwifery continuity of care: A scoping review of where, how, by whom and for whom?* PLOS Global Public Health. https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0000935

[29] Health NZ | Te Whatu Ora. *Analysis of claims under the Primary Maternity Services Notice* (2024). https://www.tewhatuora.govt.nz/assets/For-health-professionals/Workforce-development/Maternity/Analysis-of-claims-under-the-Primary-Maternity-Services-Notice-2024.pdf

[30] Anderson, K., Sadler, L., Thompson, J.M.D., & Edlin, R. (2025). *The impact of caregiver and intended mode of birth on the public cost of care in New Zealand.* Midwifery. https://pubmed.ncbi.nlm.nih.gov/39616819/

[31] International Confederation of Midwives, WHO et al. *Transitioning to Midwifery Models of Care: Implementation Guidance.* (2025). https://internationalmidwives.org/envisaging-midwifery-models-of-care/

[32]New Zealand College of Midwives. (2026). *New Zealand midwifery*. https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/

[33] Health Research Council of New Zealand. *Sustainable LMC midwifery: Balancing work and whānau responsibilities.* (2021). https://www.hrc.govt.nz/resources/research-repository/sustainable-lmc-midwifery-balancing-work-and-whanau-responsibilities

[34] New Zealand College of Midwives / Health NZ | Te Whatu Ora. *Opportunities identified to strengthen equitable access to midwifery continuity of care.* (2025). https://auckland.scoop.co.nz/2025/06/opportunities-identified-to-strengthen-equitable-access-to-midwifery-continuity-of-care/

Recognising the unique contribution of midwives requires policy settings that protect autonomy through aligned organisational policies, resource continuity of care as a core system function, value relational work alongside clinical tasks, treat workforce sustainability as a quality and safety issue, and embed equity and te Tiriti o Waitangi obligations operationally rather than aspirational.

Regardless of practice context, midwives contribute to safe, high quality maternity care through supporting physiological processes where appropriate, recognising complications, facilitating referral, collaborating with obstetricians and other health professionals when additional expertise is required. The midwifery profession is therefore characterised by partnership, continuity, and coordination of care, although individual midwives may contribute to these functions in diverse ways depending on their role and scope of practice[35].

7. Registered Nurses and Midwifery Assistants

While both Registered Nurses (RNs) and Midwifery Assistants (MAs) contribute to supporting maternity services, their increasing use reflects a shared concern that non-midwifery roles are being relied upon to manage workforce pressures, raising risks to role clarity, continuity of care, and the integrity of the midwifery led model. In hospital or birthing settings across Aotearoa New Zealand, RNs can assist with clinical tasks and help maintain service delivery during workforce shortages[36]. However, they are not educated or regulated to provide the full scope of midwifery care, which creates potential for role confusion and safety risks if boundaries are not clearly defined[37].

RNs involvement in maternity settings may inadvertently shift care toward a more medicalised model, moving away from midwifery led continuity, which is associated with improved outcomes and woman-centred care[38]. Furthermore, neither RNs nor MAs have the specialised midwifery training required to consistently recognise subtle or complex changes in maternal or neonatal wellbeing, particularly in dynamic clinical situations.

MAs provide valuable support through delegated care such as observations and basic care needs. However, as an unregulated workforce, they must work under the direction, delegation and supervision of a midwife, who remains professionally responsible and accountable for the care provided and for maintaining safety within the clinical environment[39]. A critical issue across both roles is the risk of task substitution replacing midwifery care, rather than complementing it. This can contribute to fragmented, task oriented care that undermines the midwifery model of continuity, relational philosophy, and

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[35] New Zealand College of Midwives. (2026). *New Zealand midwifery*. https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/

[36] Health New Zealand. (2024). Health workforce plan: Midwifery analysis. https://www.healthnz.govt.nz/about-us/what-we-do/planning-and-performance/health-workforce-planning/health-workforce-plan-2024-detailed-analysis-and-data/workforce-plan-profession-specific-analysis/health-workforce-plan-midwifery-analysis

[37] Midwifery Council of New Zealand, 2010. https://www.midwiferycouncil.health.nz/Web/Web/Publications/Gazette-Notices-Folder/Midwifery-Scope-of-Practice-and-Qualifications-Notice-2010.aspx

[38] Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S., Jones, L. V., Shennan, A. H., & Rayment-Jones, H. (2024). Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, 4, CD004667.

[39] New Zealand College of Midwives. (n.d.). *Scope of practice of the midwife*. https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/scope-of-practice-of-the-midwife/

holistic woman centred care[40].

The growing reliance on both RNs and MAs also risks masking underlying midwifery workforce shortages, delaying systemic investment in recruitment, retention, and safe staffing[4142]. While both roles can enhance service delivery when used appropriately, overdependence on them may compromise safe, culturally responsive, and midwifery led care. Clear role boundaries, effective delegation, and adequate midwifery staffing are therefore essential to ensure the quality and safety of maternity services.

8. Political Influence

While the Midwifery Council (*the Council*) operates independently under the Health Practitioners Competence Assurance Act 2003, professional regulation is not entirely insulated from political influence. Legislative reform, ministerial appointments, workforce policy priorities, and pressures to address health workforce shortages can influence the regulatory environment within which the Council operates.

Maintaining regulatory independence is important to ensure that decisions about education, competence, scope of practice, and professional standards remain focused on public safety rather than short-term political or workforce objective[43].

9. Te Tiriti o Waitangi

Te Tiriti o Waitangi is foundational to midwifery practice in Aotearoa New Zealand, establishing clear obligations for partnership, equity, and Māori self-determination (tino rangatiratanga) across the health system. The Ministry of Health Manatū Hauora affirms that te Tiriti o Waitangi provides the framework for achieving Māori health equity and requires the system to enable Māori participation in decision making, uphold Māori authority, and respond to Māori aspirations[44].

Within this framework, midwifery is uniquely positioned to operationalise te Tiriti o Waitangi in practice. The Council requires all midwives to honour te Tiriti o Waitangi by embedding principles of partnership, equity, and self-determination into their care, alongside the delivery of culturally and clinically safe, whānau centred practice. This places te Tiriti o Waitangi obligations at the core of professional identity, not as an adjunct to care[45].

Midwifery's continuity of care model gives practical expression to Te Tiriti o Waitangi through sustained relationships with wāhine and whānau, enabling shared decision making, informed choice, and care that reflects tikanga and Māori worldviews. This relational model aligns closely with te Tiriti o Waitangi principles by supporting mana motuhake (the ability for Māori to exercise authority over their health and wellbeing) and fostering trust, engagement, and culturally grounded care.

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[40] New Zealand College of Midwives. (2018). Philosophy and code of ethics. Christchurch, New Zealand.
[41] https://www.healthnz.govt.nz/about-us/what-we-do/planning-and-performance/health-workforce-planning/health-workforce-plan-2024-detailed-analysis-and-data/workforce-plan-profession-specific-analysis/health-workforce-plan-midwifery-analysis
[42] https://www.midwife.org.nz/news/te-whatu-ora-workforce-announcement-midwives-and-midwifery-still-invisible/
[43] Ministry of Health. (2024). *Responsible authorities under the Act*. Wellington, New Zealand: Ministry of Health. Retrieved from https://www.health.govt.nz/regulation-legislation/health-practitioners/responsible-authorities
[44] https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/scope-of-practice-of-the-midwife/
[45] https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/scope-of-practice-of-the-midwife/

Cultural safety is a critical mechanism through which te Tiriti o Waitangi is enacted in midwifery. Established in the work of Irihapeti Ramsden, cultural safety requires midwives to actively examine power dynamics, recognise and address institutional racism, and ensure that care is defined as safe by those receiving it. This reflects a shift from cultural awareness to accountability, aligning directly with te Tiriti o Waitangi obligations to achieve equitable outcomes[46].

At a system level, the Pae Ora (Healthy Futures) Act 2022[47] (the Act) reinforces these obligations by embedding equity, Māori participation, and responsiveness to Māori aspirations as core principles of the health system.

The Act requires services to engage with Māori, provide opportunities for Māori to exercise decision making authority, and actively reduce inequities. In the context of midwifery, this creates a clear mandate to strengthen kaupapa Māori models of care, grow the Māori midwifery workforce, and ensure services are designed in partnership with Māori communities[48].

For NZNO, honouring Te Tiriti o Waitangi means advocating for a maternity system in which Māori are recognised as equal partners in governance, design, and delivery of care. It requires sustained investment in Māori midwifery leadership, workforce development, and culturally grounded models of care that uphold the mana of wāhine, pēpi, and whānau.

In this context, the role of the midwife extends beyond clinical competence. Midwives are central to delivering te Tiriti o Waitangi honouring care that is relational, culturally safe, and equity focused. Through partnership, continuity, and commitment to Māori health aspirations, midwifery contributes directly to achieving pae ora healthy futures for Māori and all communities in Aotearoa New Zealand.

10. Uplift of Pepi in the Context of State Intervention

The practice commonly referred to as *uplifting tamariki* relates to the legal removal of a child from their parents or caregivers under the Oranga Tamariki Act 1989[49] as amended in 2019[50]. While *uplift* is not a formal legal term, it is widely used in practice to describe the exercise of statutory powers to remove a child where there are serious concerns about their safety and wellbeing.

Under section 39 of the Oranga Tamariki Act 1989, a Court may issue a *place of safety* warrant when there is reasonable cause to believe a child is being, or is likely to be, abused, neglected, or harmed, and that removal is necessary to protect them[51].

[46] https://midwiferycouncil.health.nz/Web/Web/I-am-a-registered-midwife/Scope-of-Practice.aspx
[47] https://www.legislation.govt.nz/act/public/2022/30/en/latest/#LMS575405
[48] https://www.midwife.org.nz/midwives/publications/continuity-of-care-in-aotearoa/
[49] Oranga Tamariki Act 1989 (NZ). https://www.legislation.govt.nz/act/public/1989/24/en/latest/
[50] Oranga Tamariki Legislation Act 2019 (NZ). https://www.legislation.govt.nz/act/public/2019/30/en/latest/
[51] Community Law. (n.d.). *When your child can be taken from you immediately*. https://communitylaw.org.nz/community-law-manual/chapter-13-dealing-with-oranga-tamariki-ministry-for-children/if-oranga-tamariki-takes-urgent-action/when-your-child-can-be-taken-from-you-immediately/

The 2019 legislative amendments strengthened the focus on child wellbeing and introduced greater recognition of te Tiriti o Waitangi**,** requiring Oranga Tamariki to commit to improving outcomes for Māori children and to recognise the importance of whakapapa, whānau, hapū, and iwi relationships in decision making. These changes emphasised that the wellbeing of tamariki is intricately linked to their identity, culture, and connections, and that removal should occur only when necessary and with careful consideration of these factors[52].

The ethical and professional implications of uplift practices are significant, particularly for midwives who may be involved in raising concerns about child safety. Midwives have a legal and ethical responsibility to prioritise the wellbeing of the child, while also balancing principles of partnership, cultural safety, and whānau centred care. The use of uplifting powers has been subject to public and professional scrutiny, particularly due to the disproportionate impact on Māori whānau, highlighting ongoing tensions between child protection, equity, and culturally safe practice.

11. Advocacy, Care & Safety

Midwives bring evidence based knowledge and hold professional credibility which gives them a mandate to advocate on issues related to maternal health, maternity health service design and policy development.

If midwives look to further their role as advocates, processes need to be in place to better prepare and support them to advocate. The midwife role in advocacy needs to be protected, and barriers to advocating removed so that midwives can advocate free from the risk of retribution.

12. Education & Health Promotion

Midwifery practice is closely aligned with public health, as midwives play a central role in promoting health, preventing illness, and improving outcomes for women, babies, and whānau. Through continuity of care and regular contact during pregnancy, midwives are uniquely positioned to deliver public health interventions that support behaviour change and reduce health inequities.

Smoking cessation in pregnancy is a clear example of how midwifery contributes to wider population health goals. In Aotearoa New Zealand, smoking is also linked to health inequities, disproportionately affecting Māori, Pacific peoples, and those living in socioeconomically deprived communities. This reinforces the importance of targeted public health initiatives within maternity services[53], in addition to broader public health strategies, including policy measures, community support, and culturally appropriate services.

12. Ethical Practice

Midwifery practice in Aotearoa New Zealand has a well-established ethical framework integrating guidelines and standards in partnership with women, respect for autonomy, cultural safety, and professional accountability.

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[52] VOYCE – Whakarongo Mai. (2019). *Amendments to the Oranga Tamariki Act*. https://voyce.org.nz/amendments-to-the-oranga-tamariki-act/

[53] British Journal of Midwifery. (2025). Addressing smoking during pregnancy. *British Journal of Midwifery.* https://www.britishjournalofmidwifery.com/content/editorial/addressing-smoking-during-pregnancy

New Zealand College of Midwives (NZCOM) Philosophy and Code of Ethics[54], provides the philosophical foundation for practice by affirming informed choice and consent and positioning midwifery as relational, holistic, and grounded in trust and respect.

Ethical standards, as articulated in regulatory documents, translate these principles into clear expectations for professional behaviour and clinical practice. Together, these frameworks guide midwives to respond to the social, cultural, emotional, spiritual, and physical needs of women and whānau, while maintaining privacy and confidentiality throughout the midwifery partnership.

These ethical guidelines and standards are reinforced through statutory regulation. The Midwifery Council's Code of Professional Conduct and Standards of Competence operationalise ethical principles by setting mandatory expectations for safe, competent, and accountable practice under the Health Practitioners Competence Assurance Act 2003[5556].

Here they inform values and decision making, while ethical standards ensure those values are enacted consistently in practice. Midwives are therefore accountable not only to the individuals they care for, but also to the profession and the wider community, and must practise in ways that minimise harm, promote wellbeing, and seek consultation or referral when required.

In Aotearoa New Zealand, the NZNO Code of Ethics reflects a bicultural approach, integrating Māori and Western ethical frameworks. Māori values such as rangatiratanga, manaakitanga, tika, whanaungatanga, wairuatanga, kotahitanga, and kaitiakitanga are incorporated alongside Western principles including autonomy, beneficence, non-maleficence, justice, confidentiality, veracity, fidelity, environmental guardianship, and professionalism[57].

13. The Pae Ora (Healthy Futures) Act 2022

The Pae Ora (Healthy Futures) Act 2022 (*the Act*)[58] impacts the role of midwife by emphasising equity, cultural competence, and community engagement and providing care that aligns with the cultural needs and preferences of Māori and other diverse groups. Midwives are also encouraged to engage with communities to better understand their health needs and to advocate for services that meet those needs.

Midwives need to engage in ongoing professional development to enhance their cultural competence and understanding of te Tiriti o Waitangi principles. Furthermore, advocating for equitable healthcare policies and practices within their workplace while, building strong collaborative relationships with local communities, particularly Iwi Māori Partnership Boards (IMPBs) and other underserved groups.

The provision of holistic care considers the physical, emotional, social, and cultural needs of

[54] New Zealand College of Midwives. (2018). *Philosophy and code of ethics*. Christchurch, New Zealand.
[55]Midwifery Council of New Zealand. (2010). *Code of conduct for midwives*. Wellington, New Zealand.
[56] Midwifery Council of New Zealand. (2021). *Standards of competence for midwives*. Wellington, New Zealand.
[57] New Zealand Nurses Organisation. (2019). *Code of ethics*. Wellington, New Zealand.
[58] https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx

women, and their family and whanau. This approach ensures that all aspects of a women wellbeing are addressed.

The Act also supports midwives in undertaking leadership roles within the healthcare system, to influence change, advocating for women and community needs, and contributing to health policy and planning while collaborating with other healthcare professionals to provide coordinated and comprehensive care.

14. Equity

The word equity is often being confused with equality. The difference is that equality looks at individuals whereas equity looks at the bigger picture such as how past discrimination creates barriers. For midwives' equity is about recognising barriers so that they can ensure more effective care.

Māori were discouraged from accessing any health care and were identified as a carrier of diseases, rather than needing care. The result of these discriminatory actions created a distrust in Māori of those institutions that were meant to support them. To provide support to those in need, midwives must understand the lived experience of those people.

Aotearoa New Zealand also has evolved from a society that was strongly patriarchal that has not given full equality to women and the vestiges of this still impact today, as recent pay equity disputes for midwives have clearly shown. Midwifery is traditionally a female profession.

In addition to resolve the pay and conditions issue the health sector needs to give midwives greater recognition as health professionals and should give greater autonomy and responsibility about the clinical expertise and leadership they bring to the sector. Continuity of midwifery care is associated with improved outcomes for Māori and other groups disproportionately affected by health inequities, when it is accessible and adequately resource.

15. Midwifery Ratios

In Aotearoa New Zealand, Midwifery Representation and Advisory Services (MERAS)[59] promotes a safe staffing model based on workload and patient acuity rather than fixed ratios, primarily through the Care Capacity and Demand Management system (CCDM). While this approach is more responsive to the realities of maternity care, ongoing workforce shortages and funding constraints mean that safe staffing levels are not always achieved, impacting both midwifery practice and women's outcomes.

In some maternity settings, Registered Nurses are increasingly used to fill roster vacancies and support workforce capacity. While this may provide short-term staffing relief, it does not address underlying midwifery workforce shortages and should not be viewed as a substitute for an appropriately staffed midwifery workforce.

[59] https://meras.midwife.org.nz/wp-content/uploads/sites/4/2025/12/MERAS-CA-formattedUpdated-signed.pdf

16. Midwifery Education

Midwifery training in Aotearoa New Zealand requires the development of a comprehensive range of knowledge, skills, and professional attributes to ensure safe, ethical, and culturally responsive care. Midwives are educated to function as autonomous practitioners who provide continuity of care across the childbirth continuum while also recognising when consultation or referral is required.

Central to midwifery education is the development of strong clinical knowledge, including an understanding of normal pregnancy, labour, birth, and postnatal care, alongside the ability to identify complications and respond appropriately. This aligns with the Standards of Competence for Midwives[60], which require midwives to provide safe and effective care across all stages of maternity.

Midwifery training also emphasises critical thinking, clinical decision making, and reflective practice. Midwives must be able to assess risk, make safe and timely decisions, and reflect on their practice to continually improve. Lifelong learning is essential, as midwives are required to maintain competence through ongoing professional development[61].

Overall, midwifery training prepares practitioners to integrate clinical expertise, ethical and legal knowledge, cultural safety, and public health principles. The key learning is that safe midwifery practice requires not only technical skill, but also the ability to work in partnership, navigate complex systems, and advocate for equitable outcomes for wāhine and whānau.

Midwifery education in Aotearoa New Zealand aims to prepare safe, autonomous practitioners, but several key issues affect training outcomes. One major challenge is the theory practice gap, where students learn principles such as partnership and woman centred care but struggle to apply them in busy clinical environments with time pressures and staffing shortages[62].

The increasing complexity of care, with midwives expected to manage clinical, social, and legal responsibilities, including child protection concerns[63]. Understanding legal frameworks, such as the Oranga Tamariki Act 1989, is essential but can be difficult to apply in practice, particularly in high-pressure situations.

Clinical placement quality is also variable. Students rely on placements for skill development, but limited supervision, high workloads, and workforce shortages can reduce learning opportunities. This contributes to student stress and burnout, which is widely reported in midwifery education and can affect both wellbeing and retention in the profession[64].

There are also challenges in ensuring effective cultural safety and te Tiriti o Waitangi

[60] Midwifery Council of New Zealand. (2021). *Standards of competence for midwives*. Wellington, New Zealand.
[61] Midwifery Council of New Zealand. (2021). *Standards of competence for midwives*. Wellington, New Zealand
[62] Midwifery Council of New Zealand. (2010). *Code of conduct for midwives*.
[63] Community Law. (n.d.). *When your child can be taken from you immediately*.
[64] Brennan, H. M., Long, H. A., Chmiel, C., & Smith, D. M. (2025). Coping strategies and interventions to prevent and alleviate work-related burnout in midwives: A rapid scoping review of quantitative and qualitative research. *Women and Birth*, 38(6).

practice. While these are embedded in curricula, applying them meaningfully in practice requires ongoing reflection and support[65]. Similarly, midwives' public health role, including smoking cessation support, requires stronger practical training in behaviour change and communication strategies[66].

Overall, these issues highlight the need for midwifery education to be more practice integrated, well supported, and responsive to system pressures, ensuring students are prepared for the realities of contemporary practice.

14. Technology and Artificial Intelligence (AI) in midwifery

Midwives ensure that technology and artificial intelligence (AI) are used safely, ethically, and in ways that strengthen woman centred maternity care. Digital tools such as telehealth, electronic health records, and remote monitoring systems support midwives to maintain continuity of care, improve access for geographically or socially underserved women, and respond promptly to emerging clinical concerns. When integrated appropriately, these technologies enhance rather than replace the relational, trust-based model that underpins midwifery practice[6768].

AI-enabled clinical decision support tools may assist midwives by identifying early indicators of pregnancy or birth-related complications and supporting timely escalation or referral. The role of the midwife is to interpret and contextualise these insights using professional judgement, clinical experience, and the woman's individual circumstances. Responsibility for decision making and care planning remains with the midwife, consistent with professional accountability and informed consent obligations. Evidence highlights that midwives are more likely to engage with AI when it is transparent, clinically validated, and clearly positioned as an adjunct to not a substitute for midwifery expertise[6970].

Technology has also changed the environment in which midwives practise. Women, partners, whānau, and support people increasingly use smartphones, wearable devices, and video-recording technologies to document pregnancy, labour, birth, and interactions with healthcare providers. As a result, midwives may provide care in circumstances where clinical encounters are being recorded, either overtly or covertly, creating a permanent record that may later be reviewed following an adverse event or unexpected outcome. While recording can support family engagement, information sharing, and recollection of care discussions, it may also contribute to increased professional scrutiny, privacy concerns, and perceived medicolegal risk for clinicians[71].

Midwives are also key guardians of ethical practice in the use of technology, including the protection of sensitive maternal data, ensuring culturally safe care, and mitigating the risk of

[65] https://www.midwife.org.nz/midwives/professional-practice/philosophy-and-code-of-ethics/
[66] [66] https://www.health.govt.nz/system/files/2014-06/the-abc-pathway-key-messages-for-frontline-health-care-workers-2021.pdf
[67] https://bmjopen.bmj.com/content/bmjopen/14/3/e082060.full.pdf
[68] https://midwife.org/wp-content/uploads/2024/10/The-Use-of-Telehealth-in-Midwifery.pdf
[69] https://pmc.ncbi.nlm.nih.gov/articles/PMC11443205/
[70] https://link.springer.com/article/10.1186/s12910-023-00990-1
[71] Ryan, L., Weir, K. A., Maskell, J., & Le Brocque, R. (2022). *Smartphone standoff: A qualitative study exploring clinician responses when a patient uses a smartphone to record a hospital clinical encounter*. BMJ Open, 12(4), e056214. https://bmjopen.bmj.com/content/12/4/e056214

algorithmic bias. This includes advocating for equitable access to digital tools and ensuring that technology does not exacerbate disparities for indigenous, migrant, or marginalised women. Policy frameworks increasingly emphasise the importance of midwives' involvement in the design, governance, and evaluation of digital maternity systems to ensure they align with principles of equity, respect, and partnership[7273].

International guidance recognises that technology should strengthen, not undermine, midwifery led care. The role of the midwife therefore includes building digital health capability, contributing to service development, and supporting women to understand and engage with technology as part of informed choice. When midwives lead and shape the integration of technology and AI, these tools have the potential to enhance safety, autonomy, and quality across the maternity continuum.

18. The Climate Crisis

Climate change is a significant and escalating threat to maternal, newborn, and whānau health. Midwives, as primary providers of maternity care in Aotearoa New Zealand, have a unique role in responding to the health impacts of climate change, both through their clinical practice and through advocacy for climate resilient, sustainable health systems.

We recognise that climate change is not only an environmental issue, but a public health, equity, and intergenerational wellbeing issue, with disproportionate impacts on pregnant people, newborns, Māori, Pacific peoples, rural communities, and those already experiencing disadvantage[74].

Evidence from the World Health Organization and United Nations agencies demonstrates that climate change increases the risk of:

- Pregnancy complications, including preterm birth, low birth weight and stillbirth
- Heat related illness and dehydration in pregnancy
- Disruption to access to maternity services during extreme weather events
- Food and water insecurity affecting maternal and infant nutrition, and
- Psychological distress and trauma for pregnant women and whānau affected by climate events[75].

Midwives are frontline public health practitioners and trusted health professionals embedded in communities. Their scope of practice positions them to:

- Identify and respond to climate related health risks during pregnancy and the postnatal period
- Support informed, culturally safe discussions with whānau about climate-related health impacts
- Contribute to emergency preparedness and continuity of care during climate related disruptions
- Advocate for sustainable, low-carbon models of maternity care, and

[72] https://www.mdpi.com/2227-9032/13/8/942
[73] https://journals.plos.org/digitalhealth/article?id=10.1371/journal.pdig.0000938
[74] https://www.who.int/news/item/21-11-2023-climate-change-is-an-urgent-threat-to-pregnant-women-and-children
[75] https://www.who.int/news/item/21-11-2023-climate-change-is-an-urgent-threat-to-pregnant-women-and-children

- Support whānau resilience through relational, continuity based care.

Midwifery is, by its nature, a low technology, low emissions health profession, and strengthening midwife led continuity of care aligns with both health equity and climate mitigation goals[76].

To address the impacts of climate change on maternity care, this policy supports:
- Integration of climate considerations into maternity policy and planning, including emergency preparedness and service continuity
- Recognition of midwives as essential responders during climate related emergencies and disasters
- Support for climate resilient maternity services, particularly in rural and high-risk regions
- Health centred climate action, including reducing the health sector's contribution to greenhouse gas emissions
- Education and advocacy, enabling midwives to engage confidently in conversations about climate, health, and wellbeing with whānau and communities, and
- Equity focused policy approaches that protect pregnant women, infants, and communities most affected by climate change.

19. The Future of Midwifery

The future of midwifery is likely to be characterised by greater integration of technology, multidisciplinary models of care, and more flexible workforce structures. Digital health tools such as electronic maternity records, telehealth, remote monitoring, and data analytics have the potential to improve continuity of care, particularly for women and whānau in rural and underserved communities[7778].

As healthcare becomes increasingly digital, midwives will require ongoing support and training to use technology effectively while maintaining the relational, woman centred approach that is fundamental to midwifery practice. Technology is expected to enhance, rather than replace, the role of the midwife by reducing administrative burden, improving communication, and supporting earlier identification of clinical concerns.

The future maternity workforce is also likely to involve stronger multidisciplinary team (MDT) approaches. Midwives will increasingly collaborate with obstetricians, nurses, general practitioners, allied health professionals, mental health practitioners, lactation consultants, social workers, and Kaiāwhina to meet the complex needs of women and babies.

As rates of maternal complexity, chronic illness, mental health concerns, and social disadvantage continue to rise, effective collaboration across professional boundaries will become increasingly important. Within these models, midwives will remain the lead professionals for normal pregnancy and birth while coordinating and navigating care across

[77] International Confederation of Midwives. (2024). *ICM strategy and global priorities*. https://internationalmidwives.org
[78] World Health Organization. (2022). *Global strategic directions for nursing and midwifery 2021-2025*. https://www.who.int/publications/i/item/9789240033863

services when additional support is required[7980].

A key priority for the future will be building a workforce that better reflects the communities it serves. The Midwifery Council's 2025 Workforce Survey shows growth in Māori and Pacific midwifery representation, but these groups remain underrepresented relative to the populations they serve. Increasing Māori and Pacific participation in the profession, supporting culturally safe models of care, and strengthening pathways into midwifery education will be critical to improving equity and achieving better maternal and infant health outcomes.

The future of midwifery will depend not only on technological and workforce innovation but also on sustained investment in education, leadership, wellbeing, and retention to ensure a resilient and highly skilled profession capable of meeting the needs of future generation[8182].

20. Conclusion

The role of the midwife in policy is critical to ensuring that maternity services are safe, equitable, and responsive to the needs of women and whānau. Midwives bring a unique perspective grounded in continuity of care and close partnerships with women, which enables them to advocate effectively for policies that reflect real world practice and improve maternal and infant outcomes.

Their involvement in policy development, implementation, and evaluation supports evidence based decision making and strengthens the quality of maternity care. In Aotearoa New Zealand, this role is further shaped by te Tiriti o Waitangi, requiring midwives to promote culturally safe practice and actively address inequities experienced by Māori.

Meaningful midwifery engagement in health policy ensures that systems remain woman centred, ethically grounded, and aligned with both professional standards and the broader goal of achieving equitable health outcomes for all.

[79] World Health Organization. (2022). *Global strategic directions for nursing and midwifery 2021-2025*. https://www.who.int/publications/i/item/9789240033863
[80] New Zealand College of Midwives. (n.d.). *Scope of practice of the midwife*. https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/scope-of-practice-of-the-midwife/
[81] Midwifery Council of New Zealand. (2025). *Midwifery Workforce Survey 2025*. https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Workforce%20surveys/Midwifery%20Workforce%20Survey%202025.pdf
[82] Health New Zealand | Te Whatu Ora. (2024). *Health workforce plan: Midwifery analysis*. https://www.healthnz.govt.nz/about-us/what-we-do/planning-and-performance/health-workforce-planning/health-workforce-plan-2024-detailed-analysis-and-data/workforce-plan-profession-specific-analysis/health-workforce-plan-midwifery-analysis

20. Recommendations

The following recommendations are proposed:

1. Establish a sustainable midwifery workforce through education and training, achieving advanced levels of practice and retention initiatives.

2. Honour te Tiriti o Waitangi by advocating for a maternity system in which Māori are recognised as equal partners in governance, design, and delivery of care., requiring sustained investment in Māori midwifery leadership, workforce development, and culturally grounded models of care that uphold the mana of wāhine, pēpi, and whānau.

3. Support the development and maintenance of effective legislation, regulation, education, and employment practices for midwives.

4. Strengthen legislation to ensure further protections for midwives and continue to enable advocacy for women and wider health initiatives.

5. Invest in building and maintaining effective governance for the midwife workforce and develop future leaders contributing to health policy, economics, and planning.

6. Collaborate with key stakeholders including the International Confederation of Midwives (ICM), Nursing Council of New Zealand (NCNZ), and the Midwifery Council of New Zealand to promote the role of the midwife.

7. Increase the number and location of Māori and Pacific midwives to contribute to equity and health gain for Māori and Pacific peoples.

8. Identify and eliminate gender-based discrimination against midwives including in remuneration, leadership opportunities and capacity to influence.

9. To enhance safety, autonomy, and quality across the maternity continuum midwives must lead and shape the integration of technology and AI.

APPENDIX ONE

The International Confederation of Midwives
Defines a midwife[83] as:
A person who has successfully completed a midwifery education programme based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title 'midwife'; and who demonstrates competency in the scope of practice of the midwife.

The ICM further recognises the midwife as:
A responsible and accountable professional, who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postnatal period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant.

This care includes preventative measures, promotion of normal birth, detection of complications in mother and child, access to medical care or other appropriate assistance, and the carrying out of emergency measure.

The ICM also affirms that midwives have an important role in health counselling and education for women, gender-diverse people, families, and communities; and midwives may practise in any setting, including home, community, hospital, clinic, or health unit.

[83] https://internationalmidwives.org/resources/international-definition-of-the-midwife/