

Maternity Care Experiences of Teen, Young, Maori, Pacific and Vulnerable Mothers at Counties Manukau Health

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As always, the primary authors are responsible for any omissions or errors of interpretation.

Names that appear in this report have been changed to protect the identify of the person/persons concerned.

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Executive Summary

What we were contracted to do

We were contracted by Counties Manukau Health (CMH) to facilitate, collate, analyse and document information generated from: Maternity Care Consumer Panel discussions convened by CMH and interviews with Pacific mothers facing barriers to accessing maternity care. The Maternity Care Consumer Panel was established by CMH to assist with identifying what is working well with its current maternity care system and where improvements can be made.

This project specifically sought the views and input of Maori and Pacific mothers, and women of childbearing age who live in areas of high socio-economic deprivation.

CMH identified 5 key themes on which they wanted input from mothers. These were:

- accessing and engaging early in pregnancy;
- utilisation of the Primary Birthing Units (these are based in Botany Downs, Pukekohe and Papakura);
- identifying gaps and solutions in accessing appropriate advice and affordable contraception in a timely manner;
- reviewing and developing strategies to reduce smoking in pregnant women; and
- developing culturally appropriate nutritional interventions to reduce pre-pregnancy obesity.

To achieve this, the project consisted of the following:

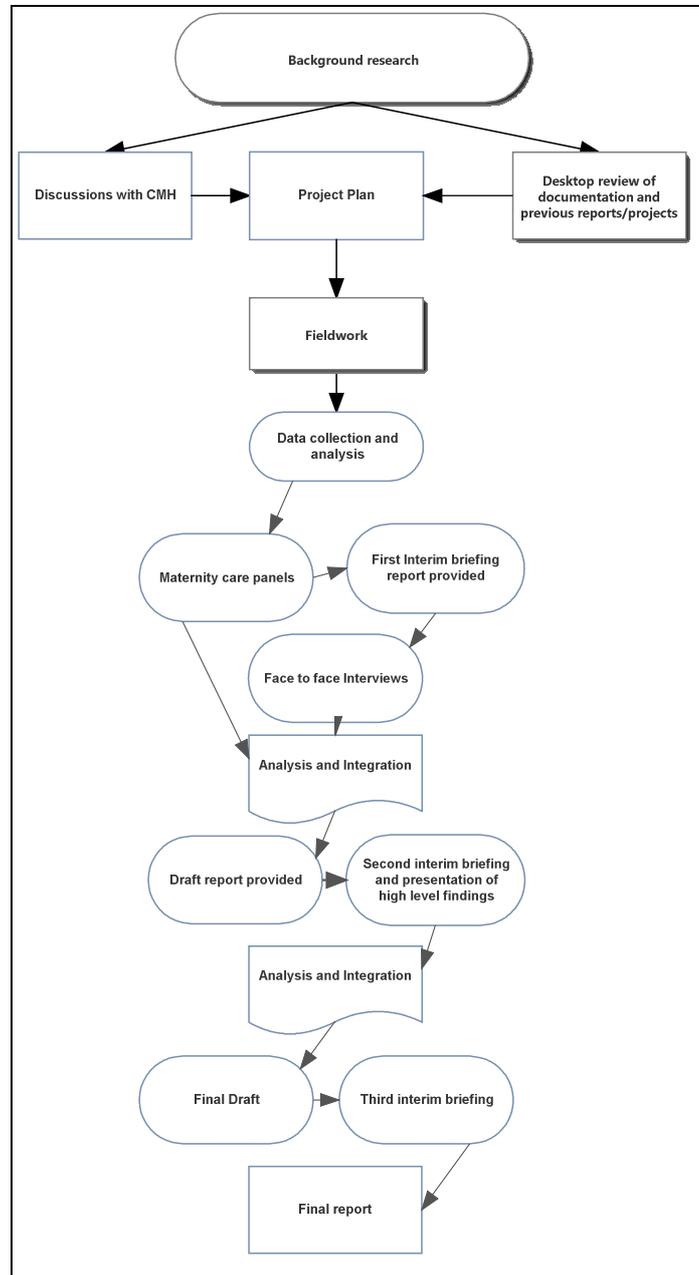
- a desktop review of existing CMH maternity care reports;
- facilitated sessions with 5 maternity consumer panels;
- ten individual interviews with Pacific mothers who speak English as a second language and who accessed maternity care services after 20 weeks gestation;
- thematic analysis of the feedback from each of the groups; and
- a report outlining the findings and recommendations.

This report is intended to contribute to projects being undertaken by CMH to explore the factors associated with the district's high perinatal mortality rate and identify ways in which these factors can be addressed.

Summary of Research Approach

Figure 1 below provides the high level research approach for this project.

Figure 1 Overview of Research Approach



Our main findings

Achieving quality in maternity care across culturally diverse populations

The CMH population of mothers and expectant mothers is diverse. We observed differences in views across ethnic groups, different age groups, groups of varying socio-economic status and social mobility, varying educational attainment, and localities. We identified that a single

approach to consumer input will not yield the granularity of information needed to meet the specific needs of each group.

In order to better understand the range of factors associated with maternity care and how tailored solutions can be developed to achieve improved outcomes for specific groups, we suggest a stratified population sampling approach. We have identified in Table 1 four groups with characteristics based on a mix of factors including age, ethnicity, family/whanau support, engagement with health and social services and proficiency in English.

Table 1 CMH maternity groups identified in this research

Group	Characteristics
Maori, Pacific Young/Teen Mothers	Age under 21 years. Maori and Pacific ethnicity. Mostly first time mothers, a few with two children. Engaged in education (including ECE for babies) through Teen Parent Units; and with social services and primary care.
Maori, Pacific and other vulnerable mothers	Age under 21 years. Maori and Pacific ethnicity. Not engaged with primary care, education or other social services. Complex familial relationships, Complex social and health needs.
Pacific Mothers	Age over 21 years. Multi-para. Engaged with primary care. Secondary level education. Speak English and one other Pacific language.
Engaged Maori and Pacific Mothers	Age over 21 years. Maori and Pacific ethnicity. Engaged with primary care, education and social support agencies. Speak English well.

We have used these groups to describe the experiences of CMH mothers in this research with respect to the five key themes of interest to CMH. These findings are included in Table 2.

Table 2 Stratified key themes

Research Key Theme	Maori, Pacific Young/Teen Mothers	Maori, Pacific and other vulnerable mothers	Pacific Mothers	Engaged Maori and Pacific Mothers
Access	<p>Are reliant on advice and support from caregivers, friends, and parents for maternity care information and access</p> <p>Initial contact determines on-going engagement with maternity services.</p> <p>Are motivated to attend the 5 month scan as most wanted to know the gender of the baby – this is an important contact point.</p> <p>Are highly vulnerable to 'dropping out' of the maternity care pathway.</p> <p>Pregnancy is often their first experience of engaging in primary care without parents/caregivers.</p> <p>Experience significant stigmatisation from named primary care health providers.</p> <p>Describe poor service experience at Middlemore Maternity ward and Primary Birthing Units.</p> <p>Want support from family and/or peers while in hospital.</p>	<p>Experience multiple barriers at all levels of the maternity care pathway.</p> <p>Will make active choices whether or not to engage.</p> <p>Are motivated to attend the 5 month scan as most wanted to know the gender of the baby – this is an important contact point.</p> <p>Are highly vulnerable to 'dropping out of the maternity care pathway'.</p> <p>Are less likely to be engaged in primary care.</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p>	<p>Have confidence in self-care (prior experience). However this can lead to late presentation for maternity care.</p> <p>Have low health literacy especially with respect to primary care.</p> <p>Describe significant issues with wait times for health services, particularly primary care.</p> <p>Describe poor quality care from named primary care health providers.</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p> <p>Want support from family and/or peers while in hospital.</p>	<p>Are self-motivating and are accessing care appropriately</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p>
Primary Birthing Units	<p>Mostly unaware of Birthing Units.</p> <p>A few mothers that accessed birthing units described poor service experience.</p> <p>Lack of access to transport meant that those who were given the option to go to the Primary Birthing Unit, post-delivery, went straight home from Middlemore.</p>	<p>Mostly unaware of Birthing Units.</p> <p>Did not know Birthing Units provide an alternative birthing option to Middlemore.</p>	<p>Mostly unaware of Birthing Units.</p> <p>A few mothers that accessed birthing units described poor service experience.</p> <p>Could not utilise due to complex health issues.</p> <p>Lack of access to transport and childcare meant that those who were given an option to go to the Primary Birthing Unit, post-delivery, went straight home from Middlemore.</p>	<p>Mostly aware of Birthing Units.</p> <p>Could not utilise due to complex health issues.</p> <p>Distance between Primary Birthing Unit and Home meant Middlemore was far more accessible.</p>
Smoking	<p>High rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>	<p>High rates of smoking.</p> <p>Less likely to give up smoking while pregnant.</p>	<p>Low rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>	<p>Low rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>
Nutrition	<p>Other family members control decision-making about purchasing/preparation of food in their homes.</p> <p>Likely to frequent fast food establishments, the dairy or supermarket for takeaways, chocolate and fizzy drinks at least once a day.</p> <p>Diet and exercise are not high priorities.</p> <p>Are motivated by desire to look good.</p>	<p>Not in control of decision-making about nutritional issues.</p> <p>Likely to frequent fast food establishments, the dairy or supermarket for takeaways, chocolate and fizzy drinks at least once a day.</p> <p>Diet and exercise are not high priorities.</p>	<p>In control of decision-making about nutrition.</p> <p>Living in highly obesogenic environments.</p> <p>May face active resistance to behaviour change from parts of their support system e.g. cultural and festive celebrations that encourage feasting.</p>	<p>Most live in obesogenic environments.</p> <p>Most describe being in control of nutrition and exercise.</p>
Contraception	<p>Get information from a trusted source, friend, teacher or school nurse.</p> <p>Access information after the fact. They need support to act on information.</p> <p>Want information earlier than currently provided through schools (Year 7 and 8). Preference for simple and pictorial forms.</p>	<p>Complex social and health needs.</p>	<p>Significant health literacy issues.</p> <p>Low awareness of the full range of contraception options.</p> <p>Cultural/religious values can determine decision-making about contraception.</p>	<p>Able to access information as required and make informed choices.</p>

We recommend utilising these groups as well as a focus on each of the four stages in maternity care identified using the Perinatal Periods of Risk (PPOR) analysis (Jackson, 2011). The PPOR analysis categorises perinatal and infant deaths into four mutually exclusive periods of risk (Table 3):

Table 3 Examples of potential interventions that address high perinatal mortality in different PPOR periods (information from Jackson, 2011b)

Perinatal period	Potential interventions
Maternal Health	<ul style="list-style-type: none"> • Improve wellbeing in women of childbirth, eg optimise conditions for planned pregnancy; reduce smoking; improve nutrition; reduce obesity • Preconception care (eg. folate supplementation) • Early engagement with antenatal care
Maternal Care	<ul style="list-style-type: none"> • Provide adequate antenatal care • Screening (eg. for infections that may increase risk of complications) • Smoking cessation programmes • Risk assessment and referral
Newborn	<ul style="list-style-type: none"> • Delivery in an appropriate facility • Provision of neonatal intensive care • Breastfeeding • Prevention of SUDI
Infant health	<ul style="list-style-type: none"> • Breastfeeding • Improve access to primary healthcare services

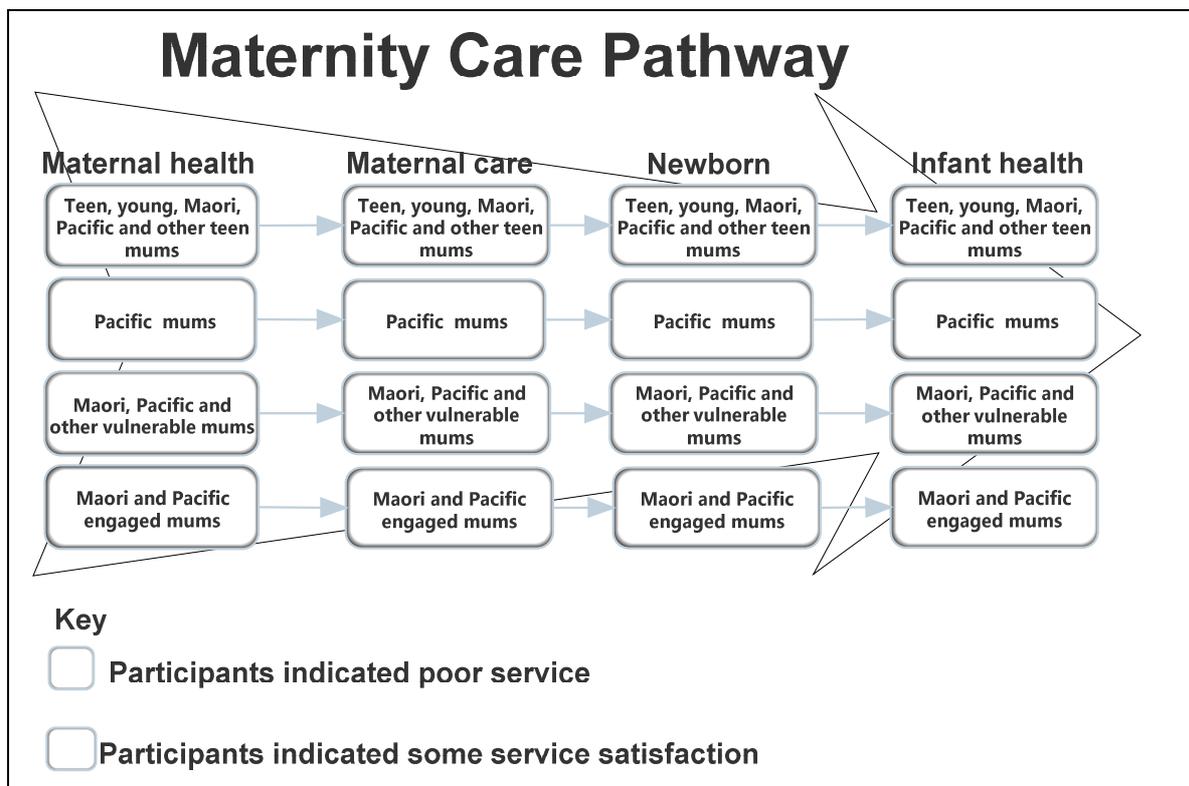
The periods of risk are associated with different drivers of perinatal mortality and therefore lend themselves to different prevention strategies (Sappenfield et al, 2010).

Counties Manukau data shows that the distribution of excess deaths by perinatal period of risk differed significantly for different ethnic groups, suggesting tailored strategies for ethnic groups are required. For Pacific women, more than half of the excess deaths occurred in the Maternal Care period. Tailored solutions for Pacific women therefore require a focus on maternal care, for example quality antenatal care, risk assessment and referral and support for smoking cessation. For Maori and Asian mothers, the predominant risk period was Maternal Health. Examples of initiatives which could be tailored for these mothers to improve wellbeing in childbearing age include planned pregnancy, smoking cessation, folate supplementation and nutrition advice.

Teen, Young, Maori, Pacific and other vulnerable mothers in CMH receive poor service

The research highlights that teen, young, Maori, Pacific and other vulnerable mothers in CMH perceive significant shortcomings in the quality of services they receive throughout the maternity care pathway. Figure 2 summarises participant feedback by CMH maternity group (refer Table 1) about the quality of services they received in the 4 stages of maternity care identified using the PPOR categories.

Figure 2 Participant feedback by Perinatal Periods of Risk and CMH maternity group



This feedback shows that all sample groups expressed dissatisfaction with maternal care services provided by CMH. The dissatisfaction relates to:

- perceived attitudes of staff towards mothers, for example vulnerable young mothers felt interactions with staff stereotyped, judged and stigmatised them;
- labour, delivery and the period immediately after delivery were mentioned as times when young mothers felt they needed support and care of health professionals and their families. However the predominant CMH culture was focussed on timeliness and efficiency. Mothers perceived they received a service, rather than nurturing and care. The service failed to utilise family support. We were told of many cases when births occurred at night, partners and families were sent home, (or charged an

unaffordable fee to stay the night). This left vulnerable young women alone in an unfamiliar environment with staff who could not or would not respond to their needs due to other work pressures. We noted that mothers who had also delivered at Auckland District Health Board (ADHB) facilities, described a marked contrast in their experience of the maternal care services provided at ADHB. In particular staff attitudes were different, including welcoming their families and going the “extra mile” to make them feel comfortable and provide care and support in the period immediately after delivery.

- women with English as a second language and or with low health literacy were not able to access additional resources to meet their needs;
- interworkforce rivalry and patch protection were obvious to mothers and their families. Mothers described tensions between private LMCs and hospital staff, with LMCs acting as advocates for them against hospital staff who were perceived as focussed on discharging mothers home early; and hospital staff who criticised the actions and competence of LMCs. This impacted on their confidence and trust in the services, and their willingness to engage for future needs.

Many of these issues lead to the conclusion that services failed to deliver and respond in a culturally appropriate way thereby aligning with the world views and socioeconomic circumstances of mothers and their families.

Our research and the desktop review of existing reports indicated that these views were prevalent in these groups and already well documented, which indicates from a consumer’s perspective that services still need to respond.

Addressing these issues requires an understanding of the complex relationship between social circumstances, health related behaviours, cultural and social world views which determine the uptake of services. We strongly recommend that CMH addresses the maternal care (antenatal care and delivery) part of the maternity care pathway as a priority.

An intervention logic which considers the whole maternity care system

The maternity care system is complex. Services are provided by a range of public, private, and not-for-profit organisations for example midwifery, primary care, secondary/tertiary care and diagnostic services in the health sector as well as education and social services. These providers have differing goals and may be joined in overlapping networks in the plethora of current national, regional and local activities.

The system intervention logic needs to be mapped in order to provide a framework for measurement and attribution. In this way, single interventions or interventions aimed at single risk factors can be seen in context and realistic achievements can be identified and prioritised. What is required, is for different strategies to work cumulatively, and being adaptable to respond to the different needs of diverse groups.

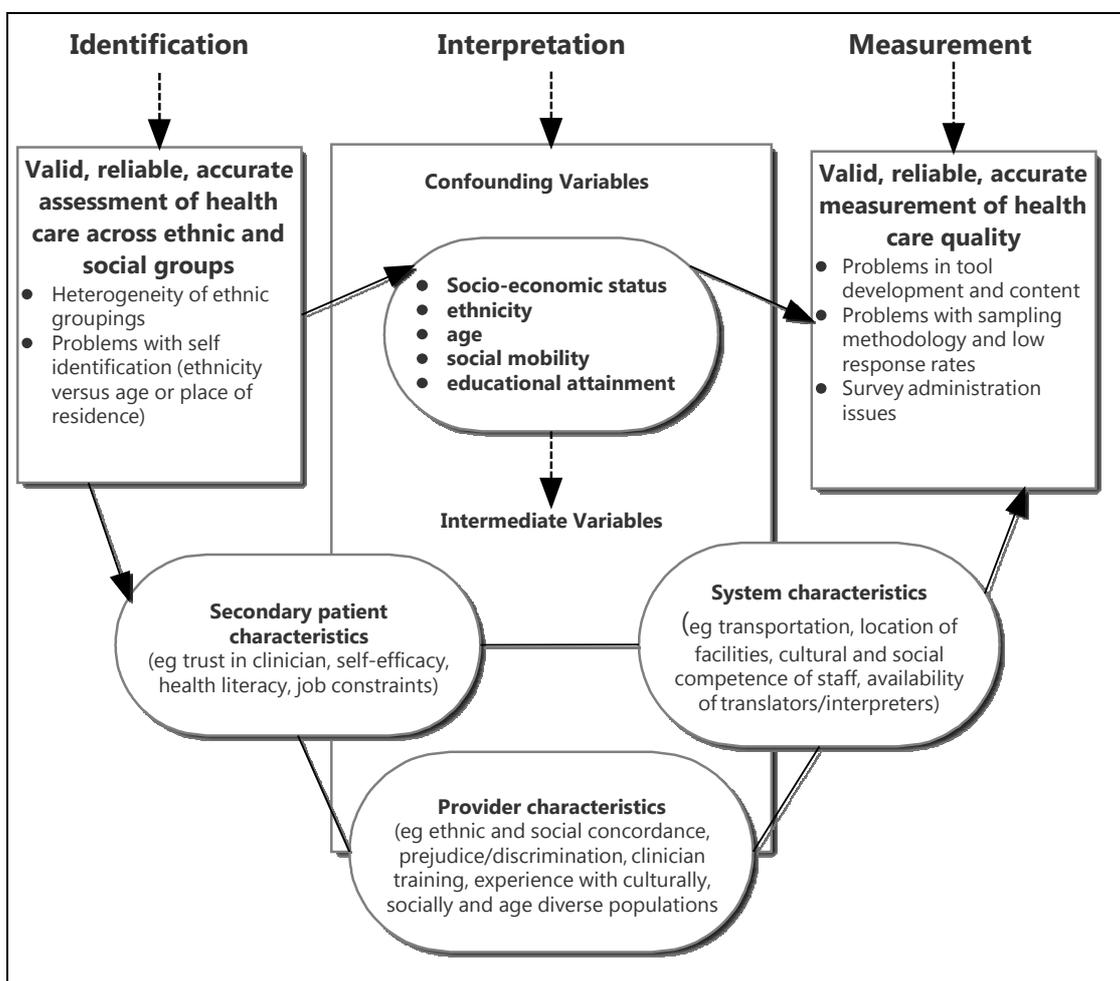
We note that a specific intervention logic for maternity care interventions has yet to be developed. An intervention logic would assist with understanding the complexity and make explicit the hypotheses and assumptions on which interventions are based. The validity of assumptions could then be tested with consumer panels and used to inform strategic planning, and the development of management performance criteria and set the frameworks for evaluation and monitoring.

Achieving robust consumer input into measuring and interpreting maternity care quality for diverse and vulnerable populations

We identified a gap between the recommended standards of care and the experience of mothers in CMH. While there are a range of existing channels for feedback, these were almost never utilised by the mothers in this research. Patient surveys and complaint mechanisms are often predicated on assumptions that are incompatible with the cultural beliefs and worldviews of diverse cultural and vulnerable mothers. For example, for many Pacific cultures respect for hierarchy, clinicians and those who are in authority, prevents the voicing of concerns or complaints.

Mechanisms and tools for assessing quality need to validly and accurately assess a range of variables including patient characteristics, provider characteristics and system characteristics. Figure 3 below provides a framework for assessing differences in healthcare across socially and culturally diverse populations to ensure a focus on consumer reported measures.

Figure 3 Assessing differences in health care across socially and culturally diverse populations: a focus on consumer reported measures¹



We recommend a review of the mechanisms used by CMH for patient and consumer input. For example patient satisfaction surveys and complaint mechanisms need to be reviewed for relevance of content, design and translation for linguistically diverse populations, survey sampling and analysis to create a picture of health within and across diverse cultural and vulnerable populations groups. Interpretation of this data must be contextualised with an in-depth understanding of the perspectives, values, world views and cultural beliefs of the groups being assessed. We recommend that for the CMH population of culturally diverse and vulnerable mothers, that this information is best attained through qualitative research based on cultural and other methodologies appropriate for the diverse population groups. Furthermore, case studies, which present the patients experience of care and their worldview can be powerful tools for changing provider behaviour.

¹ Adapted from Bethell, C. et al (2002) Measuring and Interpreting Health Care Across Culturally Diverse Populations – A focus on consumer-reported indicators of health Care Quality.

Effective relationships are key to engagement

A significant finding of this research is that high quality relationships are the key to addressing the significant challenges to providing quality maternity health services for the diverse populations of CMH. We recognise that staff and providers work in an environment characterised by ambiguity, uncertainty and chaos. Addressing the range of complex issues requires collaboration across disciplines, providers and sectors. Effective collaboration will only occur person to person, through relationships.

As well, mothers do not experience maternity care in isolation from other health care services. Their personal and family health care experiences impact on the choices they make to engage with maternity care. Similarly their experience of maternity care will affect future engagement with other health services.

For many young women, pregnancy is their first experience of primary health care (and other health services), independent of parents and caregivers. We note the evidence that mothers are more likely to act on information if the messenger is similar to themselves in age or behaviour or demonstrates a comprehensive, non-judgemental and practical understanding of the mothers background and worldview.

We also noted from the literature and from participant's experiences many examples of excellent practice based on long term care relationships. We were told about continuity of care, with mothers choosing one provider for maternity care across a number of pregnancies; vulnerable mothers able to access general practice care daily for concerns in the newborn care and infant health period; and culturally competent care integrating health, social and educational needs. We noted that these 'champions' of maternity care worked in private and public midwifery practices, general practices and secondary care settings and readily identified by mothers. These champions are a valuable resource for CMH in implementing change.

We recommend that CMH begins with building a positive culture towards the mothers and families they serve. High quality and effective health services will contribute to establishing and maintaining trusting care relationships with mothers and their families throughout the maternity care pathway and their life course. This will provide the basis for CMH to work more effectively with its diverse populations so that they are empowered to contribute to developing the innovative solutions across health and other sectors required for improving health outcomes and reducing inequalities.

An effective maternity care system will enable mothers to emulate the trust relationships they have with their family/whanau in their relationships with LMCs and other maternity care providers.

Recommendations

Achieving quality in maternity care cross culturally diverse populations

1. To better understand the range of factors associated with maternity care and how tailored solutions can be developed to achieve improved outcomes for specific groups a stratified population approach must be used. This should include:
 - Implementing strategies to cluster teen, young, Maori, Pacific and vulnerable mothers by residential location and by the general practices they choose to attend. Clustering can lead to solutions being developed for mothers with variable health and social needs.
 - For Pacific families, a strategy to support improved health literacy is urgently required. The strategy should include innovative initiatives and monitoring and evaluation for effectiveness to ensure improved communication between Pacific mothers and health care providers especially in the maternity care period. Specific topics which should be prioritised include post-natal contraception information in Tongan and Samoan languages.
 - Using family centred and group approaches for antenatal care and health promotion initiatives. For example, health professionals and LMC's need to understand that diverse groups attitudes to contraception and sexual health promotion are influenced by cultural, religious and social beliefs. Taking account of these views will improve targeting of information to meet the needs of mothers and their families. Similarly appropriate support for women who smoke in pregnancy will take account of the family and other people they live with who are also likely to be smokers and whose behaviour will impact on an individual's ability to make changes in their own lives.

Addressing poor service to Teen, Young, Maori, Pacific and other vulnerable mothers

1. CMH must urgently address issues of service quality and poor care in the maternity care (antenatal care) and newborn (delivery) stages of the Perinatal Periods of Risk. This should include, and is not limited to:
 - Addressing the workforce shortages and inconsistent information provided at the first antenatal care visit (when the pregnancy is first diagnosed) that prevent teen, young, Pacific and vulnerable mothers accessing an LMC early in their pregnancy.

- Undertaking a 'fit for purpose' and tailored training programme to improve customer service provided by maternity care staff at CMH starting with staff employed at Middlemore maternity ward and the Botany and Papakura Primary Birthing Units.
- Reviewing current policies for family members to provide support to teen, young, Maori, Pacific and vulnerable mothers at Middlemore maternity ward and investigate options for improved family centred-approaches.
- Establishing a best practice network focussed on capturing and spreading best practice maternity care strategies in Mangere, Otara, Papatoetoe, Manurewa and Papakura localities for working with teen, young, Maori, Pacific and vulnerable mothers.

Development of an intervention logic which considers the whole maternity care system

1. Develop a specific intervention logic to underpin the First 2000 days Framework to help inform strategic planning, define management performance criteria and set the frameworks for on-going evaluation and monitoring.
2. The hypotheses and assumptions on which interventions are based, as well as performance information should be tested with consumer panels for validity and interpretation of data contextualised with an in-depth understanding of the perspectives, world views and cultural beliefs of the target groups for interventions.

Achieving robust consumer input to measuring and interpreting maternity care quality for diverse and vulnerable populations

1. We recommend a review of the mechanisms used by CMH for patient and consumer input. This should include:
 - Expanding options and opportunities for teen, young, Pacific and vulnerable mothers to provide quality input to (and participate in) decision-making processes. This may include facilitated events for users and staff to introduce user perspectives into planning and developing services.
 - Putting in place a wider variety of feedback processes that allow increased 'real time' feedback from teen, young, Pacific, vulnerable mothers and /or their family members about service experience.
 - Continuing to undertake qualitative research based on cultural and other methodologies appropriate for the diverse population groups.

Effective relationships are key to engagement

We recommend that CMH:

1. Develops workforce and leadership development initiatives that support the skills required for collaborative, customer and family focussed approaches to service provision. The CMH workforce needs to be empowered and supported to respond to the complex health and social needs of the population it serves. This requires specific training but also system changes so that appropriate resources (for example translation services) are provided.
2. Identify existing 'champions of maternity care' who provide excellent maternity care in CMH and support these champions to share their skills, knowledge and experience with others.
3. Develop opportunities such as 'Masterclasses' for on-going training where individuals from a range of maternity care services including social services, independent and CMH midwives, Well Child providers can come together, share experiences and improve skills within an atmosphere of supportive change.
4. Broaden current maternity care options to encourage group prenatal care and other alternative approaches that build models of social pregnancy networks within localities.

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2 Introduction

2.1 Purpose

This report aims to contribute to projects being undertaken by Counties Manukau Health (CMH) to explore the factors contributing the District's high perinatal mortality rate and identify ways in which these factors can be addressed. This project specifically sought the views and input of Maori, Pacific mothers and women of childbearing age who live in areas of high socio-economic deprivation.

The findings of this report will help inform a wider suite of activities being implemented by CMH and underpinned by the 'First 2000 Days' population framework which has three key objectives in relation to improving health outcomes for children. These are:

- Planned, healthy pregnancy
- Optimal maternal, infant and nutrition; and
- Healthy attachment development and appropriate parenting skills.

2.2 Background

As a response to the report from the National Perinatal and Maternity Mortality Review Committee highlighting that CMH had perinatal mortality rates higher than the rest of New Zealand, CMH commissioned an independent review panel to review perinatal mortality rates in the district. The findings of this panel are outlined in the *External Review of Maternity Care Report*, which, among other things, concluded that the higher perinatal mortality rates in Counties Manukau can be attributed to the socioeconomic composition of the district, where women of childbearing age predominantly live in areas of higher socioeconomic deprivation, are much younger and have more babies than the rest of New Zealand.

A Maternity Programme Board was established to consider the findings in the *External Review of Maternity Care Report* and, where agreed, to implement the Board's recommendations. One such recommendation was the formation of a Maternity Care Consumer Panel, the objective of which is to assist CMH to identify what is working well with its current maternity care system and where improvements can be made.

2.3 Project Objectives

The objective of this project was to seek input from mothers who have birthed or are in the process of birthing with CMH to assist CMH to plan and implement actions to improve the cultural appropriateness of its maternity care services. To achieve this, the project consisted of the following components:

- a desktop review of existing CMH maternity care reports;
- two facilitated sessions with 5 maternity consumer panels;
- ten individual interviews with Pacific mothers who speak English as a second language and who accessed maternity care services after 20 weeks gestation;
- thematic analysis of the feedback from each of the groups; and
- a report outlining the findings and recommendations.

2.3.1 Key themes

CMH identified 5 key themes which they specifically wanted input from mothers on. These were as follows:

- Accessing and engaging early in pregnancy;
- Utilisation of the Primary Birthing Units (these are based in Botany Downs, Pukekohe and Papakura);
- Identifying gaps and solutions in accessing appropriate advice and affordable contraception in a timely manner;
- Reviewing and developing strategies to reduce smoking in pregnant women; and
- Developing culturally appropriate nutritional interventions to reduce pre-pregnancy obesity.

2.4 The Maternity Care Consumer Panels

The initial recommendation of the Maternity Programme Board was to form a single Maternity Care Consumer Panel. However when implementing the recommendation CMH faced a significant challenge establishing a single consumer panel that could successfully represent the views of teenage mothers, Maori, Pacific, young and older mothers, second language speakers and vulnerable mothers. Furthermore creating an environment that enabled equity of participation would be difficult given the diverse backgrounds, experiences and languages. Maternity Programme Board therefore agreed that CMH should organise 5

separate Consumer panels. Each panel had 2 focus group sessions with the research team. Table 4 below provides the breakdown of the consumer panels.

Table 4 Consumer Panels

1	Teen Mums Supported by a Charitable Organisation
2	Teen Mums Supported by Secondary School
3	Young Mums in Living in a Supported Home
4	Young Mums living in the Community
5	Maori and Pacific mums representing CMH localities

More information about the specific profiles of each Consumer Panel is outlined in Section 3.3.

2.5 Population Context

2.5.1 *Mothers and Babies in Counties Manukau*

- Fourteen per cent of all births in New Zealand are to women residing in Counties Manukau. The combined CMH birthing facilities form one of the largest providers of birthing services within New Zealand and Australia. Approximately 8,500 babies are born each year to women living in CMH , of whom more than 50% are born to Maori or Pacific mothers (25% and 32% respectively in 2007–9) and to mothers who predominantly live in areas of high socioeconomic deprivation (Jackson, 2011b).
- Women of childbearing age (15–49 years) make up 30.4% of the total CMH population (Statistics NZ, 2006). This is significantly different from elsewhere in New Zealand, with the childbearing population being younger, more frequently Maori (17.4% vs 15.7%), Pacific (21.6% vs 6.5%) or Asian (20.4% vs 12.3%), and more often living in the most deprived areas (47% in quintile 5, the highest deprivation quintile, vs 26% in New Zealand overall (Sadler, 2012).
- The proportion of Maori preterm births in CMH (7.6%) is consistently higher than the proportion of European preterm births (6%) in the region and also higher than the overall New Zealand rate of Maori preterm birth (7.6% CMH compared to 6.7% for NZ Maori (Jackson, 2011b).
- Jackson notes that between 2007–9, teenage birth rates in CMH were higher than the New Zealand average (43.9 per 1000 compared with 32.2 nationally) and that

23% of all births during this period to mothers under 15 were to young women who lived in CMH. There were also noticeable differences in teenage birth rates in CMH by ethnicity: Maori (72/100,000), Pacific (49/100,000), European (13/100,000), Asian (5/100,000) (Jackson, 2011b).

- Tobacco use in CMH is highest for women in their teens, followed by women aged 20–24 years (Craig, MacDonald, Reddington & Wicken, 2009). Maori women have the highest rates of tobacco use during pregnancy (40% in 2008), followed by Pacific (15%) and European women (10%).
- Between 2007 and 2009, only 35% of CMH women who delivered in a CMH facility had a Body Mass Index (BMI) within the normal range, 27% were overweight, and 38% were obese (Jackson, 2011b). Pacific women, during pregnancy, are more likely to be overweight or obese than women of other ethnicities (86%) (Maori women, 69%, and European/other, 50%).

Table 5 refers to women domiciled to CMDHB – some of who deliver at CMDHB facilities (inborn) and some who deliver at other DHB facilities (outborn) in 2012

Table 5 CMDHB Women who delivered “inside” and “outside” CMDHB, 2012

	Inborn		Outborn	
	Number	Percentage	Number	Percentage
Ethnicity				
Maaori	1871	95.7	85	4.3
Pacific	2661	96.3	102	3.7
Asian				
Indian	565	91.6	52	8.4
Chinese	291	47.9	317	52.1
Other Asian	315	78.2	88	21.8
European/Other	1681	75.3	551	24.7
Total	7384	86.1	1195	13.9
Maternal Age				
<20 years	672	96.6	24	3.4
20-24 years	1801	93.9	117	6.1
25-29 years	2025	86.4	319	13.6
30-34 years	1715	79.9	431	20.1
35-39 years	899	79.1	237	20.9
40+ years	272	80.2	67	19.8
NZ Deprivation Index 2006 Decile (CAU*)				
Unknown	10	100.0	0	0.0
Decile 1-2	732	63.9	413	36.1
Decile 3-4	384	70.2	163	29.8
Decile 5-6	831	76.4	257	23.6
Decile 7-8	672	84.4	124	15.6
Decile 9-10	4755	95.2	238	4.8
Suburb				
Franklin	937	88.3	124	11.7
Howick	968	59.1	671	40.9
Mangere	1193	91.1	117	8.9
Manurewa	1711	94.6	97	5.4
Otara	793	94.2	49	5.8
Papakura	866	93.8	57	6.2
Papatoetoe	906	91.9	80	8.1
CMDHB nfd*	10	100.0	0	0.0

Source: National Minimum Dataset. Note: Ethnicity is prioritised. NZ Deprivation Index is at Census Area Unit level. Suburbs are Auckland City subdivisions.* nfd= not further defined

3 Research Methodology

3.1 Research approach

The research undertaken to inform this report took place over a period of 4 months, between June 2013 and September 2013. Prior to the commencement of the research, a project plan was agreed between CMH and Pacific Perspectives to inform the nature and course of the research. The project plan included the development of consent and information documentation for participants, interview tools and schedules; completion of a desktop review which summarises findings from other CMH reports focusing on perinatal mortality, primary maternity services and the antenatal experiences and needs of expectant and new mothers in the district; and a schedule of consumer panel meetings.

The scope of the project initially focused on 5 consumer panels with 2 sessions for each panel. After the preliminary round of focus groups sessions Pacific Perspectives met with CMH to review progress and discuss potential gaps in the research approach which could impact on the ability of CMH to achieve the project purpose.

One of the concerns was that the focus group approach to seeking input from panel participants may not be conducive to those who may have a different experience to the majority that is, rather than speak out about their different experience; participants say nothing or agree with the majority. Furthermore it was agreed there was a potential gap in the participation of Pacific mothers, who speak English as a second language and who present to maternity care services late (after 20 weeks gestation). CMH therefore requested that Pacific Perspectives develop a process to identify 10 Pacific mothers from a range of Pacific ethnicities and complete face-to-face interviews with them.

3.2 Desktop review

Between 2011 and 2013 a number of reports and projects have been commissioned by CMH to explore factors leading to its high perinatal mortality rate. Rather than undertake a full literature review, CMH requested that Pacific Perspectives undertake a desktop review of documents and reports produced during this period to inform this research project.

The documents included in the desktop review are listed in Table 6 below.

Table 6 CMH documents included in the desktop review

Document	Summary
Jackson (2011a)	Examines perinatal mortality and its key drivers in women residing in CMH.
Jackson (2011b)	A companion report to the Perinatal Mortality document; focuses on CMDHB antenatal care, describes the CMH maternity population, examines the provision and use of CMH maternity services and reviews the literature on antenatal models of care.
Sheridan, Schmidt-Busby & Kenealy (2011)	This report documents the perspectives of SAMCL self-employed midwives on the provision of primary maternity services in CMH.
Litmus (2011)	Outlines the results of interviews with young mothers and providers of primary maternity care services in CMH. Aims to identify factors that prevent women from accessing LMC services, better understand the experiences of women who did not have an LMC, and identify features of an accessible primary maternity service.
Friday (2011)	Describes the essential components of a successful Lead Maternity Carer Practice currently providing continuity of care in Counties Manukau.
Boladuadua (2013)	A stocktake of the antenatal and pregnancy services available for teenage pregnant women in Counties Manukau. Includes a gap analysis that identifies where services could be developed or strengthened.

3.3 Consumer Panels

The consumer panels were co-ordinated and organised by CMH. This section provides more detailed information about the research process and the make-up of each panel.

3.3.1 Research process and approach

With the exception of the '*Maori and Pacific mums representing CMH localities Panel*', two focus group sessions were held with each panel. The focus groups were between 2-3 hours in duration. The focus groups sessions were organised as follows:

-
- | | |
|-------------------------|--|
| Session 1 Topics | <ul style="list-style-type: none"> - Accessing and engaging early in pregnancy - Utilisation of Primary Birth Units - Identifying gaps and solutions in accessing appropriate advice and affordable contraception in a timely manner |
|-------------------------|--|
-

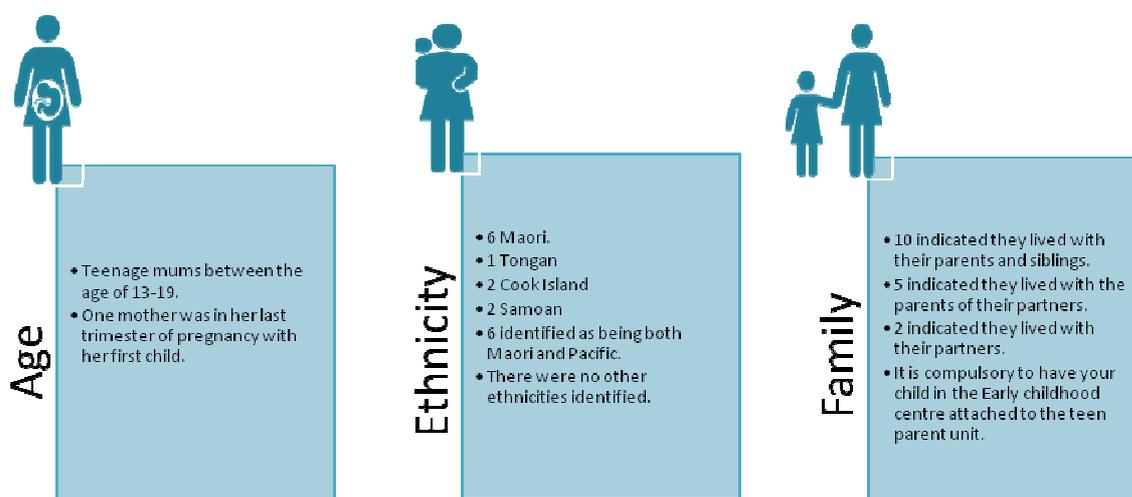
-
- Session 2 Topics**
- **Strategies to reduce pregnant women/and mothers smoking**
 - **Culturally appropriate nutritional interventions to reduce pre-pregnancy obesity**
-

For the consumer panel sessions:

- A discussion guide, information sheet and consent form were developed in consultation with CMH. These are attached as Appendix one.
- A baseline survey was developed in consultation with CMH to gather ethnicity, age, and household and contraception data. This is attached as Appendix two.
- Fieldwork was undertaken by Dr Debbie Ryan and Gerardine Clifford-Lidstone. To ensure a kaupapa Maori perspective was maintained, Pacific Perspectives and CMH undertook some fieldwork with Chrissy Norris, who is both Tangata Whenua and a Community Support Worker.
- Participants completed and signed consent forms agreeing to participate in the research. Focus group sessions were audio recorded with participant's permission.
- With the exception of the '*Maori and Pacific mums representing CMH localities consumer panel*', participants were given a \$20 koha for participating in each session.

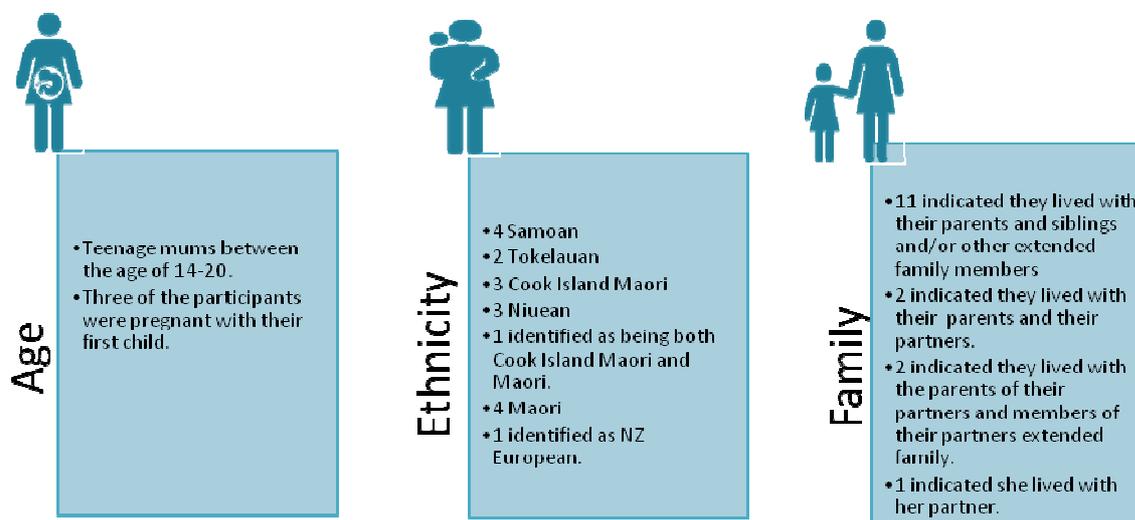
3.3.2 Teen Mums Supported by a Charitable Organisation Consumer Panel

The participants in this group attended a Teen Parent Unit in Clendon. The focus groups were run during school hours from 12.30-2.45pm. Participation was optional. There were 16 participants in session one and 17 participants in session two.



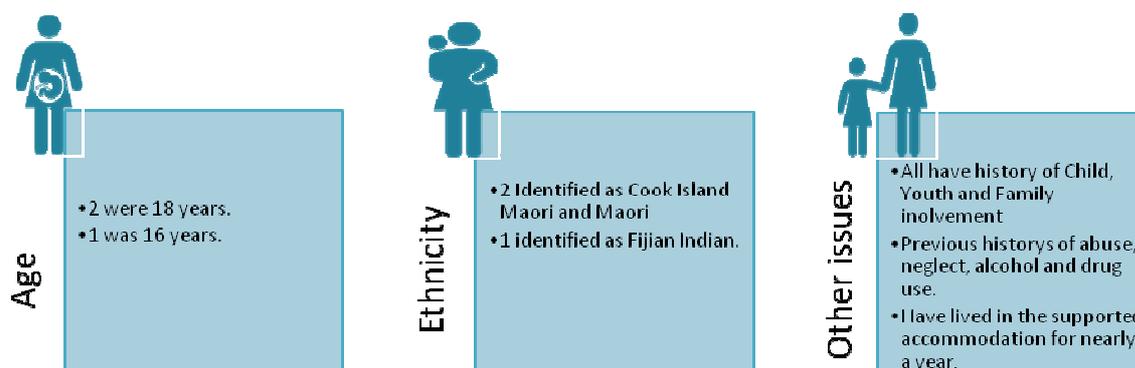
3.3.3 Teen Mums Supported by Secondary School Consumer Panel

The participants in this group attended a Teen Parent Unit attached to a South Auckland college. The focus groups were run during school hours from 12.30-2.45pm. Participation was optional. There were 18 participants in session one and 12 participants in session two².



3.3.4 Young Mums in Living in a Supported Home Consumer Panel

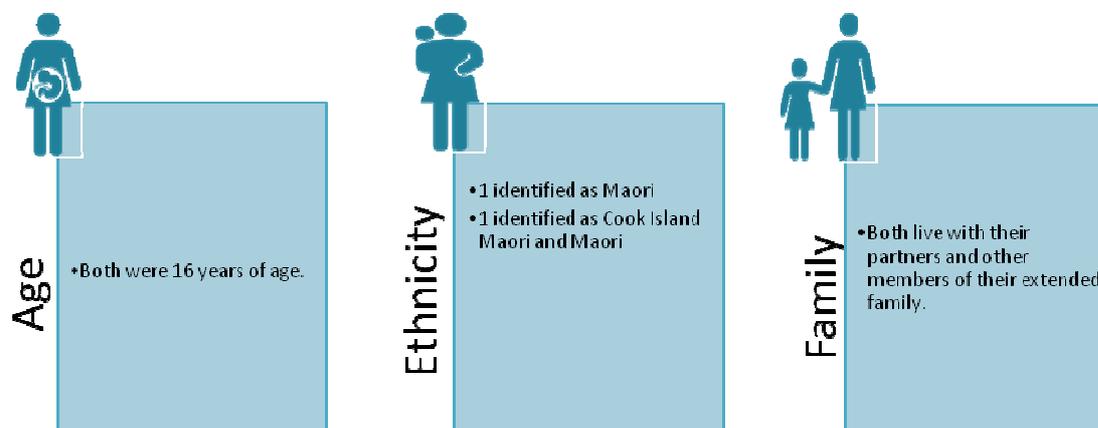
The participants in this group were living in supported accommodation for teen mothers. The home is operated by (delete) Trust, a charitable kaupapa Maori organisation that runs multifaceted programmes for teenage mums in the South Auckland area. Mothers living in supported accommodation require significant support and have experienced substantial adversity in life. There were two participants in the session one and three participants in session two.



² One participant opted not to complete the baseline data survey

3.3.5 Young Mums living in the Community

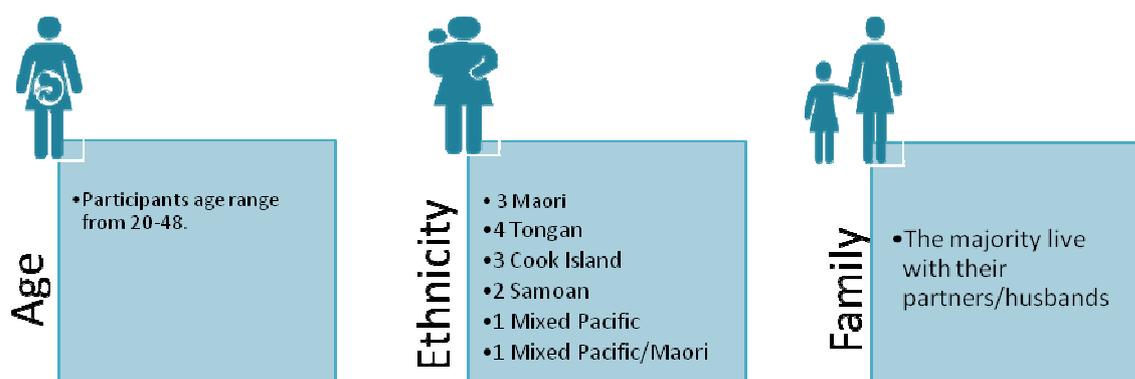
The participants in this group were teenage mothers who were not in school and were known to (delete) Charitable Trust. There were 2 participants who attended both sessions 1 and 2.



3.3.6 Maori and Pacific mums representing CMH localities Consumer Panel

The Maori and Pacific mums representing CMH localities Consumer Panel (the Localities consumer panel) were recruited by CMH using a different recruitment process than that used for the other consumer panels. It is the intention of CMH that the Localities consumer panel provide on-going input to the development of maternity care services, that is, beyond the lifecycle of this research project. Therefore, to recruit for this panel CMH advertised within their localities (Mangere, Otara, Papatoetoe, Howick, Manurewa, Papakura and Franklin), for Maori and Pacific mothers to nominate themselves to participate in the localities maternity care consumer panel. To participate in this panel mothers must have accessed CMH maternity services during pregnancy. Fourteen mothers were selected to participate in the Localities consumer panel.

This panel participated in session one only. The second session involved direct feedback as part of the CMH First 2000 Days Forum held on 5 July 2013. Appendix three provides list of questions provided by CMH. The panel provided their feedback directly to the Forum.



3.4 Face to face interviews

Identification of eligible participants was led by Pacific Perspectives. Pacific Perspectives along with CMH developed a purposeful sampling framework for this part of the research structured by ethnicity. The target audience was Pacific mothers who speak English as a second language and who present to maternity care services late, after 20 weeks gestation, in pregnancy. Table 3 below provides the sample matrix.

Table 7 Sample matrix

Samoan	3
Tongan	3
Cook Island	3
Niuean or Tokelauan	1

Pacific Perspectives used its extensive networks with Primary Care and Social Service providers in South Auckland to recruit for the face to face interviews. Initial approaches were made to these networks with Pacific Perspectives providing information sheets and preferred participant profile information to potential referrers. Screening and identification of eligible participants occurred very quickly using this process. Table 8 below provides the referral sources for the face to face interviews.

Table 8 Referral sources for face to face interviews

Referral Source	Ethnicity	Location
Otara Health	Tongan	Otara
Otara Health	Tongan	Flatbush
Otara Health	Cook Island	Otara
Otara Health	Cook Island	Otahuhu
Otara Health	Niuean	Mangere East
Community network	Cook Island	Mangere East
Community network	Samoan	Clendon
Community network	Samoan	Manurewa
Community network	Samoan	Flatbush
Community network	Tongan	Otara

The face to face interviews took 2-3 hours. Pacific Perspectives uses cultural methodologies and frameworks to underpin its research approach with Pacific peoples. This is outlined further in section 3.6 below. The interviews took place in the home of the participant. If participants wanted another family member to participate in the research, this was encouraged primarily because families play a significant role in the health and wellbeing of Maori and Pacific peoples collectively and as individuals (Tiatia & Foliaki, 2005). A semi

structured interview guide was developed by the research team based on the research objectives prescribed by the CMH. The questionnaire included a number of probes to ensure key information was collected, whilst allowing free flowing dialogue to occur during the interview process.

For the face-to-face sessions:

- A semi-structured guide was developed to guide the talanoa; information sheets and consent form were developed in consultation with CMH.
- Fieldwork was undertaken by Gerardine Clifford-Lidstone. Two Tongan participants required a translator. This role was undertaken by Pisila Ikahihifo a Tongan Community Support Worker from Otago Health³.
- Participants completed and signed consent forms agreeing to participate in the research. Interviews were audio recorded with participant's permission.
- Participants received a \$100 koha/meaalofa for participating.

3.5 Summary of Research Participation

A total of 61 mothers participated in this research. Table 9 provides a summary of participation in this research project by ethnicity.

Table 9 Summary of Participation in Research

Ethnicity Group	Samoan	Tongan	Cook Island Maori	Niuean	Tokelauan	Maori	NZ European	Mix Pacific	Mix Maori/Pacific	Asian
TPU Clendon	2	1	2			6			6	
TPU Otago	4		3	3	2	4	1		1	
Localities Consumer Panel	2	4	3			3		1	1	
Supported Home			2							1
Young mums in the community			1			1				
Face to face interviews	3	3	3	1						
Total	11	8	12	4	2	13	1	1	8	1

3.6 Cultural Methodologies and Frameworks

3.6.1 Kaupapa Maori

The kaupapa Māori approach adopted for this research was developed by (Pakura, 2011). The kaupapa Māori approach supported the data collection methods. It recognised the value which Māori place on the processes of welcome and engagement which in a cultural context

³ Otago Health is a social service provider based in Otago Town Centre.

include powhiri (formal welcome), karanga (first calls of welcome by female orator/s), whaikōrero (formal speech making which follows the karanga) and mihimihi (less formal introductory speeches). Meaningful engagement with the participants was, in most instances, kanohi ki te kanohi (face to face), and included the sharing of food and other stories.

The research teams reflections included:

We walked into the lounge and it was very big. From my point of view the physical environment needs to reflect our kaupapa. We were about to talk about very private and personal experiences. This seating distance between us was a problem, it would make the situation more formal and more difficult to establish trust. When I looked to see where my colleagues were going to sit I knew they saw the same problem, because instead of sitting on the chairs that were far apart, they went and sat on the floor, right next to the participants who were on couches. Within about 15 minutes we were all sitting on the floor, kanohi ki te kanohi.

The girls in the house have a Whaea (mother) who lives with them all the time and provides support for them and the babies in the house. Whaea wasn't meant to participate in the focus group but we asked her to stay for the mihi as this is an important part of whakawhanaungatanga – we are in her whare. After the mihi we invited her to participate, if she wanted to. She said she would like to stay and her contribution provided useful insights to the mother's decision making.

3.6.2 Talatalaga A Aiga (talking with families)

The Talatalaga A Aiga methodology is the overarching framework that was used to support the research methodology. This framework was first applied by Pacific Perspectives to the Primary Care for Pacific People: A Pacific and Health Systems approach project (Southwick, M., Kenealy, T., Ryan, D, 2012). The Primary Care for Pacific People initiative sought to improve knowledge about the most effective ways to improve both Pacific peoples' access to and use of primary care and, ultimately, Pacific health outcomes. It required a thorough and detailed cultural methodology to be developed and applied.

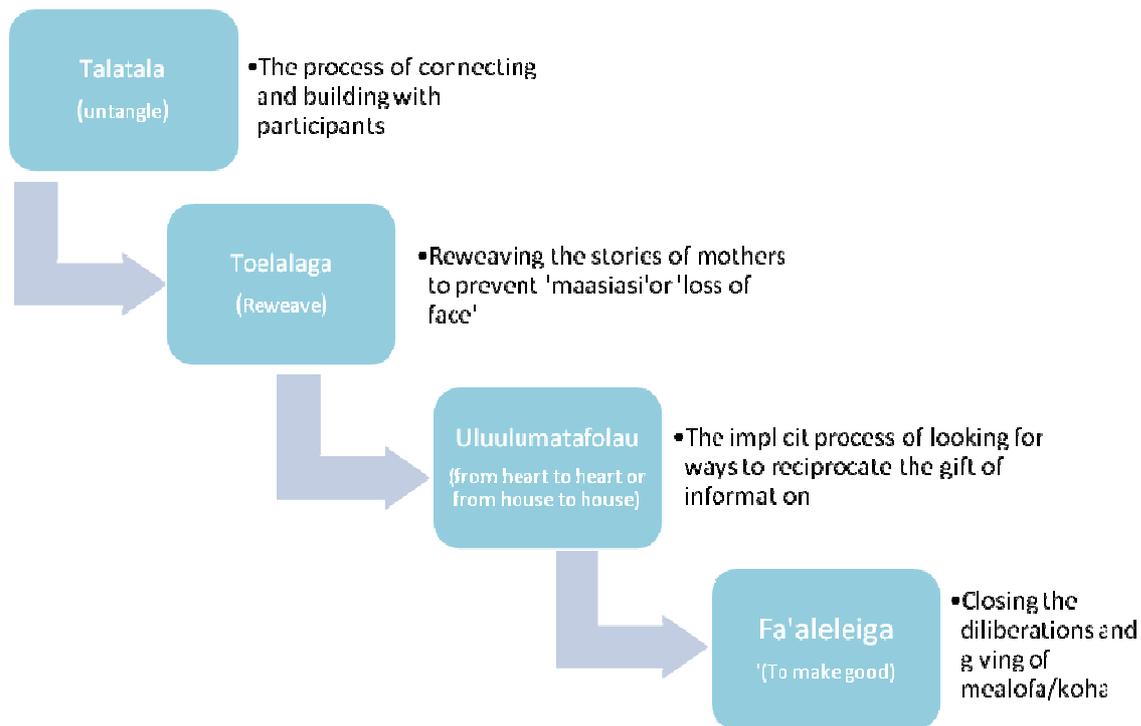
Talatalaga a aiga simply means talking with families. The model was developed in 1999 by (Masoe & So'o) as a way of engaging primarily Samoan, Tongan, Cook Island and Tokelauan families and communities in the process of talatalaga or talanoa.

The concept of *talanoa* is central to the talatalaga a aiga model. The word *talanoa* according to Halapua consists of ‘*tala*’ meaning talking or telling stories and ‘*noa*’ meaning zero or without concealment (2002). He reconstructs the word *talanoa* to mean

“...engaging in dialogue with or telling stories to each other absent concealment of the inner feelings and experiences that resonate in our hearts and mind...” (Halapua, 2002).

Figure 4 describes the 4 phases of the Talatalaga A Aiga model.

Figure 4 Phases of Talatalaga a Aiga model



3.6.3 Talatala - Untangle

The first step in the Talatalaga a Aiga process is called talatala, which is best translated as “untangle”. The word talatala is used to describe the untangling of strands of an old fala or mat when it needs to be repaired or when parts of the mat have become worn. Careful talatala allows a skilled weaver to salvage the good strands of the mat, while discarding what is no longer useful. This process equates to that of establishing kinship with research participants to help them develop a sense of mutual association and affinity (Southwick, M., Kenealy, T., Ryan, D, 2012).

3.6.3.1 Talatala in action

The research teams reflections included:

I drove up the driveway and sitting on a couch outside the house was a massive, vicious looking dog. It eyeballed me as I sat in the car. No one came out of the house so I beeped the horn a few times to alert people that I was outside, the dog sat up. The husband, wife and a teenage son came out of the house to see what the commotion was about. I could see on their faces they were annoyed by my beeping the horn. I wound down the window and said in Samoan 'In my village, dogs that look like that eat people. I'm scared of your dog, does it bite?!' The husband laughed and responded back in Samoan 'Our village is different, the dogs look like they bite

but they are gentle'. He shooed it away and they invited me in whilst asking where my family came from in Samoa.

I asked her what her daughter's name was. It was a long name and it included the words 'Ariki' and 'nui'. I said my limited understanding of Turanga Kuki Airani Maori languages was that 'Ariki' meant 'Chief' and 'nui' meant 'big'. She said I was correct and then explained to me what her daughter's name meant, her ancestral lineage and her role in the family, from here our talanoa started.

3.6.4 Toelalaga – Reweave

The next step in the process is toelalaga, which translates as reweave. This step is not typically done in a palagi research setting, but it is an important step when dealing with Pacific peoples. The process of talatala or untangling can leave research participants feeling raw and vulnerable. Most often, this is driven by ma asiāsi or loss of face. This can invoke a feeling or worry that you have disclosed too much information or have said something thoughtless and, in doing so, sullied the family name (and therefore your ancestors and heritage). It can lead to a number of emotions such as anger, crying, frustration and fear. These emotions may not always be visible, but an experienced Pacific researcher will be cognisant they may be just beneath the surface (Southwick, M., Kenealy, T., Ryan, D, 2012).

3.6.4.1 Toelalaga in Action

The research teams reflections included:

Every participant in the face-to-face interviews and some participants in the focus groups broke down at some point during in the talanoa. For some their tears were because they thought they had brought shame on their family because of their pregnancy, for others it was frustration at not knowing how to navigate the health system to seek help and support or to language their concerns appropriately and for others still it was out of anger because of perceived mistreatment and disrespect by health professionals. Whenever this happened my response needed to be appropriate for the situation. In some cases I stopped the interview periodically, in other cases I used stories and imagery to help participants to identify a pathway forward, sometimes it was appropriate to use humour. What I was clear of, was a response was required. I could not close the interview until I felt confident that I had left each participant in a positive state.

When I used the word 'sex' the body language of the two women in the room quickly told me they were very uncomfortable. They both diverted their eyes and shifted in their seats. I knew immediately that my use of this word in English was taboo from their perspective. I apologised and refrained from using the term again, carefully choosing language that was less direct. Later in this interview the women disclosed that, from their experience, issues relating to conception were not openly talked about but they wanted to share their perspective with me about why this was so.

3.6.5 Uluulumatafolau – from one heart to another

Uluulumatafolau is a Samoan term meaning to enter house after house or to go from heart to heart. This goes hand in hand with toelalaga or reweaving, because it describes a usually implicit process whereby the researcher will investigate opportunities to reciprocate the gift of knowledge imparted by participants (Southwick, M., Kenealy, T., Ryan, D, 2012). This is different to the giving of koha, as the concept of reciprocity in this context is not usually a monetary transaction.

3.6.5.1 Uluulumatafolau in action

The research teams reflections included:

The participant disclosed that at 33 years of age, she had 13 children with her husband. When we started talking about contraception, she said that after her 10th child she went with her husband to the GP to enquire about a vasectomy. She said they really wanted one but at \$400 the vasectomy was unaffordable to them. She then disclosed she was two months pregnant with her 14th child. A few days after the focus group concluded I contacted the participant's Community Support Worker and asked her to seek their consent for me to approach CMH to see if they could fund the vasectomy. The participant and her husband agreed. Within two weeks CMH was able to provide a vasectomy for this family, at no cost.

We found out some of the participants were travelling from South Auckland to Wellington to participate in a national netball competition for teen parents. Some had never been on a plane before. As I am based in Wellington, I contacted the organisers of the event to find out when and where the women were playing. We arrived at their game with drinks and food. They were shocked and happy to see us and were elated to have some support for their games.

When we started talking about contraception, it was clear that participants had very mixed understanding about what, if any, contraception could be used immediately after child birth. I knew I needed to clarify this for the participants so prior to the second focus group I contacted CMH and asked them to provide me with contraception information for mother's post-partum. I took this information with me

to the next focus group and made sure all participants were aware when different types of contraception could be used.

3.6.6 Fa'aleleiga – to make good

Fa'aleleiga is the final step in the talatalaga a aiga process and means “to make good”. This process relates to bringing the entire process to a close (Southwick, M., Kenealy, T., Ryan, D, 2012). In this research project this required bringing the interview to a close and the giving of a koha to the participant.

3.6.6.1 Fa'aleleiga in action

At the conclusion of the interview the mother invited me to have something to eat with her family. I told her I wasn't hungry and knew this could be perceived as me not wanting to eat their food OR that I had what I needed and now I was rushing off. Instead I asked for a cup of tea and drank it while they ate. As the family ate, she told me I could come back anytime but she asked that I ring first so she could make sure she could shower and make sure the house was tidy. I could tell it was a genuine invite.

I planned to stay a maximum of 3 hours at this house. I ended up being there for 4 hours but I knew that if I left earlier it would have been premature and I needed to stay longer to make sure I had given adequate time to close off the process.

Table 10 provides an outline of the key concepts of Talatalaga a Aiga used for this project.

Table 10 Key elements of the Talatalaga a Aiga model that were used for this project

<p><i>Fa'amasani</i></p>	<p><i>Building a relationship with the participants</i></p> <ul style="list-style-type: none"> • Identifying kinship, village and familial ties both in NZ and the islands • Gaining an understanding of the migratory journey/history • Identifying the family members and their respective roles and responsibilities • Identifying the powerbase and power structure within the family unit
<p><i>la mau se mafutaga vavalalata</i></p>	<p><i>Establishing Trust</i></p> <ul style="list-style-type: none"> • Helping them understand your role as a researcher • Being honest whilst treating with respect
<p><i>Va fealoai</i></p>	<p><i>Keeping relational boundaries, respecting participants</i></p> <ul style="list-style-type: none"> • Respecting the sacred space between people
<p><i>la mataalia</i></p>	<p><i>Keeping the process lively and motivational</i></p> <ul style="list-style-type: none"> • Being inclusive • Allow people to contribute • Use imagery, allegory and stories

4 Desktop Review

Perinatal mortality, defined as fetal or infant deaths occurring from 20 weeks gestation until the age of 28 days, is consistently higher in the area served by CMH than the rest of New Zealand (Jackson, 2011b). This desktop review is intended to help inform decisions about service improvement. The review summarises findings from other reports focusing on perinatal mortality, primary maternity services and the antenatal experiences and needs of expectant and new mothers in CMH.

This review has five parts and includes a brief discussion of the following:

- A. Perinatal mortality in CMH
- B. Characteristics of the CMH maternity population
- C. Maternity Care in New Zealand
- D. Maternity Care in CMH
- E. Services for teenage mothers in CMH

The documents included in the review are summarised in section 3.2 on page 25.

4.1 Perinatal mortality in CMH

Obesity, smoking and a lack of antenatal care have been identified as important potentially modifiable risk factors for perinatal mortality in the CMH population

The high perinatal mortality rate in CMH has been recognised as a key issue warranting investigation to identify the factors contributing to the excess mortality. In particular, the CMH has been interested in practical strategies it can implement; these are likely to occur within the context of the provision of antenatal care (Jackson, 2011a).

Compared to women living in other areas of New Zealand, women living in CMH, and particularly Maori and Pacific women in the area, have a higher prevalence of important potentially modifiable risk factors for perinatal mortality, including obesity, smoking, pre-existing high blood pressure and/or diabetes, placental abruption, pregnancy-induced hypertension, fetal growth restriction, and a lack of antenatal care (Jackson, 2011a). In a comprehensive review of these risk factors, Jackson (2011a) identified the following as important components of an approach to reduce perinatal mortality: community engagement, smoking cessation and reducing overweight and obesity.

Jackson estimated that if no CMH women smoked during her pregnancy, the total perinatal mortality rate could be expected to decrease by 21% for all infants and by 67% for infants born to Maori women. Similarly, if all CMH women had a weight in the normal range at conception, the total perinatal mortality rate could be expected to decrease by 12% for all

infants and by 26% for infants born to Pacific women. Clearly, smoking and obesity have important impacts on perinatal mortality for Maori and Pacific women in CMH. These factors are ideally addressed in women prior to pregnancy; however, effective and appropriate antenatal care can also be used as a vehicle for promoting positive changes. Engaging expectant mothers in maternity services at an early stage of pregnancy presents an opportunity to optimise the potential for antenatal care to improve outcomes (Jackson, 2011a).

4.2 Characteristics of the maternity population in CMH

The CMH maternity population is significantly different from other parts of NZ

CMH is the third largest DHB by population in New Zealand. It has the fastest growing population of any DHB, with an annual growth rate of 1.8% between 2006 and 2012, compared to the New Zealand average of 1.0% (Boladuadua, 2013). In 2009, 11% of the New Zealand population lived in CMH, but 14% of all births were registered to women living in the area.

Women of childbearing age (15-49 years) make up 30% of the total CMH population, compared with 27.5% of the New Zealand population. Compared with the national childbearing population, those residing in CMH are generally younger and more frequently Maori, Pacific or Asian and living in the most deprived areas. Nearly 60% of CMH women live in areas of high deprivation (NZDep deciles 8-10) compared to 37% of women across New Zealand. Deprivation varies by ethnicity; with 76% of Maori and 93% of Pacific women in CMH living in high deprivation areas compared with 38% of Asian and 31% of European/Other women (Jackson, 2011b).

CMH has one of the highest birth rates of DHBs in the country (it is second only to Tairāwhiti DHB). During 2007-09, the CMH birth rate was 72.6 per 1000 women, compared to the national rate of 60.5 per 1000 women. This higher birth rate was almost entirely due to higher birth rates in women aged less than 30 years, particularly Maori, Pacific and Asian women. Higher birth rates in CMH and throughout New Zealand are also seen in those living in areas of high deprivation (deciles 8-10) (Jackson, 2011b).

CMH mothers are younger on average than mothers across NZ. CMH also has a very high rate of teenage pregnancy: between 2007 and 2009 the birth rate for women aged 15-19 years of age was 44.2 per 1000, compared to 30.0 per 1000 nationally (Boladuadua, 2013).

4.3 Maternity care in New Zealand

Maternity services in New Zealand follow a unique model that is principled on choice but can be confusing and difficult to access

New Zealand has a unique maternity care model, driven by the principle of a woman's right to choose. The Lead Maternity Care model, which has been in place for well over a decade, allows for one practitioner, the Lead Maternity Carer (LMC) to take responsibility for the care of a woman and baby through pregnancy and up to six weeks post-partum. A woman is required to register with a single LMC, who may be a midwife, general practitioner obstetrician, specialist obstetrician, maternity provider, or an employee or contractor of a maternity provider. The LMC then holds the budget for the woman's primary maternity care. Primary maternity services are funded by the Crown. LMC services provided by a midwife or GP must be provided free, but specialists may charge additional fees (Jackson, 2011b).

A number of reviews have been conducted on maternity services in New Zealand since the introduction of the LMC model. These reviews have raised several concerns about the LMC system including the fact that it is confusing (20% of women surveyed in 2007 did not know that they needed to choose and register with an LMC), not always easy to access (11% of women living in Auckland, Counties Manukau and Waikato DHBs reported that they were not able to secure their first choice of LMC), and not entirely free (10% of women report having to pay for a positive pregnancy test and 60% for an antenatal ultrasound scan). In addition, there are no national standards for the provision of maternity care, leading to geographical and other variations in the receipt of care (Jackson, 2011b).

4.4 Maternity care in Counties Manukau DHB

The CMH model of antenatal care has aspects that differ from other parts of NZ

Like other DHBs, primary maternity services in CMH are available from a private LMC or hospital midwife. However, women living in CMH can also choose to enter into a Shared Care arrangement led by their General Practitioner (GP). Shared Care is a unique system developed in CMH in response to a shortage of private LMCs. Women who choose Shared Care receive most of their antenatal care from a GP, but are also entitled to three antenatal visits with a DHB employed community midwife and delivery by a CMH employed midwife. GPs that offer Shared Care are not required to have specific training in antenatal care and are not required to have a postgraduate Diploma in Obstetrics and Gynaecology (Jackson, 2011b).

During 2007-09, the majority of expectant mothers living in CMH were cared for by a private LMC (mostly midwives) (50%, compared to 80% nationally) or in a Shared Care arrangement (24%) (Jackson, 2011b). According to Jackson's (2011a) *Perinatal Mortality Report*, the different models of care offered in CMH are not contributing negatively to the perinatal mortality rate in the region, as perinatal mortality rates do not differ significantly by primary maternity provider.

Midwives in CMH perceive problems with current maternity services

In the latter part of 2011, 25 self-employed midwives (plus three midwifery students and one midwifery educator) working in CMH participated in three focus groups aimed at identifying the most important issues and barriers in their daily work and any changes they felt would strengthen self-employed LMC practice in the future (Sheridan, Schmidt-Busby & Kenealy, 2011). These midwives were motivated to work in CMH because they felt their efforts made a difference in the community, they provided quality maternity care that women deserved, they enjoyed building long-term relationships with women and their families and they had established long-standing professional relationships with other midwives.

However, they noted a high rate of attrition of the midwifery workforce (11% annually between 2005 and 2008), and some were themselves contemplating leaving midwifery practice. These women identified a number of important barriers to staying in self-employed practice in CMH, including stress and burnout, difficulties accessing resources, and a hostile work environment between health professionals and across primary and secondary sectors (Sheridan, Schmidt-Busby & Kenealy, 2011). Worryingly, these midwives reported that the maternity care system in CMH was not well integrated, due to bullying, cultural discrimination and a lack of teamwork and low levels of trust in intersectoral relationships. For example, midwives shared a common perception that many pregnant women in CMH were not given the choice to have a self-employed midwife by GPs who were participating in Shared Care, due to financial incentives.

The underrepresentation of Maori and Pacific midwives in CMH was also identified as an important concern. Nationally, Maori and Pacific midwives make up 7% and 2% of the midwifery workforce, respectively, while 21% and 11% of births are to Maori and Pacific women. Further, Maori and Pacific peoples make up a small proportion of midwifery students and have the highest drop-out rate of all ethnic groups (40%), so this underrepresentation is unlikely to change in the foreseeable future (Sheridan, Schmidt-Busby & Kenealy, 2011). Pacific midwives in particular were singled out as needing greater support: while Maori midwives have some assistance from Nga Maia and Nga Manukura o

Apopo, there is currently no support system or workforce development programme for Pacific midwives.

Engagement of CMH women with antenatal care could be improved

On average, 190 pregnant women in CMH per year do not have any antenatal care (ie. are unbooked) and just over a third of women book very late in pregnancy (after 18 weeks) (Jackson, 2011b). This lack of early antenatal care limits the capacity to offer screening or health promoting interventions.

In addition to registering for antenatal care at a late stage, it appears that many women who are enrolled in maternity services are not fully engaged: in 2007-2009, up to 50% of women in a Shared Care arrangement and 30% of women cared for by a CMH community midwife did not attend their expected number of CMH midwife visits (Jackson, 2011b).

Several pieces of work have been undertaken to understand the reasons behind this apparent lack of engagement with antenatal care and explore successful models of care.

Barriers to accessing antenatal care exist at most stages of the maternity care pathway

In 2011, Litmus was commissioned by the Ministry of Health to conduct qualitative research into the experiences of young mothers in CMH accessing a range of different types of primary maternity care (LMC care, Shared Care, no antenatal care). Twenty-five young mothers identifying as Maori, Pacific, New Zealand European and Asian and five representatives from different service providers were interviewed to explore: barriers to accessing LMC primary maternity services; experiences of young women who did not have an LMC; and features that would make primary maternity services more accessible.

Barriers to accessing LMC primary maternity services were identified at most points of the maternity care pathway. Although doctors were the first contact for young mothers to confirm their pregnancy and their main source of information regarding different antenatal care options, they provided very little information and guidance. Women were unsure about the different options of maternity care, how to make choices and how to access the different types of care. This uncertainty contributed to care being accessed late in pregnancy (Litmus, 2011). Women developed preferences about care through first-hand experience of previous pregnancies rather than information available in the community.

Shared Care was entered into by default and/or practical considerations (no cost, proximity) rather than by choice or true engagement. The experience of Shared Care was often rushed with long waiting times. It was perceived to be medically focused and inflexible. And

because Shared Care is serviced by different midwives, young mothers found it difficult to build supportive relationships based on their individual needs. The already disengaged were therefore inclined to miss appointments and see no value in the service.

Care during birth by hospital midwives was generally viewed very positively; the young mothers particularly valued the one-on-one coaching and assistance, especially when the baby was born. Postnatally, almost all young mothers felt rushed to leave the hospital. Those in Shared Care reported inadequate continuity of care on discharge (some mothers had no follow-up care; others were seen many days after discharge and/or had an insufficient number of follow-up visits). All women felt that the postnatal period was when they most needed the support.

Satisfaction with maternity providers, regardless of the model of care, was directly related to the quality and continuity of the relationship with one key contact. Young mothers identified the ideal maternity service as one that allowed them to develop a one-on-one relationship with their maternity provider that was directional (recommending the best choice of care for them), non-judgemental and delivered at home.

Based on these interviews, Litmus concluded that LMC and Shared Care models in Counties Manukau were failing to meet the needs of young mothers, especially the most disadvantaged. Instead, Litmus recommended that young mothers needed a model of care that was non-judgmental, empowering, directional, flexibly delivered (at home or in the community), focused on the baby and integrated support from a range of organisations to assist with young mothers' complex life needs (Litmus, 2011).

Successful models of care are based on continuity of care within a partnership model (midwives working alongside women and their families)

To explore ways in which the needs gap identified by the Litmus report could be addressed, CMH identified a particularly successful midwifery practice in the region and asked its members to describe the way it was integrated into the community of consumers and other professional providers. The midwifery practice selected provided continuity of care for predominately Maori and Pacific young women (many of whom were teenagers) living in areas of high deprivation. The practice booked the majority of its clients before 20 weeks gestation and enjoyed excellent birth outcomes (low perinatal mortality and morbidity) (Priday, 2011).

Midwives, community health workers, receptionists, family doctors and nurses from family health centres were interviewed as part of the feedback process. Because the midwifery

practice provided an integrated model of care (whereby midwives work alongside the woman, her family, other health professionals and community services to enable seamless provision of integrated maternity, primary health care and social services), a wide range of individuals from supporting organisations were included. Care provided by the practice was consistent with the principle of Whanau Ora (an inclusive culturally centred approach to whanau and families, rather than focusing on an individual) and the current Government's drive for Better, Sooner, More Convenient Care. Midwives at the practice provided care in the woman's immediate community and were co-located with other health services that families need to access, including laboratory and radiology services, as well as Community Health Team services, such as smoking cessation and well child services (Priday, 2011).

Midwives from the successful practice viewed their role as that of a navigator to maternity and midwifery care, recognising the increased needs of clients from a background of high deprivation, where understanding of the local health care systems is limited and English is often a second language. In their role as navigators, these midwives were able to improve a woman's health status by enhancing her understanding and access to health services, enabling more appropriate care.

However, like Sheridan's (2011) report on midwifery practice in CMH, Shared Care was viewed as an important barrier to LMC continuity of care in the region, as it was felt that GPs who were part of the Shared Care programme did not offer other choices of maternity care provision (Priday, 2011). Two other significant areas of concern emerged from the report, including the need for accessible and culturally acceptable antenatal education and the specific requirements of pregnant teens.

4.5 Services for Teenage Mothers in CMH

Teenage mothers in CMH have more complex needs than their older counterparts and therefore require tailored care

Between 2006 and 2011, teenage births made up 9% of all births in CMH. The majority of teenage mothers were Maori (48%) or Pacific (34%) (Boladuadua, 2013). Teenage pregnancy and early motherhood are associated with poor educational achievement, poor physical and mental health, social isolation and poverty – key factors in widening existing health inequalities. Pregnant teenagers in Counties Manukau currently have poor uptake of maternity care, which is likely to contribute to adverse outcomes.

In March of this year, a stocktake of current services for pregnant teenagers in CMH was carried out (Boladuadua, 2013). There are currently 10 services catering solely for teenage

pregnant women and mothers in Counties Manukau: five provided by the health sector, three by the Ministry of Social Development/Child Youth and Family and two by the Ministry of Education. Although all services are provided free of charge, the stocktake identified a number of barriers to access, most importantly a lack of knowledge about the services and the perception of providers having a judgemental attitude (Boladuadua, 2013). The stocktake identified a number of areas for improvement and development, including a need for: early engagement with midwifery services; greater social worker support; teenage-specific pregnancy services and antenatal education; readily accessible contraception; more parent units and the expansion of the current Teenage Parenting Service.

4.6 Summary

CMH has a higher perinatal mortality rate than other DHBs in the country. The demographic characteristics of its maternity population (with its high proportion of Maori, Pacific women, teenagers and women living in areas of high deprivation), as well as a shortage of practising midwives, mean that providing consistent maternity services of a high quality are challenging. Shared Care, a unique system developed in response to the midwife shortage, is perceived by some providers and women as a barrier to continuity of maternity care. Women, particularly young women, appear to value a one-on-one relationship with their provider that is easily accessible and well integrated with their local community.

5 Findings

5.1 Accessing and engaging early in pregnancy

This section covers three areas as follows:

1. Engaging early in pregnancy;
2. Accessing maternity care; and
3. Consequences of poor access and late engagement

5.1.1 *Engaging early in pregnancy*

Engaging early in pregnancy means that before 10 weeks of pregnancy all women should have a personalised assessment of their specific needs and a detailed and individualised care plan must be developed. These assessments should be provided in easily accessible locations and be undertaken by suitably trained GPs or midwives using a comprehensive and expanded assessment form that identifies medical and social risk factors. The process should include obtaining a mental health history, screening for family violence and ascertaining any family history of pre-eclampsia, hypertension and heart disease (Paterson, Candy, Lilo, McCowan, Naden, & O'Brien, 2012). All women who are under the direct care of CMH should then be triaged to ensure they are appropriately referred for medical care and allocated a community midwife who will assist with co-ordination and planning of care (Paterson et al, 2012).

5.1.1.1 *Factors preventing early engagement*

While some mothers (predominantly those from the Localities consumer panel) accessed maternity services within the first 10 weeks of pregnancy, the majority of those that participated in this research did not.

5.1.1.1.1 *Fear and/or Denial*

Teen and young mothers indicated they had noticed symptoms of pregnancy, particularly missing periods, but did not seek assistance straight away. Others indicated they had no symptoms but family members had prompted them to go to the doctor for a pregnancy test because their eating and/or sleeping habits had changed.

My sister noticed my different eating habits then my partner told me I should take a test.

I was sleeping from the morning to the afternoon... yeah it was my sister and my aunty fofo (massaged) my belly and she said it was hard I could be pregnant.

When prompted as to why they did not get the pregnancy confirmed many said they were scared of a positive result. Others said they did not go because they did not want to know the answer.

I was 3.5 months when I found out...I was in denial because I didn't want to find out I was pregnant. I had no symptoms I just missed my period hoping it would come the next month.

I don't know, I was nervous, scared. Scared of being pregnant.

I didn't want to know, I just pretended it wasn't happening, but deep down I knew.

When asked why they were scared some said it was because of the reaction and disappointment of their parents.

I kind of had a feeling at 3 months but I was scared to tell my dad. Even when I did find out (by buying a pregnancy test) I still didn't go to the doctor until I was 5 months.

I kept it from my parents.

Interviewer: *What were some of the things that stopped you telling your parents?*

Um just being too scared to tell them, disappointment

Interviewer: *You didn't want to let them down?*

...Just the disappointment. You know how parents want you not to have kids before you're 21. That was the big thing....I knew my mum and my grandma was gonna be disappointed.

Others said it was because they just didn't want to know.

My mum had her first baby at 16, my sister had her's at 15 and then I got pregnant just after I turned 15, in our family we have babies young, I hated little kids so I didn't want to know, that's changed now though.

5.1.1.1.2 Multipara/Experienced Child Bearers

Mothers with multiple children (more than 5) were also less likely to access maternity care in the first 10 weeks of pregnancy. In most instances the mothers indicated they knew they were pregnant, yet they did not get this formally verified by health professional or by purchasing a pregnancy test. Some of the factors for this include difficulties managing childcare, maternity services that are slow and cumbersome, a perception that maternity

care services do not offer any benefit and a belief they are experienced so they only need support when it is time to deliver.

I usually don't. I just get me a midwife when I'm about six months

I'm like that too

All my cousins and aunties do it. When they are six months they will do a check-up and all the blood tests and all of that

In one instance the mother described arriving at hospital having had no maternity care throughout the duration of her pregnancy.

Interviewer: *Have you ever rocked up to hospital and just had a baby? You know like no midwife check-ups at all?*

Yep with number 10, I've done it once and there was nowhere to put me and there were already chicks like in labour in the hallway bit and I went into the linen cupboard cos my baby was already here.

In another instance a mother described giving birth to twins, without knowing she was pregnant with twins.

Interviewer: *So you're pregnant with twins (babies 6 and 7) and you don't know you're pregnant with twins?*

Until I gave birth

Interviewer: *Did you have check-ups before?*

At about 7 months I had bloods and urine and then one scan. At 7 months I had one scan.

Interviewer: *And they didn't tell you that you were having twins*

Nope, just one baby and it's a girl.

Interviewer: *So now you're pregnant again, what will you do?*

Probably the same go maybe at six months.

To me I know my body. I know when I am ready. I could have my baby myself.

5.1.1.1.3 Low Health Literacy

Low health literacy was particularly an issue for Pacific mothers of all ages. Prior to pregnancy some Pacific mothers had very little engagement with health services, for others, navigating maternity services in New Zealand is significantly different from their experiences in the Islands.

She told me I had to find a midwife and I was like what is this word? I have never heard this word before.

I was told I have to go here and here and here and I was like, why do I have to go all these places. In Raro I saw one person; it gave me a sore head to think of all these new things.

Where I come from there is no doctor, the nurse does the job for the doctor. I came here it's the first time I see the doctor.

Interviewer: *so you go and see a midwife but you don't know what for?*

Yeah, all I know is midwife – so I pretend to know exactly what is a midwife, but I don't, so I go to see the lady at the front and I say 'I need to see a midwife – she says 'ok' then they told me to go into the toilet, here's a thing...'because I have never done that before

Interviewer: *You've never had a urine test?*

No

Interviewer: *Did you know why you were having this urine test?*

No, she just said do this, do this, then come back.

Interviewer: *So you just did what you were told?*

Yeah and then I can back to her and she said 'ok, urine is normal' then I said 'what is a midwife?' I asked her that and she said 'that's me, that's my job – I look after a mum's pregnancy through' and I said 'awwww ok' and she said 'why?' and I say all I know is a nurse and a doctor' but to me I said nevermind, because for me that's the way I grew up.

Pacific mothers also described having very little prior knowledge about the symptoms of pregnancy.

Well for my first one, I didn't realise I was pregnant the first time....I didn't go at first....and I went to see my nurse because the nurse was my auntie....My auntie asked me 'when was the last time I had my period' and I said 'what's that?' I know I had my period but that's when I realised 'ahhhh that's how women know....'

Interviewer: *So you know nothing about it*

Nothing

Interviewer: *so you didn't know that when your period stopped....*

No

Interviewer: *So did anyone talk to you about the symptoms of pregnancy?*

No way, no one talked about 'it'. Yeah it's a sacred thing to talk about.

My first child I was 16 and I was in the Islands. I knew nothing. I was shocked to find I was having this baby. I was just getting bigger and I fatter and fatter.

For some, the lack of awareness about pregnancy seemed to be an on-going characteristic with subsequent pregnancies

I feel heavy, after my daughter...So I don't realise I was pregnant at the time, I feel heavy and ...I just went to the doctors to see what's happened to me....actually I've got the flu, but when I went I was 21 weeks already.

Interviewer: *So the next one how did you know you were pregnant with number 7 – how many weeks along were you?*

I feel heavy, heavy, heavy and I am 31 weeks and it's a boy.

A further complicating factor contributing to this is religious and cultural beliefs and experiences. When prompted for their views about why they knew so little about the symptoms of pregnancy participants indicated religious and cultural beliefs played a role.

Christianity and culture – and to talk about some things, you don't talk about them with your children...it's just taboo you just try and bring them up in a way where they lead good Christian Tongan lives.

...I grew up with my granddad and my nana and uncles and cousins, they were all boys. In my culture it's not right for them to talk to me about those things....

...we can only talk to the married one, but my other daughter (24 years) no. Because I know she won't be doing that till she is married.

In my family we talk about everything while the baby is in the stomach after it is born and how to do everything....but in the beginning, it's nothing. Like Mary and Joseph, the baby just happen you don't know how, you just are blessed.

There's no way we would talk about anything like that in our family, no one in my culture does, you have to find out from your friends.

5.1.1.1.4 Interworkforce rivalry

Interworkforce rivalry and patch protection were obvious to mothers and their families. Some mothers described tensions between private LMCs and hospital staff, with LMCs acting as advocates for them against hospital staff who were perceived as focussed on discharging mothers home early; and hospital staff who criticised the actions and competence of LMCs.

My midwife warned me...she said get out of hospital as soon as you can because I can come back and see you then. The shorter you suffer those hospital nurses the better....and she was right.

I had a show and bad cramps, I waited three days and the baby still didn't come. I couldn't sleep or anything. I rang the hospital and they kept saying don't come, it's

not time. I finally rang my own midwife because I was scared, I was worried I would be too tired to push this baby out. My midwife met me at the hospital and she told them off. I heard them argue up in there.

5.1.1.1.5 History of State/Government intervention

Vulnerable mothers described difficulties engaging with *any* mainstream services because of historical and on-going relationships with agencies such as Child, Youth and Family (CYF), the Police and Work and Income. These relationships have been premised on fear, mistrust and significant anxiety, making these mothers very sceptical about the ability of services, like maternity care, to meet their needs in a competent and transparent way.

When I told her my age she looked at me funny and I was a bit terrified because she asked me who's my supporters and I was worried in case she was going to get CYF.

I hate CYF; they threaten me all the time that they're going to take my kids.

They (Social Service provider) sent someone to help me; it took them two years to get through my door.

When I was a kid me and my brothers and sisters were taken by CYF. My mum would go out and leave us for days, but we knew what we were doing aye, like that movie Boy. Then they come and take us somewhere we have no idea about and we're not safe. I'm 16, I know they will have their eyes on my kid and I know they (mainstream services) all talk and plan.

*I stand on my balcony having a smoke and when I see people that look like they are official coming up my driveway I just start yelling "***** off, we don't want you here, get the ***** out of here". That usually scares them off.*

If I don't know who they are, they aren't coming near me or my body

5.1.1.2 Factors supporting engagement

The research identified a number of factors that support engagement with maternity care. It should be noted however that this engagement was instigated by mothers and often did not occur within the first 10 weeks of pregnancy.

5.1.1.2.1 School Nurses

Young and teen mothers indicated that School Nurses have been their first point of medical contact in relation to maternity advice and assistance.

I went and saw my school nurse because I missed two of my periods so she took me to a doctor and I took a test and it was positive. The next day the nurse took me to get a scan and I found out I was nearly 3 months.

I was feeling bored at school and I went to the school nurse to ask for a test and it came out positive....before she gave me the test she asked me what would I do if I was pregnant and I told her, I don't know.

I took my first test with my school nurse...my school nurse took me to my first scan without my parents knowing.

5.1.1.2.2 Whanau/Family and Peer Support

Participants indicated they relied on Whanau/family and peer support to navigate maternity services. They would seek advice and input on a wide range of issues including:

- seeking information about the symptoms of pregnancy;
- teen mothers asking friends to accompany them to the doctor/school nurse for a pregnancy test;
- understanding the process once a pregnancy has been confirmed; and
- seeking advice on a good midwife.

Because I wasn't skinny and I didn't know what being pregnant was like but my sister knew and then I went and took a pregnancy test and I was pregnant.

I went with a friend. One of my best friends, so she was the first one that I told and so she was the one that said 'you need to do this' and she came with me.

Interviewer: *How did you find your midwife again?
It was though my sister.*

5.1.1.2.3 Mothers want good quality care

The research team noted that despite multiple barriers to engagement and access to maternity care, with the right approach, young, teen, Maori, Pacific and vulnerable mothers want access to good quality care.

5.1.2 Accessing maternity care

This section discusses matters relating to accessing maternity care after diagnosis of a viable pregnancy, including quality of care, accessibility of midwives and/or GP services to

support pregnancy. For more detailed information about the maternity care model in CMH refer to section 5.4 on page 41

5.1.2.1 Barriers to access

5.1.2.1.1 Continuity of Care

Continuity of care in the context of this report relates to the ability for the mother to access high quality support throughout the maternity process, from diagnosis to 28 days after delivery.

Mothers participating in this research highlighted significant issues with the continuity of care. For many the ability to form a relationship with health professionals especially with their Lead Maternity Carer (LMC); is an important conduit to ensure they maintain engagement with maternity care services. For this reason the current maternity care model in CMH poses challenges for mothers to stay engaged with maternity care, particularly teen and young mothers, Pacific and vulnerable mothers.

I never had a midwife, due to when I did have a midwife she was very judgemental because of my age being pregnant young...so I felt uncomfortable so I just basically looked after myself through the whole 9 months and gave birth in my own bath tub. I didn't go to the hospital.....I just did it on my own.

Interviewer: *So can I just ask...you know at 12 weeks you had a pregnancy test, did you also have a scan around that time?*

I went back at 5 months so I could find out what day I was due. Then I never went back. I didn't like the way they treated me.

I found with my last baby there were just too many phone calls and it was obvious no one had communicated with each other so it delayed some things and the appointments which were really frustrating.

I got asked if I had a midwife and I was six months then I said no and they just gave me a list of names. I was like yeah whatever and I didn't call any of them.

The day I gave birth to my daughter my midwife didn't come and didn't see me until 3 weeks later. They gave me someone else when I was in labour and I was like "who the hell are you?"

So I went for the scan and I asked if I was having a boy or a girl. The lady said to me 'it's got a diddle that's all you need to know'. I was like, shame! I was referred back to the same place for a scan at 7 months but I didn't go because I didn't want to go back to Mangere and the next closest was Manukau which is too far. Funny thing is no one even noticed I didn't go for that check.

Interviewer: *Was it hard for you to get a midwife?*

Yes....and I was like sore I was like 'nah, I'm giving up and just stay in bed.

When you get someone that's like I know that you're hating on me, I'm not going to tell you anything!

5.1.2.1.2 Quality of care

This research finds significant issues with the quality of care spanning the entire spectrum of maternity care from diagnosis to delivery and post natal support.

5.1.2.1.2.1 Cultural and Social Competence of Staff

Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients (Betancourt, 2002). Social competence relates to the ability for health providers and staff to achieve improved outcomes through social interaction while simultaneously maintaining positive relationships with over time and across situations. This research project highlights the need to have staff who can provide maternity care in a culturally and socially competent manner. For the CMH district cultural and social competence must include the ability to relate to and understand the experiences of mothers who:

- are from diverse ethnicities;
- come from adverse socio-economic backgrounds;
- are young (12-19 years);
- are extremely vulnerable
- speak English as a second language; and
- have poor health literacy.

Without this, the ability to empower mothers to become more self-managing will be difficult. The experiences of mothers participating in this project highlight significant shortcomings in cultural and social competence which impacts on the quality and way services are currently being delivered.

When she walked into my house she looked around and said 'so where am I supposed to sit?'

So I had my baby at midnight and she told me I could stay until I went to the toilet. At 4am after I went to the toilet she told me to leave. It was the middle of winter and I am sitting in the foyer waiting for my mum to come back and pick me up with my new baby. My mum only just left two hours before because they said she can't stay the night. I was thinking of her petrol.

I was looking out the hospital window in my room and I could see my mum sitting in the dark at Middlemore train station and we were both crying.

I don't know why they think they can come to my house without calling. I have 4 kids under 5 and I'm pregnant, they come and bang on the door, it's my only time to rest we all asleep and they wake us up and then treat me like I'm an angry mother.

I said, I don't understand, what this mean and she said 'just do it like I said' and walked away.

When I was delivering I had my mum and my nana in the room. My midwife didn't know who to listen to. She tried to listen to me but then my nana was all up in her face like 'NO YOU LISTEN TO ME, YOU DO THIS'. Yeah, so I think she was finding it hard like who to listen to. I know she was putting me first but it's hard with my nana around. You can't really ignore or walk past her.

Interviewer: *Who do you think your midwife should have listened to?*

Um I'd say my nana. My nana or my mum seeing as they have the experience

I had it from my doctor, she's nose – when she found out she was like 'I don't think you should have your baby you know you should give it up or something'.

Those dumb (name of organisation) workers, they come in they ask if they can come check you and they walk in with their bag and look scared....it's not like I'm a dog that's going to bite you.

Notably participants described multiple situations where health professionals and mothers, particularly at the maternity suite in Middlemore, talked past each other. Cross-cultural communication is defined as "the process whereby individuals from different cultural backgrounds attempt to share meanings and feelings through the exchange of verbal and non-verbal messages" (Harris & Moran, 2000). The importance of effective communication cannot be over emphasised because it is the ultimate means by which behaviour is modified, change is effected, knowledge is acquired and shared, and goals are achieved (Howes & Tah, 2003).

The following morning the nurse came and said 'you have to go and shower' I said 'no way' I said 'you come and do your job'.

Interviewer: what was her reaction to you?

Shocked and I said 'I don't care what you do...this is your job – you come and look after me' and she didn't believe it that I could talk to her that way. I said 'look it's not just a small...its huge (referring to caesarean section) it goes from one side to the other...and you telling me to get up and go shower, no! Come and do your job!'

And my husband goes push push push and the midwife; there was no midwife in the room because she had to go faikakala (gossip) somewhere. And then I pushed and then my husband brought the baby out.....he's trying to push the button and they come rushing in and she goes 'oh it's a baby', what a silly thing, was I bringing out a pig or what? What else am I delivering? And I think....these people are stupid.

I have had it from....especially from Middlemore too.....So they are rude to me and when I push the buzzer then they come and say 'What do YOU want?' and so I go 'NOT YOU!' and I push the buzzer again so no one comes.

They think I don't care about my baby but the truth is I can see they don't talk to me properly, but with my mum they talk more serious than when they are with me, give her more information and I know this will help my baby more. So I let them think I don't care that so my baby gets help.

A number of mothers described experiences where they weren't listened to and they believe this lead to further complications either during the birthing process or not long after.

I just didn't feel right, when I stood up after giving birth, blood was just gushing out. I told them I feel dizzy and I feel wrong and she said 'no, everything is fine and when I saw the placenta it only looked like a little bit and I asked her if she was sure she checked it properly. I knew she hadn't taken the placenta out properly. It was so much smaller than the first one. I knew something was up and I was very very upset with the midwife.

I didn't want to go home, I wanted to stay I sensed there's something wrong. But they said to me the hospital was full and I can't stay. When I walked past the rooms all I saw was empty bed, empty bed. Two days later I was back I had an infection because they didn't fix something down there when I had the baby.

So they took this baby down to another room and I didn't want it (to go) and then they bring it back and they said it caught another bacteria and I said 'oh what bacteria is this? You know? You fella's own bacteria from the hospital.... Then they put us in a room.

Interviewer: An isolation room?

Yeah and a nurse walks in with no gloves and I said 'excuse me?' We're in this special room. "Why are we in here and you haven't got a gown and gloves on?" She said 'Oh I'm sorry' "That's not good enough! You nurses should know what to do when you come in this room. So you are the ones bringing bacteria to my son.'

5.1.2.1.2.2 No complaints culture

This research highlights that participants very rarely complain about service quality, even when it is very bad. Pacific participants, who speak English as a second language indicated they are more likely to complain directly to the person concerned, but this can be confused by the recipient of such a complaint as overly aggressive behaviour, refer to section 5.1.2.1.2.1 above. Notably, participants in this research did not make any formal complaints, even if they have had a significant issue with a health professional. There were also instances where multiple research participants separately identified and named the same health providers, health professionals and LMC's because they had each had an extremely poor service experience..

It was so stressful, I was being wheeled into theatre and I was also trying to calm my partner, he wanted to knock out the guy pushing the bed.

Interviewer: *Why?*

He told my husband 'I have the best job; I get to see all the pussies I want'

Interviewer: *Did you complain?*

No

She kept getting sore stomach and the doctor said there was blood in her urine. He said my daughter had been sexually abused. I was like 'WHAT?' 'HOW?' I asked myself how could this happen, how could this happen? We only have family here. I didn't know how this could happen. I checked the other twin and nothing, she said nothing, but they always together. Then she kept getting sore tummy and I took her back and back and they keep saying to me about the abuse. Then after a few months, I find out she has kidney failure, she was not sexually abused, her kidneys were failing.

Interviewer: *Did you complain*

No

I'm in labour my legs are wide open and people are coming in and out. I can see men walking past and looking at me. I said to them 'Please do you mind keeping the door shut' and the lady said to me 'Look honey we need to get in and out, the only other people around here are people in labour like you' and I thought '...and people like me's husbands and partners!!'

Interviewer: *Did you say anything or make a complaint*

No

Tere found out she was pregnant with her 4th child at 21 weeks. She went to some checks with the midwife but often did not attend scheduled appointments because it was hard to get childcare to attend. She delivered a 9.5lb baby girl at full-term. Staff at Middlemore told her the baby couldn't breathe and so it had to go to neonatal. She was told to go and shower. She went to look at the baby with her husband and then went to her room. She asked if her husband could stay and she was told family aren't allowed to stay in the hospital. At 4am in the morning she sensed someone in the room. She sat up and the nurse told her that her baby won't make it. "She said your baby drank too much meconium and the lungs are still closed". Later that morning the baby was transferred to Starship. Tere was told to go in the car with her husband (not in the ambulance taking the baby) 'in case the baby needs help or dies on the way'.

Sera found out she was pregnant with twins when she was 6 months. Her other 6 children had been born in the Islands. The twins were premature, born at 7 months. They were put into the neonatal unit at Middlemore. Three days after giving birth, Sera was told the twins would be moved to Waitemata hospital because Middlemore needed the incubators for other babies. She agreed, even though she didn't know where Waitemata hospital was. It would take over an hour each way for Sera to travel from Manurewa to Henderson every day so she could provide milk for the twins. It cost over \$100 for petrol every three days. It was money they didn't have. They were given lots of claim forms to complete but they didn't understand what they were. The younger kids would spend up to 3 hours a day in the car because there was no one to look after them. It was like this for two months. When the twins came home Sera said a 'blackness' came over her. She couldn't get up and she couldn't lift her head. She said she felt like she was dying, life was slowly leaving her body. She felt sorry for her children that they had got a bad mother. She received a visit from Plunket but she was too tired to tell the visitor anything. Sera's husband was worried. He called her family to come and take Sera and 5 kids down the line. Sera went to her family and she said was bedridden for two months. Her family looked after the children.

At 21 Lolo suspected she was pregnant but didn't get it confirmed until she was 4 months. She went for her 5 month scan and was told everything was fine, she was having a boy. She didn't go to many appointments with her midwife because she was working. She had a ventouse delivery, once delivered the baby didn't cry and she asked 'What's wrong with my baby?' She was told nothing was wrong. On the second day in hospital they said her baby had to go for a scan. That's when she found out he had a hole in his heart. Lolo said 'how come you guys didn't see that in the tummy when you were doing the scan? They had nothing to say. After the scan Lolo finds out that he also has Daniel Walker (sic) syndrome. 'I said what's that and they told me one side of his brain is bigger than the other'. The baby is now 12 weeks and Lolo has been to Accident and Emergency 10 times, once by ambulance.

Note: the actual name of the syndrome is Dandy-Walker syndrome is a congenital brain malformation involving the cerebellum and the fluid filled spaces around it. A key feature of this syndrome is the partial or even complete absence of the part of the brain located between the two cerebellar hemispheres

5.1.2.1.2.3 GP Wait times

Some mothers said that GP wait times were also a significant barrier to accessing maternity and care and/or care for other children.

When I go to the doctor for the baby I pack a lunch for my kids because we're there for such a long time waiting and I can't afford to go and get them something to eat.

Interviewer: How long would you wait for?

2-3 hours

I take my kids at 10.30 at night, they close at 11pm so if I go then I don't have to wait so long.

5.1.3 Consequences of poor access and late engagement

The consequences of poor and late engagement have significant impact for some mothers and babies.

5.2 Utilisation of Primary Birthing Units

CMH requested that Pacific Perspective seek input from participants about the issues preventing utilisation of the Primary Birthing Units which are based in Botany Downs, Papakura and Pukekohe.

5.2.1 Distance/Transport

Some mothers opted not to use the Primary Birthing Units because of the distance for family (or themselves) to travel to get there.

I live in Mangere East, how was I going to get to Botany? It's too far to get there so I went straight from Middlemore home.

Its good Middlemore is by the train station and my family could come and see me, but at Botany it's not so easy.

We don't have a car so getting to any of those places (the birthing units) would have been a hassle for us.

Of note in Table 5 CMDHB Women who delivered “inside” and “outside” CMDHB, 2012 on

After visiting her general practitioner Zana (15 years) was told she was 3 months pregnant. She was given a maternity book and told to contact a midwife. The medical centre said if she didn't contact a midwife, they would allocate one for her. She didn't see a midwife and had no further checks. She continued to smoke (tobacco and marijuana) and drink alcohol. At 5 months she knew she could find out the gender of the baby so she went to the doctor and asked for a referral for a scan. She went with her partner for the scan. After lying on the bed for 10 minutes she realised the staff weren't saying anything to her. People were coming and going but no one said anything to her. She realised something was wrong. She was told her baby would not live and the best option for her was to be induced immediately. She was referred to a specialist and the baby was diagnosed with Body Stalk Anomaly. She was induced at 6 months. The baby lived for half an hour. Risk factors for Body Stalk Anomaly include alcohol, marijuana and tobacco consumption.

page 23, Manurewa (1711) and Mangere (1193) accounted for the highest number of ‘inborn’ births in CMH so it is likely transport to Papakura, Pukekohe and Botany from these suburbs will be difficult.

5.2.2 Childcare

Others stated a lack of childcare meant they only planned to stay in hospital for a minimal amount of time.

I have four other kids at home under 5 years and I felt sorry for my husband to look after them and get to work so I have to go straight home too.

Yes my kids need their mother so I can't use those other places.

Interviewer: So who was looking after your children?

The older children

5.2.3 Risk factors

There were several instances where the mothers stated they could not use the Primary Birthing Units because of risk factors such as preeclampsia, previous caesarean sections, obesity, and gestational diabetes. As far as these participants were aware the Primary Birthing Units did not have the facilities to cope with complex births.

5.2.4 Option not provided

Finally a number of mothers stated they were unaware that the Primary Birthing Units existed and that they were not given this as an option for child birth.

I don't know what a Primary Birthing Unit is.

I thought you only have the baby at the hospital.

Well I was confused because they told me I had to leave and that I had to go to Papakura. So I go out there from Middlemore, and I see another girl that I know there. She said she had her baby there and I was like 'What? So I didn't have to crawl around the car in labour, I could have just come here'.

5.3 Identifying gaps and solutions in accessing appropriate advice and affordable contraception in a timely manner

5.3.1 Gaps in accessing appropriate advice and affordable contraception

Feedback from participants in relation to accessing appropriate and affordable contraception advice was highly variable.

For teen and young mums, many were very knowledgeable about the types of contraception available and how to access it. That being said, there was a great deal of confusion about what types of contraception could be used immediately after birth.

I was going to get the pill but I can't get it until I have finished breastfeeding

I was going to get the Jadelle and when I went for the check-up they made me do a pregnancy test. Hello, I was pregnant again. I thought you can't get pregnant when you're breastfeeding so I didn't use anything.

I can't use anything until my uterus gets back into normal shape after having my baby.

Interviewer: *How old is your baby?*

Four months

For others health literacy was an issue in relation to the use of the word contraception.

Contr...con.....what's that?

Interviewer: *Like the things you can use to stop you from getting pregnant, like the pill*

Oh like the Jadelle, IUD and stuff like that?

What did she say?

Other participant: *She said contraception*

What's that?

Other participant: *The pill and condoms and stuff*

Oh yeah, oh yeah

Others knew about contraception but there was still a naivety about the consequences of having sex.

When prompted as to how they knew so much about contraception, most teen and young mums said they were informed by their school nurse, support workers at teen parent units, midwives who specialise in teen pregnancy, their peers and from information packs given to them when they leave the hospital or birthing units. When asked whether they knew much about contraception before they got pregnant, most said they did not.

I knew nothing about it; I still can't even say the word.

I knew condoms but that's it.

No I didn't even know anything, not until after the baby.

I always had unprotected sex with my partner and I never got pregnant so I just kept on going and then I got pregnant. I never bothered to use contraception, I only knew about condoms but nothing like the pill. My midwife talked to me about the Jadelle and I got it.

When asked whether they actively used contraception the responses were varied.

No I don't because I've learnt my lesson so I won't do it anymore

Yes I have the Jadelle implant

I'm going to get the Jadelle but I'm not using anything at the moment

No because my partner wants me to have another baby

For some there was a general naivety about the consequences of sex, even though they knew about contraception.

I know about it but I didn't think I was going to get pregnant because I didn't want kids so I was surprised when I got pregnant.

The emergency pill was often relied on by younger participants to prevent pregnancy.

I never took contraception but after sex I used the emergency pill but it didn't work (this time).

I was hoping the emergency pill would save me but I got pregnant.

Pacific mothers were less knowledgeable about the options available for contraception. Health literacy and the issues raised in section 5.1.1.1.3 are pertinent here.

We don't talk about it, as Christians we don't let our children have sex before marriage.

Interviewer: *Did your mum talk to you about it?*

No way, they didn't talk about it

I remember they (health professionals) talked to me about something like that but for me I didn't go for it (contraception) because I feel alright.

For some Pacific mothers, there is a genuine desire to have big families. In their view, when they compare life in New Zealand to life in the Islands, they are better positioned here to provide for the children.

I come from a family of ten, my husband came from a family of 15. There was a woman in my village that has 17 children.

Interviewer: *Okay so many children are a good thing?*

Only if you can look after them.

Interviewer: *So you have 5 now, your husband has 8, that is 13 so far. Do you want any more?*

Yes I want 3 more

Interviewer: *So how are you going to manage bread, milk, nappies etc*

For me it's easier to have kids here in New Zealand. It's easier.

Even though I have six girls, I really want to try for the boy. Lots of kids to look after me when I'm old.

There were some mothers who indicated they did not have time to get contraception even though they did not want to conceive again. In addition some stated that they rarely went to the doctor for themselves, even when severely unwell. It indicates that many families are dealing complex health and social issues which makes accessing contraception very low on their priority list.

I have tried everything, with the pill...well when you have as many kids as me; you can't even remember their names let alone to take your pill on time. Then I went for Depo and every time I went I was pregnant again. I don't want the Jadelle and the IUD keeps falling out.

It's funny I have 9 kids and I write down when I gave them their antibiotics so I make sure they take it on time. But for me, I don't. I can't remember to take the pill, let alone going to the doctor to get a prescription and I just keep getting pregnant.

Interviewer: *Do you ever go to the doctor for yourself or is it mainly for the kids? It's for my kid's aye; with myself I put my kids first to make sure they're alright first before I put my own needs first, yeah that's just me.*

Interviewer: *So you have rheumatoid arthritis and suspected bronchiectasis?*

Yes

Interviewer: *When will you follow these issues up?*

Probably when the boys get to school, it will be time to focus on me

Interviewer: *These boys? They're 10 months old.*

Yeah

5.3.2 Solutions to accessing appropriate advice and affordable contraception

When prompted for solutions for access appropriate advice and affordable contraception teen and young mothers indicated that currently contraception advice is given too late.

Yeah I reckon they should give it at year 7 and 8. By the time I got it, I had just had my baby. I didn't want to get pregnant.

Other teen and young parents said that in some South Auckland colleges getting pregnant is not seen as a negative thing.

I saw other girls from my class pregnant and I wanted to have a baby too because I wanted to be able to dress them (the baby) up all skux (cool) and they look so cute.

However when reality hits:

...so I freaked out when I was in labour, I was not expecting that and then now with my partner I have no time for him and we have heaps of fights because he thinks I'm doing everything for the baby and I don't do anything for him.

The solution provided by this participant was that, if she was aware of the full implications of motherhood, she would have not wanted to do it so soon. The suggestion was to provide more practical experience like getting young students to volunteer in Teen Parent Units and the associated childcare centre so they can experience first-hand the responsibilities that go along with motherhood. Another suggestion is to provide opportunities for young students to hear from other teen mums about the ups and downs of being a teen parent.

Another significant issue highlighted by this research is that many young and teen mothers come from mothers who were also teen parents.

My mother, she is young that's why....she's my homeboy or homegirl or something. She is 32.

***Interviewer:** Your mums 32? And how old are you I'm 19...She just turned 15 when she had me.*

***Interviewer:** How old are your parents*

My mum is 31 and my dad is 32

***Interviewer:** So your daughter is pregnant at 17. How old are you?*

I'm 33

***Interviewer:** So you're pregnant at the same time!*

Yeah

It indicates that for some families, teenage pregnancy is quite normal and so the need to prevent it may not be as paramount as other more pressing day to day issues.

For other mothers the key solution is making contraception easily accessible and in an integrated way, so if they are seeing the midwife, doctor or WellChild nurse for a visit, that they can access contraception with relative ease, otherwise they will continue not to access it at all.

5.4 Reviewing and developing strategies to reduce smoking in pregnant women

Smoking was most prevalent in teen, young parents and vulnerable mothers. Most of these participants indicated that they stopped smoking while they were pregnant. A small few continued to smoke.

I wanted to smoke so I kept on smoking.

Those that continued to smoke were aware that smoking during pregnancy was not socially acceptable; they did not indicate that it was because of the health effects on the child.

I liked it when I wasn't showing, when I started to show I made sure I smoked where people couldn't give me the evils because of smoking with a big puku.

For those that stopped smoking, most started smoking almost immediately after giving birth.

Yeah I stopped smoking because I'm against smoking during pregnancy, that's why I think I lost my first one.

Interviewer: *So I don't understand how you can give up for 9 months then start up again.*

Well I had my baby and straight after, I didn't even shower I got someone to wheel me outside and I had a smoke.

Interviewer: *What made you start smoking so quickly?*

I stopped for my baby, but not for me, when the baby was out then I don't have to worry about them getting bad things from me.

Interviewer: *So why do you smoke?*

It helps me deal with the stress in my life.

I just felt really bad doing it. I found it really hard but I had support to help me not smoke and because I lost my first baby I was smoking and drinking during pregnancy and I didn't want this to happen to my second.

When asked whether they wanted to remain smokefree almost all indicated they did want to remain smoke free but for a range of reasons this was difficult. Those participants that started smoking again stated it was because it helped them deal with stress in their lives. When prompted to identify the types of stress in their lives they indicated relationship problems with partners and/or family, worrying about housing, bills and dealing with agencies such as Work and Income also featured prominently.

Interviewer: *So what are the things that make you smoke now?*
Stress and when I'm angry.

Interviewer: *So what made you start smoking again?*
Relationship problems, my partner was being an egg.

Participants were asked to provide input to strategies that would encourage them to give up smoking. Responses were predominantly about helping them to cope with stress and assistance to live in smoke free environments.

*Interviewer: So giving up for 9 months is a major success, what can be done to encourage you to continue this?
Get rid of the stress in my life.*

*Interviewer: What would help you give up smoking?
There are other people in my house that smoke. To give up and I need to be away from other people that smoke.*

Participants indicated that a financial incentive would encourage them to give up smoking.

*Interviewer: If I said to you, here's \$50 bucks, you can get this if you stay smokefree for a month what would you say?
I would say mean! \$50 bucks for two weeks though!
Interviewer: How would you cope with stress then?
I'd cope!*

Of the Pacific mothers that participated in the face-to-face interviews, none of them smoked. Most of them stated it was because of health and/or religious reasons.

I don't smoke because I am Morman, we don't smoke.

I never, touched that stuff.

Good Christians don't bring that thing into the lives of their children.

5.5 Developing culturally appropriate nutritional interventions to reduce pre-pregnancy obesity.

5.5.1 Purchasing and preparing meals

Many teen, young and vulnerable mothers were not responsible for their own meals. Meals were predominantly provided for by family members or people they were living with. Participants contribute financially to purchasing food, but rarely purchased or cooked meals themselves. Some took turns cooking; this may be once or twice a week. Very few were solely responsible for cooking their meals.

The majority indicated that household shopping would take place at least once a week.

*Interviewer: Who does the shopping in your house?
Mu mum and dad
Interviewer: how often would they go shopping
Once a week.*

My Auntie mainly cooks the meals, we go shopping every week and sometimes together but we always put money in but I don't usually cook.

In addition, almost all teen and young mothers indicated they would buy takeaways, visit a dairy for chocolate, fizzy drinks or snacks at least once a day.

Interviewer to panel: So how often would you go to the dairy, takeaway or to Pak n Save to buy something to eat straight away?

*(Sniggers and laughing) **Group response:** Every day of the week!*

When asked whether participants were aware of the importance of good nutrition both before and during pregnancy. Most indicated that they were aware of it but also felt they had no control over it because others were not involved in the purchasing of food and preparation of meals.

Well I don't buy the food. It's not up to me to decide what I eat.

My brother, he is the one that was responsible for this when we were kids, so he buys the stuff and tells us what we have to cook.

When teen, young and vulnerable mothers were asked about the reasons why nutrition was important, most stated personal cosmetic reasons.

You need to look skux (good)

'Cause my tummy looked ugly and I thought like you know competition, no pregnant (women)...you know baby mama can't join because it will look funny. And it's just me I didn't want to do it because I don't have the figure anymore.

While almost all mothers indicated a desire to lose weight or improve their nutrition, none had a plan in place to achieve this.

5.5.2 Family/Whanau approaches to nutrition

For Pacific mother's, nutrition was important to nourish the baby. However for most, being pregnant was almost a license to eat whatever they wanted to ensure the child was well nourished. One morbidly obese participant described being acutely aware of the importance of good nutrition and the need to eat appropriate food during pregnancy.

***Interviewer:** So what then was the cause of your putting on weight....besides having babies?*

Probably I don't know maybe stress? Because I still remember when I was carrying, I was eating too many fattening food. Too many junk foods that I'm not supposed to be eating and I just can't help it because that's what I crave for.

This particular participant highlights the need for a family approach to health promotion for nutrition. The participant stated she was responsible for preparing all the meals and she had taught all her daughters (6) to cook. She also stated that she found it difficult to move around so relied on her daughters to gather the ingredients from the shops. Finally she then talked about her eldest daughter who had a 12 week old baby.

Like the other day I went and cooked him an apple. I cook the apple. Even though the baby is only three months. So we fight over that. She says 'oh mum you can't do that, Plunket book says!' and I say 'look I feed you when you were only two months. I cook a coconut for you so you are telling me not to? Oh shut your mouth! Go away! I did it for you, there is nothing wrong with you!'

The key point here is that while the daughter receives the information from her Wellchild provider, it is the mother (grandmother) who dictates how the family learns about and gets nutrition.

5.5.3 Obesogenic Environments

The obesogenicity of an environment is defined as 'the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations (Swinburn, Egger, & Raza, 1999.). Pacific mothers in particular described living in obesogenic environments.

We came home, we had tea, a huge feed with the family because we have about 3 families living at home here with us and they had prepared a feast to celebrate the birth of my first daughter.

We eat what we can afford, if the ulu pua'a (pigs head) is there, we will get that because it is cheap and it feeds more people and tastes good.

I would like to do more walking but in these streets it's not so good to be walking by yourself with your kids, especially daughters. People whistle to them, even to the young ones. I want them to stay in home, safe is better than to worry about going out.

There is also evidence that indicates Pacific mothers have perceptions about what a healthy weight/size is which may differ from a medical definition of a healthy weight/size.

The only exercise my kids do is the Cook Island dancing, that's it. Nothing else, stay home and be good kids. It looks better when kids are not skinny for this. You have to look healthy.

Interviewer: *So what size is healthy?*

(To interviewer) Your size is good.

Interviewer: *I'm about a size 14-16.*

Yes that's a good size, it would be good if my daughters all your size. Only the 10 year old is skinny, same like you, the rest are bigger.

Interviewer: *A lot of people would say I'm not skinny. People might also say a 10 year old who is size 14-16 is overweight too.*

Well they don't know what a healthy size is.

6 Summary of Findings

The findings of this research show there are multiple and wide-ranging barriers preventing participants in this project from accessing maternity care. However within the research cohort, there were differences in experience which are primarily based on a range of risk factors such as age, ethnicity, family/whanau support and language. The research team have therefore stratified and summarised these experiences according to the key themes⁴ (refer section 2.3.1). There are four emerging groups from the research participants. Table 11 below provides the characteristics of each group.

Table 11 Emerging groups from research participants

Group	Characteristics
Maori, Pacific Young/Teen Mothers	Age under 21 years. Maori and Pacific ethnicity. Mostly first time mothers, a few with two children. Engaged in education (including ECE for babies) through Teen Parent Units; and with social services and primary care.
Maori, Pacific and other vulnerable mothers	Age under 21 years. Maori and Pacific ethnicity. Not engaged with primary care, education or other social services. Complex familial relationships, Complex social and health needs.
Pacific Mothers	Age over 21 years. Multi-para. Engaged with primary care. Secondary level education. Speak English and one other Pacific language.
Engaged Maori and Pacific Mothers	Age over 21 years. Maori and Pacific ethnicity. Engaged with primary care, education and social support agencies. Speak English well.

Based on these four emerging groups from the research participants, the key findings for each group is described further in Table 12 below.

⁴ Accessing and engaging early in pregnancy and Utilisation of the Primary Birthing Units have been condensed into one heading 'Access'

Table 12 Summary of key findings for each research cohort

Research Key Theme	Maori, Pacific Young/Teen Mothers	Maori, Pacific and other vulnerable mothers	Pacific Mothers	Engaged Maori and Pacific Mothers
Access	<p>Are reliant on advice and support from caregivers, friends, and parents for maternity care information and access</p> <p>Initial contact determines on-going engagement with maternity services.</p> <p>Are motivated to attend the 5 month scan as most wanted to know the gender of the baby – this is an important contact point.</p> <p>Are highly vulnerable to 'dropping out' of the maternity care pathway.</p> <p>Pregnancy is often their first experience of engaging in primary care without parents/caregivers.</p> <p>Experience significant stigmatisation from named primary care health providers.</p> <p>Describe poor service experience at Middlemore Maternity ward and Primary Birthing Units.</p> <p>Want support from family and/or peers while in hospital.</p>	<p>Experience multiple barriers at all levels of the maternity care pathway.</p> <p>Will make active choices whether or not to engage.</p> <p>Are motivated to attend the 5 month scan as most wanted to know the gender of the baby – this is an important contact point.</p> <p>Are highly vulnerable to 'dropping out' of the maternity care pathway'.</p> <p>Are less likely to be engaged in primary care.</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p>	<p>Have confidence in self-care (prior experience). However this can lead to late presentation for maternity care.</p> <p>Have low health literacy especially with respect to primary care.</p> <p>Describe significant issues with wait times for health services, particularly primary care.</p> <p>Describe poor quality care from named primary care health providers.</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p> <p>Want support from family and/or peers while in hospital.</p>	<p>Are self-motivating and are accessing care appropriately</p> <p>Describe poor service experience at Middlemore maternity ward and Primary Birthing Units.</p>
Primary Birthing Units	<p>Mostly unaware of Birthing Units.</p> <p>A few mothers that accessed birthing units described poor service experience.</p> <p>Lack of access to transport meant that those who were given the option to go to the Primary Birthing Unit, post-delivery, went straight home from Middlemore.</p>	<p>Mostly unaware of Birthing Units.</p> <p>Did not know Birthing Units provide an alternative birthing option to Middlemore.</p>	<p>Mostly unaware of Birthing Units.</p> <p>A few mothers that accessed birthing units described poor service experience.</p> <p>Could not utilise due to complex health issues.</p> <p>Lack of access to transport and childcare meant that those who were given an option to go to the Primary Birthing Unit, post-delivery, went straight home from Middlemore.</p>	<p>Mostly aware of Birthing Units.</p> <p>Could not utilise due to complex health issues.</p> <p>Distance between Primary Birthing Unit and Home meant Middlemore was far more accessible.</p>
Smoking	<p>High rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>	<p>High rates of smoking.</p> <p>Less likely to give up smoking while pregnant.</p>	<p>Low rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>	<p>Low rates of smoking.</p> <p>Likely to give up smoking while pregnant.</p>
Nutrition	<p>Other family members control decision-making about purchasing/preparation of food in their homes.</p> <p>Likely to frequent fast food establishments, the dairy or supermarket for takeaways, chocolate and fizzy drinks at least once a day.</p> <p>Diet and exercise are not high priorities.</p> <p>Are motivated by desire to look good.</p>	<p>Not in control of decision-making about nutritional issues.</p> <p>Likely to frequent fast food establishments, the dairy or supermarket for takeaways, chocolate and fizzy drinks at least once a day.</p> <p>Diet and exercise are not high priorities.</p>	<p>In control of decision-making about nutrition.</p> <p>Living in highly obesogenic environments.</p> <p>May face active resistance to behaviour change from parts of their support system e.g. cultural and festive celebrations that encourage feasting.</p>	<p>Most live in obesogenic environments.</p> <p>Most describe being in control of nutrition and exercise.</p>

7 Discussion

Over the next 4 years CMH is focused on how it can achieve a balance between delivering excellent healthcare while being sustainable. Addressing long term conditions and reducing demand for services, particularly acute presentations to hospital, will require unprecedented changes not only to the way CMH deliver services, but also to how they work with other health providers.⁵ CMH is also committed to the Triple Aim of:

- improved health and equity for all populations;
- improved quality, safety and experience of care; and
- best value for public health system resources.

The challenge is to develop recommendations that will assist CMH achieve that balance.

7.1 Scope of project

The scope of this project was fairly narrow, the key requirement was to provide recommendations on how CMH may engage a wider community audience to discuss proposed changes it wishes to implement to its maternity care services based on feedback received from the Consumer Panel discussions. The findings highlight a need to think in terms of overseeing the overall maternity care system, rather than launching stand-alone initiatives that try to ignore or supplant all predecessors. A single approach will not work as the appropriate response requires different strategies working cumulatively, being adapted to respond to different needs. This research identified numerous instances of avoidable hospitalisations for both mother and baby because maternity care was not as efficient and effective as it could be. The desktop review highlights that CMH has made considerable investment into reports and projects to explore factors leading to its high perinatal mortality rate. Table 13 below summarises the recommendations from these reports (refer section 4)

Table 13 summarised recommendations from reports and projects commissioned by CMH

Report	Recommendation
Litmus	Need a model of care that is non-judgemental, empowering, directional, flexibly delivered, focused on the baby and with integrated support from a range of organisations.
Maternity Programme Board	Formation of maternity care consumer panels
Sheridan, Busby-Schmidt, Kenealy	Need for accessible and culturally acceptable antenatal education
Boladuadua	Early engagement with midwifery services Teen-specific pregnancy services and antenatal education; accessible contraception; more parent units, expand teen parent units

⁵ <http://www.countiesmanukau.health.nz/achievingbalance/default.htm>

Current maternity care interventions in CMH have yet to demonstrate improvements in outcomes for teen and young, vulnerable and some Pacific mothers. Given the challenges facing maternity care in CMH (workforce shortages, youthful population with high birth rate) an overhaul of the current maternity care system is unrealistic. It highlights a need to look for opportunities where small interventions can have significant impact through contagion effects.

A complex adaptive system is a dynamic network of many agents, who each act according to individual strategies or routines. These agents have many connections with each other, so they are constantly both acting and reacting to what others are doing. At the same time, they are adapting to the environment they find themselves in. Because actors are so interrelated,

changes are not linear or straightforward: small changes can cascade into big consequences; equally, major efforts can produce little apparent change. Control in the system tends to be highly dispersed and decentralised, so if there is coherent behaviour, it emerges from all the interactions between the various actors.⁴

Dr Karaponi Okesene-Gafa tells the story of a Pacific mother who was encouraged to attend prenatal sessions with her Lead Maternity Carer. To get to her first check she had to catch two buses, it took 2 hours, with children in tow. Once there, it took 15 minutes to complete the checks. The mother was told 'you're fine' and sent home. She did not attend subsequent checks.

7.2 Levers of Change

Levers of change must be cognisant of the wider context, structural and practical barriers, and choices available to people, rather than focussing narrowly on the desired behaviour change (Dolan, Hallsworth, Halpern, King, & Vlaev, 2010).

7.2.1 Changing rules and resources

This research highlights that relationships are a key to engagement. Traditionally, populations are more likely to act on information if experts deliver it (Dolan, Hallsworth, Halpern, King, & Vlaev, 2010). The behaviour of participants in this research however indicates they are more likely to act if the messenger has demographical and behavioural similarities and experiences as themselves, or in the very least has a comprehensive, non-judgemental and practical understanding of the mother's background and world view. The ideal would be a maternity care system that enabled mothers to emulate the trust relationships they have with family/whanau, in their relationships with LMCs. The current system does not allow/encourage this type of relationship building. Single episodic prenatal care may suit mothers who are engaged with the system. However alternative approaches which encourage relationship building, for example, group prenatal sessions combined with

an antenatal education component, may provide the building blocks for more effective prenatal education and assessment.

7.2.2 Nudging System Users

The research highlights the significant difficulties CMH faces encouraging teen, young, Pacific and vulnerable mothers to access maternity services early, appropriately and consistently. Aside from the impending birth of a new baby, there are no incentives in place to nudge system users to behave differently. There is considerable opportunity to increase the profile and importance of maternity care in CMH by specifically targeting high risk population groups and incentivise them to behave differently.

7.2.3 Capacity and Capability Building

The research highlights significant gaps in capacity and capability building. Capacity building activities must be '*fit for purpose*' and specifically designed to meet the needs of the CMH population. The workforce shortage of midwives will be on-going and specific career pathways for Community Support Workers to specialise in maternity care could provide a useful support mechanism to support mothers.

7.2.4 Connecting and Catalysing

Mothers participating in this research heavily relied on whanau, friends, peers and trusted support people to provide a wide range of assistance and advice. Given participants take their social norms from the behaviours of others, both positive and negative behaviours can develop and spread rapidly. Identification of 'champions' within these networks could be a useful conduit for CMH to shed the current perception of poor maternal care in the district.

The research also highlights there are few processes for teen, young, vulnerable and Pacific mothers to provide real time feedback to the maternity care system. This makes it very difficult for services to be adapted to meet their specific needs.

Recommendations

Achieving quality in maternity care cross culturally diverse populations

1. To better understand the range of factors associated with maternity care and how tailored solutions can be developed to achieve improved outcomes for specific groups a stratified population approach must be used. This should include:
 - Implementing strategies to cluster teen, young, Maori, Pacific and vulnerable mothers by residential location and by the general practices they choose to attend. Clustering can lead to solutions being developed for mothers with variable health and social needs.
 - For Pacific families, a strategy to support improved health literacy is urgently required. The strategy should include innovative initiatives and monitoring and evaluation for effectiveness to ensure improved communication between Pacific mothers and health care providers especially in the maternity care period. Specific topics which should be prioritised include post-natal contraception information in Tongan and Samoan languages.
 - Using family centred and group approaches for antenatal care and health promotion initiatives. For example, health professionals and LMC's need to understand that diverse groups attitudes to contraception and sexual health promotion are influenced by cultural, religious and social beliefs. Taking account of these views will improve targeting of information to meet the needs of mothers and their families. Similarly appropriate support for women who smoke in pregnancy will take account of the family and other people they live with who are also likely to be smokers and whose behaviour will impact on an individual's ability to make changes in their own lives.

Addressing poor service to Teen, Young, Maori, Pacific and other vulnerable mothers

1. CMH must urgently address issues of service quality and poor care in the maternity care (antenatal care) and newborn (delivery) stages of the Perinatal Periods of Risk. This should include, and is not limited to:
 - Addressing the workforce shortages and inconsistent information provided at the first antenatal care visit (when the pregnancy is first diagnosed) that prevent teen, young, Pacific and vulnerable mothers accessing an LMC early in their pregnancy.

- Undertaking a 'fit for purpose' and tailored training programme to improve customer service provided by maternity care staff at CMH starting with staff employed at Middlemore maternity ward and the Botany and Papakura Primary Birthing Units.
- Reviewing current policies for family members to provide support to teen, young, Maori, Pacific and vulnerable mothers at Middlemore maternity ward and investigate options for improved family centred-approaches.
- Establishing a best practice network focussed on capturing and spreading best practice maternity care strategies in Mangere, Otara, Papatoetoe, Manurewa and Papakura localities for working with teen, young, Maori, Pacific and vulnerable mothers.

Development of an intervention logic which considers the whole maternity care system

1. Develop a specific intervention logic to underpin the First 2000 days Framework to help inform strategic planning, define management performance criteria and set the frameworks for on-going evaluation and monitoring.
2. The hypotheses and assumptions on which interventions are based, as well as performance information should be tested with consumer panels for validity and interpretation of data contextualised with an in-depth understanding of the perspectives, world views and cultural beliefs of the target groups for interventions.

Achieving robust consumer input to measuring and interpreting maternity care quality for diverse and vulnerable populations

1. We recommend a review of the mechanisms used by CMH for patient and consumer input. This should include:
 - Expanding options and opportunities for teen, young, Pacific and vulnerable mothers to provide quality input to (and participate in) decision-making processes. This may include facilitated events for users and staff to introduce user perspectives into planning and developing services.
 - Putting in place a wider variety of feedback processes that allow increased 'real time' feedback from teen, young, Pacific, vulnerable mothers and /or their family members about service experience.
 - Continuing to undertake qualitative research based on cultural and other methodologies appropriate for the diverse population groups.

Effective relationships are key to engagement

We recommend that CMH:

1. Develops workforce and leadership development initiatives that support the skills required for collaborative, customer and family focussed approaches to service provision. The CMH workforce needs to be empowered and supported to respond to the complex health and social needs of the population it serves. This requires specific training but also system changes so that appropriate resources (for example translation services) are provided.
2. Identify existing 'champions of maternity care' who provide excellent maternity care in CMH and support these champions to share their skills, knowledge and experience with others.
3. Develop opportunities such as 'Masterclasses' for on-going training where individuals from a range of maternity care services including social services, independent and CMH midwives, Well Child providers can come together, share experiences and improve skills within an atmosphere of supportive change.
4. Broaden current maternity care options to encourage group prenatal care and other alternative approaches that build models of social pregnancy networks within localities.

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9 Appendix One Discussion Guide, Information Sheet and Consent Forms

Review of Maternity Care Services in Counties Manukau

PARTICIPANT CONSENT FORM

1. I understand that I am taking part in a focus group to improve maternity care in Counties Manukau.
2. I understand that taking part in this focus group is voluntary (my choice) and that I may withdraw from the focus group at any time.
3. I understand that no material which could identify me will be used in any *written reports* on this study.
4. I have had time to consider whether to take part.
5. I know who to contact if I have any questions about the focus group.
6. I agree to the focus group in which I am participating being digitally recorded, and that I may request the recording to stop at any time
YES/NO
7. I wish to receive a summary of the results
YES/NO

(First name)

(Last name)

I _____ have read the
Terms and Conditions and hereby consent to participating in this study.

Address (should you wish to receive a 'Summary of Results')

What made you think you were pregnant? Skipped period, felt sick, started to show, thought you were putting on weight	Establish prior knowledge of pregnancy
How did you find out you were pregnant? Did you go to the doctor? Do a pregnancy test yourself? Did you ask anyone for help or advice, if so who? What information did you receive about caring for yourself and baby before it was born?	Links with health professionals for support in early pregnancy.
At what point did you tell people you were pregnant? At what point 1 st trimester, 2 nd trimester, 3 rd trimester. Who did you tell?	Establish support networks, whanau support, friends
Describe the check-ups you had while you were pregnant? Urine tests, listening to the baby's heartbeat, measuring your stomach	What medical support during pregnancy did the mother have?
If you did have check-up, who did them and how did you see them? Did they come to your house or did have to go to them. Did you miss appointments? What are the things that made you miss appointments? Did your maternity carer miss appointments or cancel?	Who provided maternity care and how did they access this care, how regular was the care and was it consistent.
Do you know what a Lead Maternity Carer or LMC is? How easy or hard was it for you to find one? Did anyone help you? Did you have to wait a long time?	
Did you want to find out the gender/sex of your baby? Did you find out what you were having before the baby was born?	Access to scans during pregnancy
Can you remember having any problems during pregnancy? If so, what additional support did you get and how did you access it.	Complications during pregnancy that may prevent use of Primary Birth Units
Did you do any antenatal programmes prior to having the baby? Or any other programmes like alternative therapy, traditional healers?	Knowledge of and access to pregnancy education programmes
How did you know when you went into labour? Can you remember where you were and what you did?	Establish knowledge of labour
What did you prepare for when the baby arrives	Preparedness for arrival of baby
What support did you have when you went into labour? Who was in the room with	Family/clinical support

you?	
After baby arrived how long did you stay in hospital for? Did you feel you were ready to go home?	Complication level/Comfort with self-managing
How did you find breastfeeding? Did you need help?	Post-birth support
Do you remember being visited by a midwife or health professional either during the pregnancy or after you went home?	Home visiting and p post-birth support
How comfortable did you feel having the health professional in your home?	Comfort with health professionals/ability for health professionals to relate to young/new mums
What are 5 tips you would give other mums in your situation about having a baby? What worked well?	Service-focus/change
What are 5 things you would change about the way you were treated during pregnancy? What would you improve?	System-change
What is your understanding now of pregnancy/delivery care. What is your understanding of the roles of doctors/midwives/hospital	
Utilisation of Primary Birth Units;	What we're wanting to understand
Were you given options about where to have your baby? If so, by who? What are the options available to you?	Do they know what the birthing options are?
Thinking about before you had the baby, did you know where you were going to have the baby? Had you seen inside the labour room before?	Knowledge of birthing units before baby was born.
Those of you that didn't have complications during pregnancy, what do you know about the places you can have a baby?	Were those eligible to use the birthing, aware of it?
Have any of you heard of the Botany Downs Birthing Unit? What have you heard? Have any of the things you have heard influenced where you had the baby?	Influencers of decisions around birthing
What are the things you considered about where to have your baby? Availability of transport, proximity to the hospital.	Birthing decision making factors

Where did you birth and what did you think of the conditions?	Quality of facilities
Reviewing and developing multi-media educational material	What we are wanting to understand
How do you identify gaps and solutions in accessing appropriate Identifying gaps and solutions in accessing appropriate ?	Where people are accessing information
How would like advice and affordable contraception in a timely manner advice and affordable contraception in a timely manner (pamphlets, websites,	Preferred method of accessing receiving information
Before you Before you had your baby, were you aware of the ways you can prevent pregnancy,	Knowledge of contraception prior to pregnancy
What are some of the things that prevented you from using contraception e.g. lives, What are some of the things that prevented you from using contraception e.g. lives,	What prevents What prevents use of contraception
parents would freak, no one knew you were doing things that could make you pregnant, did have anything at the time it happened, you really wanted to have a baby	
Can you name what things you can do to prevent pregnancy now?	Knowledge of contraception now
What prevents you from taking any of these options? Cost, not around when you need it, forgetful, makes you feel unwell	What prevents use of contraception now
Other issues to cover	
Can you identify any illnesses you have while you were pregnant	Comorbidities
What happened when you have complications	Quality and integration of care
What happened when you left hospital and had to go back to your medical centre	

radio stations etc?	
Thinking about the way you access information now – What are the good places to go to for information and what makes them good in your eyes?	Elements that consumers see as positive for information dissemination
Thinking about when it has been difficult to access information – what are the barriers?	Barriers to manage/eliminate
What should the DHB do to ensure that information designed for mothers is appropriate and relevant on a day to day basis?	Meeting needs
Who do you trust to provide you with information, referral to other sources of information – health worker- eg GP, midwife, CHW; family member- parent, sibling; peer – friends, mothers group etc; education or other professional eg pharmacist, teacher etc; community leader- church leader, ECE teachers etc; celebrity – eg Beatrice faumuina or other prominent community leaders.	Testing trusted sources of advice
Strategies to reduce pregnant women/and mothers smoking;	What are we wanting to understand?
Do you have smokers in your family .i.e did your parents/caregivers smoke? How old were you when you started smoking? How did you get access to smokes then/now? If you're not a smoker have you been tempted to smoke – what are some of the things that stopped you from smoking?	Family personal experience with smoking
For smokers, what makes you smoke. Have you tried to give up? How many times have you tried to give up? What are some of the things that you think prevent you from giving up totally?	Identification of enablers
Did you give up smoking while pregnant? What are the main things that stopped you smoking during pregnancy? What are some of the reasons you started smoking again after you had the baby? What support did you need to remain smoke free after you had the baby?	Reasons for giving up while pregnant/instigators post pregnancy
For those that don't want to give up, what would need to happen in order to encourage	Identification of smoking cessation ideas

you to give up?	
Are you aware of some of the 'Stop Smoking' programmes how useful are they? Do you know how to access support if required?	Current messages
What would make it easier for you to give up smoking? What would motivate/encourage you to stay smoke free	Incentives
Smoking- how old when you started, how many cigarettes a day, how often have you stopped- how long has it lasted when you stopped. Do you smoke inside the house/car? Testing smoking history	Testing impact of price and antismoking efforts
Does the price of cigarettes make a difference to how much you smoke? Who pays for your cigarettes, do you get them from other family members or friends?	
What do you know about how smoking can affect your baby and your own health? If have information, who/where did that come from?	Health literacy
Who would give you information on how to keep you and your baby well that you would trust? How would you get information that would make you act?	Trusted sources of advice
Culturally appropriate nutritional interventions to reduce pre-pregnancy obesity;	What are we wanting to understand?
Who does the food shopping in your household? Do you have much say in what is bought? Does the same person do the cooking? If not who does? Do they make a shopping list? How often is food shopping done in the house?	Who controls food purchasing and preparation
What kind of food do you eat at home? Is mainly pakeha/palagi food like pasta, mince, rice, or is it cultural food like taro, boil-up, chop suey or is it a mixture? How often would you eat cultural food?	Type of food eaten
In the past two weeks how many times did you eat from a fast food place like McDonald, Chinese takeaways, fish n chips etc? Is normal for you or do you eat out more often.	Fast food consumption

How many people live in your house/how many people eat meals together/how many people contribute money to the household budget to buy food and essentials?	Testing food security
How often would you say you eat vegetables and fruit? Everyday, when its available etc	Consumption of fruit and vegetables
How often would you drink soft drinks?	
How much water do you drink?	
What do you consider to be overweight or obese? What do you know about how being overweight or obese can affect your health- and how about when you are pregnant or your babies health? Is there anyone in your family with diabetes? Do you know anyone with diabetes during pregnancy? What do you understand causes this and what did they have to do about it?	Testing health literacy and knowledge of obesity related illnesses
When you think about the people you live with – how many of them would you say are overweight	Family dynamics
Now thinking about when you were pregnant did any of the above change? Did you eat differently? Did you think differently about the food you ate? Did you eat the same as everyone else at home?	Knowledge of nutrition during pregnancy?
When you were pregnant did you exercise more or less?	Physical activity
What prevented you from doing physical activity	Barriers to physical activity
When you were younger were you physically active. Were you encouraged to play sport? Were your family/parents/caregivers actively involved in your sporting commitments?	Family support of physical activity
Since you have had your child/ren do you worry about weight? Would you say you have lost weight/put on weight.	Post pregnancy weight
Would you like support to lose weight or to understand what you need to do to lose weight?	Support for weight loss

How would you like to receive this support?	Information dissemination processes about nutrition and physical activity

10 Appendix Two – Baseline Survey

SURVEY ABOUT MATERNITY SERVICE IN COUNTIES MANUKAU

Thank you for completing this anonymous survey to help us improve maternity services in Counties Manukau.

What is your ethnicity?

(Tick more than one box
If required)

<input type="checkbox"/>	NZ European	<input type="checkbox"/>	Samoaan
<input type="checkbox"/>	Māori	<input type="checkbox"/>	Asian
		<input type="text"/>	Other
<input type="checkbox"/>	Cook Island	<input type="checkbox"/>	Tongan
		<input type="checkbox"/>	Niuean
<input type="checkbox"/>	Tokelauan	<input type="checkbox"/>	Tuvaluan
		<input type="checkbox"/>	Fijian

How old are you? (Please state) _____

INFORMATION ABOUT YOU

This section is to help us understand more about the people participating in helping us to improve maternity care in Counties Manukau

1	Who do you live with? _____
---	------------------------------------

2	<p>What languages do you speak at home?</p> <hr/>
3.	<p>How many people are living at home with you?</p> <hr/>
4.	<p>How many children do you have? (state ages of children)</p> <hr/>
4.	<p>Did you smoke during pregnancy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
5.	<p>Did you giving up smoking while pregnant and start again after?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
6.	<p>Did you drink alcohol while you were pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
7.	<p>What support do you have to raise your baby?</p> <p><input type="checkbox"/> <input type="checkbox"/></p>

	<p>Parents</p> <p><input type="checkbox"/> Social Worker</p> <p>Father of baby</p> <p><input type="checkbox"/> Other family members</p> <p>Other (please state) _____</p>
8.	<p>What is your education level?</p> <p><input type="checkbox"/> Intermediate <input type="checkbox"/> Secondary School <input type="checkbox"/> Polytechnic (MIT)</p> <p><input type="checkbox"/> Other Institute <input type="checkbox"/> University</p>
9.	<p>Please state which medical clinic you go to</p> <p>_____</p>
10.	<p>How old were your parents when you had your first baby (the baby's grandparents)</p> <p>_____</p>

CONTRACEPTION

This section is about contraception. Contraception is any method that stops you from having a baby until you wish to have another baby or until your family is complete.

1	<p>Was contraception discussed with you by a doctor, midwife, nurse or any other health professional before you gave birth?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
2	<p>Do you know what contraception you will use?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
3	<p>Do you know how you will access it?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
4	<p>What would be your ideal contraceptive?</p> <table><tr><td><input type="checkbox"/></td><td>Condoms</td><td><input type="checkbox"/></td><td>The pill</td></tr><tr><td><input type="checkbox"/></td><td>Depo provera (injection)</td><td><input type="checkbox"/></td><td>Jadelle (goes into your arm)</td></tr><tr><td><input type="checkbox"/></td><td>Mirena (internal, reversible)</td><td><input type="checkbox"/></td><td>Copper IUD</td></tr></table>	<input type="checkbox"/>	Condoms	<input type="checkbox"/>	The pill	<input type="checkbox"/>	Depo provera (injection)	<input type="checkbox"/>	Jadelle (goes into your arm)	<input type="checkbox"/>	Mirena (internal, reversible)	<input type="checkbox"/>	Copper IUD
<input type="checkbox"/>	Condoms	<input type="checkbox"/>	The pill										
<input type="checkbox"/>	Depo provera (injection)	<input type="checkbox"/>	Jadelle (goes into your arm)										
<input type="checkbox"/>	Mirena (internal, reversible)	<input type="checkbox"/>	Copper IUD										

	<input type="checkbox"/> Tube tie <input type="checkbox"/> Vasectomy (for partner) <input type="checkbox"/> Other
5	Is anything stopping you from getting your ideal contraception (tick as many boxes as you wish) <input type="checkbox"/> No <input type="checkbox"/> Time <input type="checkbox"/> Don't know where to go <input type="checkbox"/> Cost <input type="checkbox"/> Childcare <input type="checkbox"/> Transport <input type="checkbox"/> Don't know enough about it
6	If your choice is Jadelle (goes into your arm) would you prefer to have this inserted before you leave the hospital <input type="checkbox"/> Yes <input type="checkbox"/> No, prefer it later <input type="checkbox"/> Don't want a Jadelle
7	If your choice is a tube tie would you prefer to have this done before you leave the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No, prefer it later <input type="checkbox"/> Don't want it done

RHEUMATIC FEVER

1.	Have you heard of rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Did you have any complications arising from rheumatic fever during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER COMPLICATIONS DURING PREGNANCY

1.	Did you have any complications during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Describe any complications you had <hr/> <hr/> <hr/>

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PLEASE GIVE THIS TO GERARDINE OR DEBBIE WHEN COMPLETED

11 Appendix Three – Issues discussed by the Localities consumer panel feedback at the First 2000 Days Forum on 5 July 2013.

Locality Consumer Group

Ask them to consider:

- What are the highlights and successes in your locality?
- What are the key issues for your locality relating to the 3 themes?
- What are the greatest issues or opportunities for improvement where we could work across services/sectors to improve outcomes for CM children?
- Where are the opportunities to link into the Localities work?

Consumers invited to go to a separate table to discuss:

- Where have the greatest improvements been made in recent years?
- What are the key health issues for pregnant women and young children in Counties Manukau?
- What would you see as the greatest opportunities for improvement? Where would you like the DHB and other services to focus on improving?