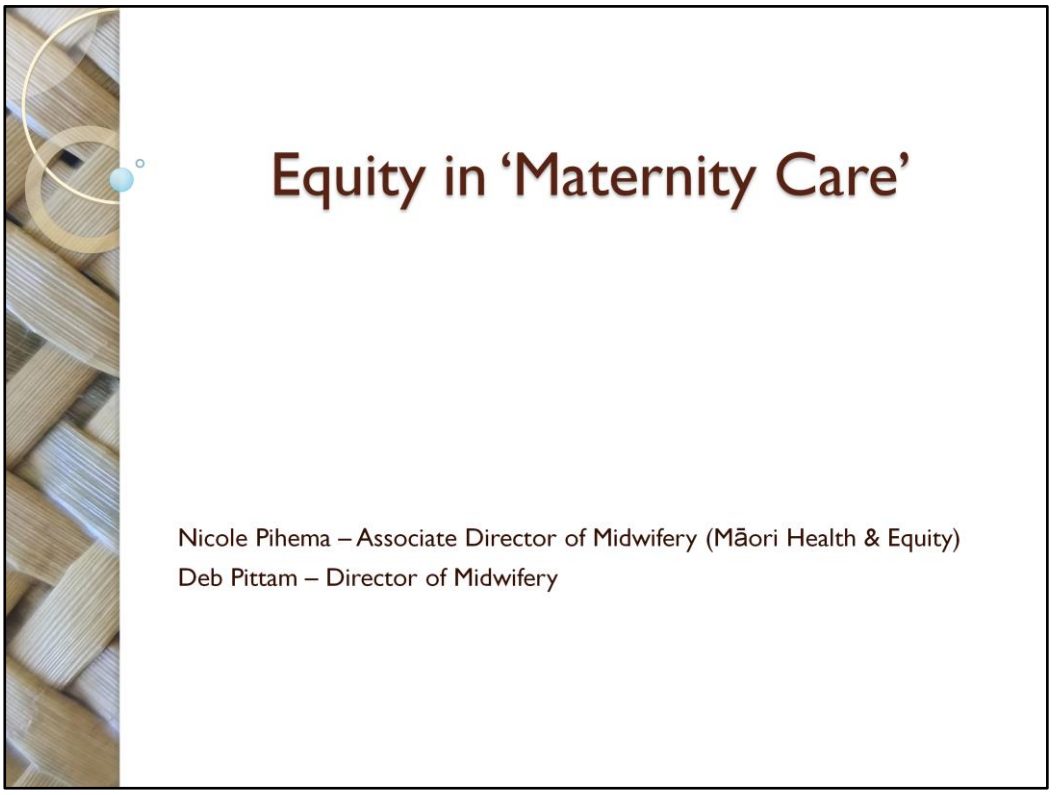
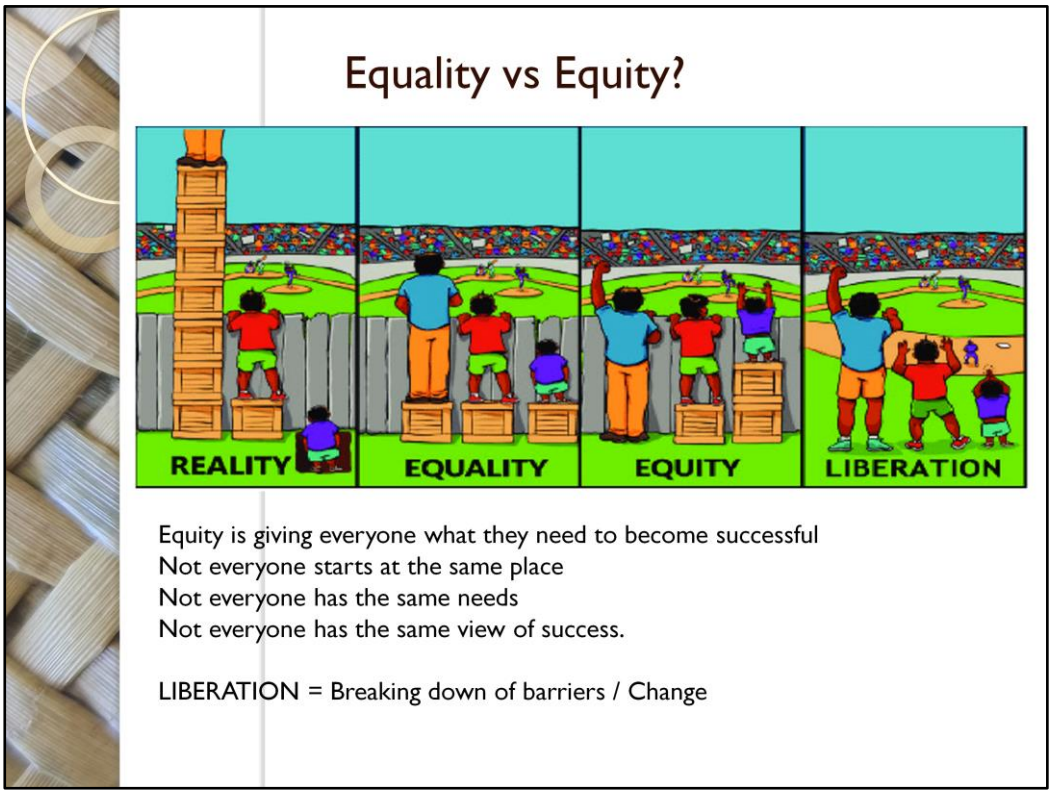


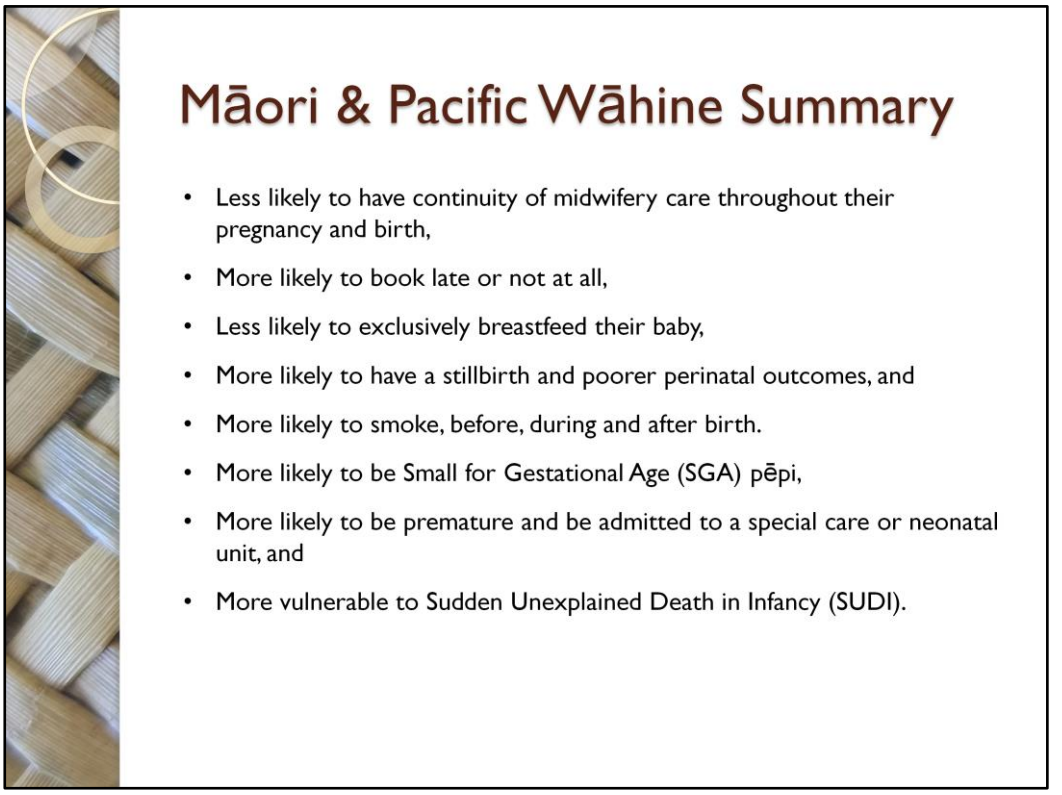
I was asked to present equity in maternity care as presented in the Annual clinical report.

Actually I should be presenting inequity because that is really where we sit. What is good however is that we are working to address those inequities.

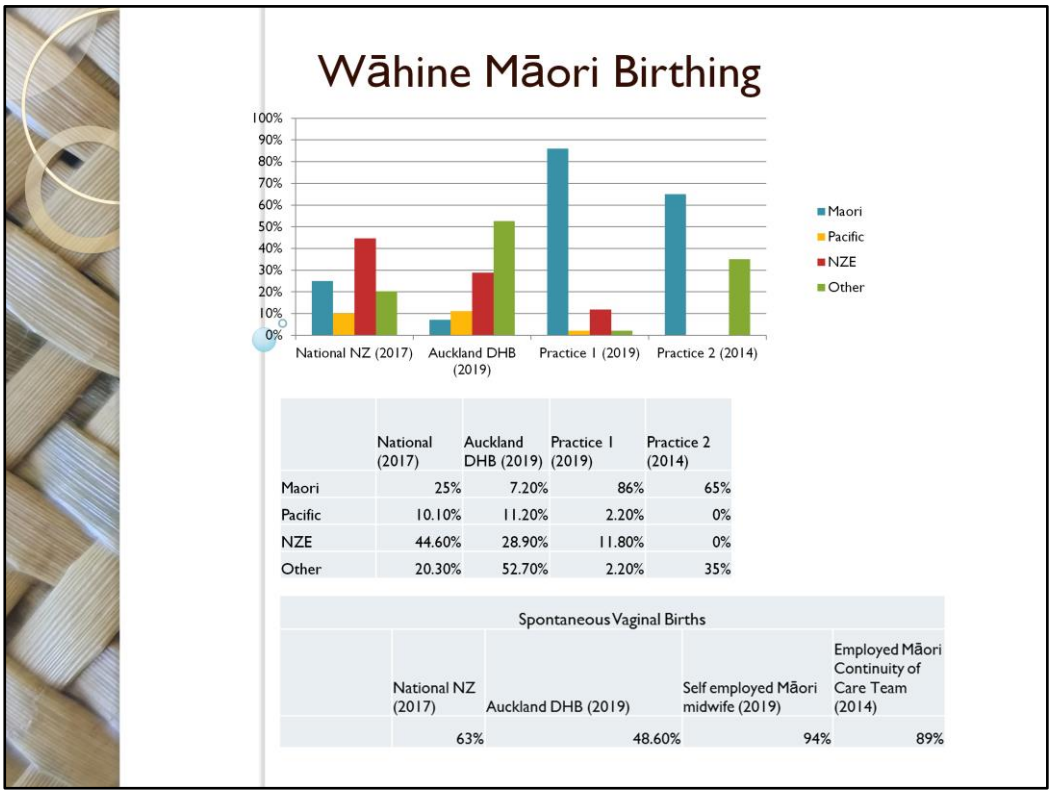


So lets start by understanding Equity:

Equality only works if everyone starts from the same place. We need to put in the extra work and give everyone what they need.



These are the issues identified within the report clearly showing the level of inequity in our system

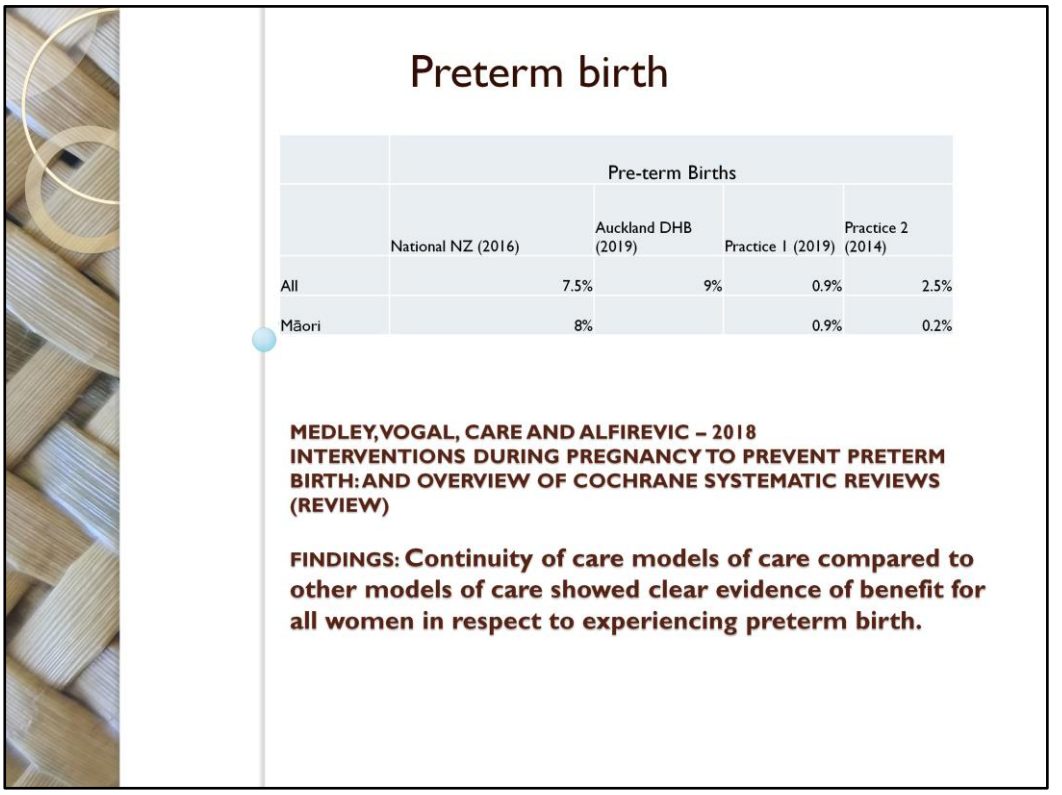


	National (2017)	Auckland DHB (2019)	Practice 1 (2019)	Practice 2 (2014)
Maori	25%	7.20%	86%	65%
Pacific	10.10%	11.20%	2.20%	0%
NZE	44.60%	28.90%	11.80%	0%
Other	20.30%	52.70%	2.20%	35%

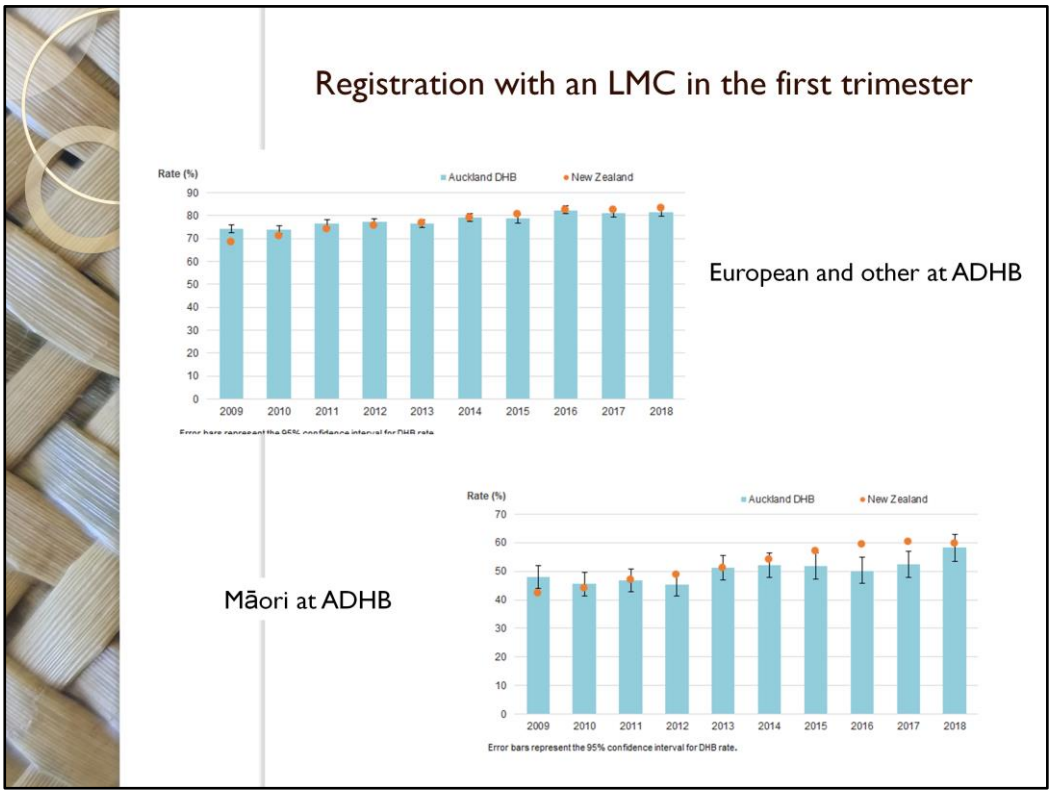
Spontaneous Vaginal Births				
	National NZ (2017)	Auckland DHB (2019)	Self employed Māori midwife (2019)	Employed Māori Continuity of Care Team (2014)
	63%	48.60%	94%	89%

If we look at birthing outcomes our wahine maori do well but look at the differences depending on the model of care within which service is provided

One of the other issues we have been told is key is preterm birth, while anecdotally I am told maori are highly represented in the preterm birht statistics, I wasn't able to identify numbers for maori from the report



So one of the things we know is that continuity of midwifery care models reduce preterm birth rates. This has been shown in a number of international studies and reviews although the reason is not clear.



WE know that registration with an LMC in the first trimester best enables access to all required services for every woman and there are start inequities when we look at the bookings in the first trimester for Maori and other european women at ADHB.

In 2018 over 80% of other european women booked in the first trimester and only 58% of Maori women did the same.

These international studies showed that Continuity of care reduced preterm labour, led to fewer interventions and less maternal morbidity and at least as good neonatal outcomes as other models of maternity care.

These are studies are of particular interest as they were done specifically looking at outcomes for continuity of midwifery care compared to other models of care in indigenous populations

Kildea et al – Carried out a prospective cohort study in Brisbane, Australia looking at reducing preterm birth amongst Aboriginal and Torres strait Islander babies. They identified that the existing higher rate of preterm birth amongst the population of Aboriginal and Torres Strait Islanders compared

to other populations could be reduced by the implementation of a midwife led continuity of care model, increasing indigenous governance of services and indigenous workforce and providing services from within a community-based hub.

They described a situation where Preterm birth rates in Aboriginal and Torres Strait Islanders was 13.3% in 2008 and only 8% for non-indigenous women and there was little change between then and 2017.

It was accepted that preterm birth contributed significantly to childhood disability and mortality and associated with an increased risk of chronic disease in adult life, such as diabetes, cardiovascular and renal disease.

The study has so far found that Aboriginal and Torres Strait Islanders have significantly less preterm labour when cared for in a midwife led continuity of care model than those who are cared for in a standard care model. They note that the risk is reduced by half.

The model was culturally safe and appropriate, midwife led and women were identified and commenced care early in their pregnancy to achieve these results.

McRae et al carried out a population based cohort study comparing midwifery and physician models of care in British Columbia Canada.

Women had a low socioeconomic position , low to moderate obstetric risk and birthed between 2005 and 2012. The study included 57872 pregnant women.

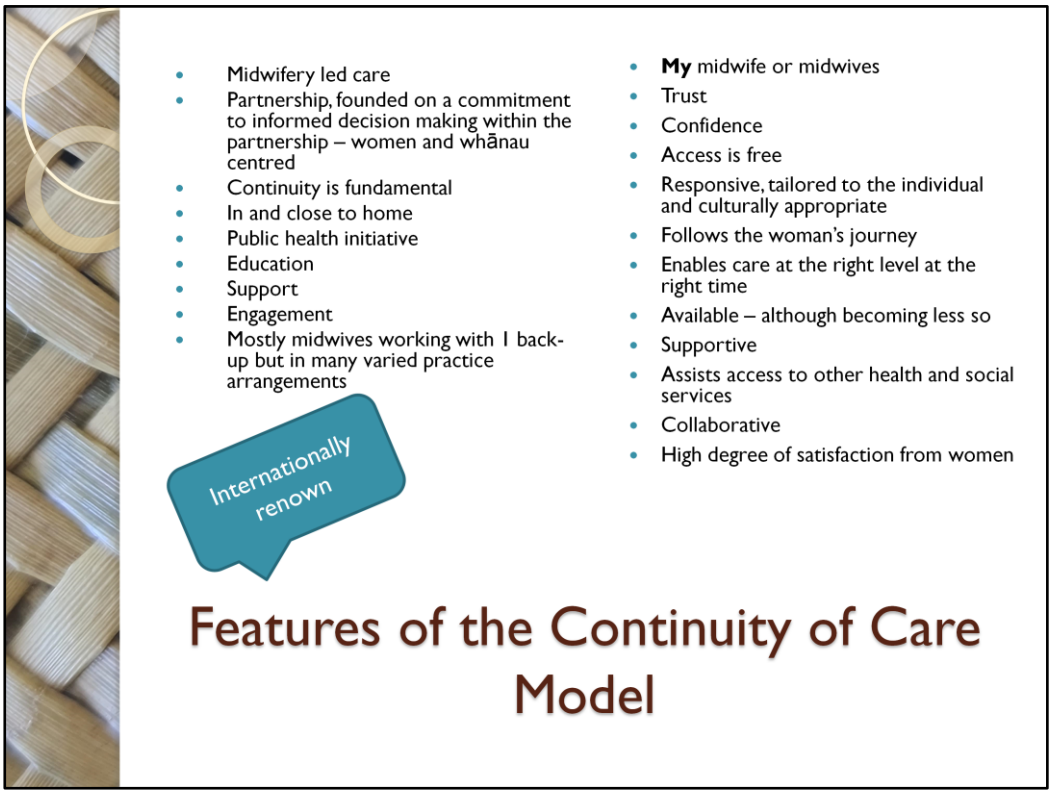
Primary outcomes were Small for gestational age at birth (<10th

centile), preterm birth before 37 weeks gestation and low birth weight (<2500g)

In all three of those primary outcomes rates were lower when antenatal midwifery care was available, accessible and undertaken from early pregnancy.

In this low socioeconomic group women were 2.5 times more likely to fully utilise antenatal care when their carer was a midwife compared to physician (GP or Obstetrician) models.

Canadian researchers recommended that availability and access to midwifery models be extended to ensure access for all, particularly those from low socioeconomic environments.



So we talked about the evidence supporting continuity of care models in indigenous and all populations. But what does true continuity of midwifery care looklike and what advantages does it offer.
Te Manawa o Hine offers all these advantages and more – specifically tailored to meet the needs of whānau.

Ultrasound access is an issue for wahine Maori. Many reasons given include child care issues, no transport, lack of petrol, rude staff

Access to ultrasound scans *copayments*

access to continuity of care *availability of continuity of care providers – significant cost for private obstetric care and lack of LMC midwives in the district*

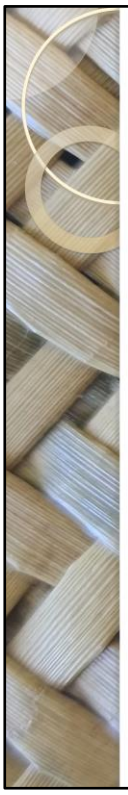
referral pathways not user friendly for the average Whānau who find traversing the system challenging

lack of cultural literacy

health literacy

fear of institutional racism and bias *The environment matters Māori have to feel welcome, valued and able to express themselves appropriately*

So what have we done to improve services for whānau and what more can we do?



Models in Practice

TE MANAWA O HINE (EMPLOYED)

- CURRENTLY TWO MODELS OF CARE
- 1. ANTENATAL/INTRAPARTUM/POSTNATAL
- 2. ANTENATAL/POSTNATAL + NAVIGATION

LEAD MATERNITY CARER MIDWIFE (SELF-EMPLOYED)

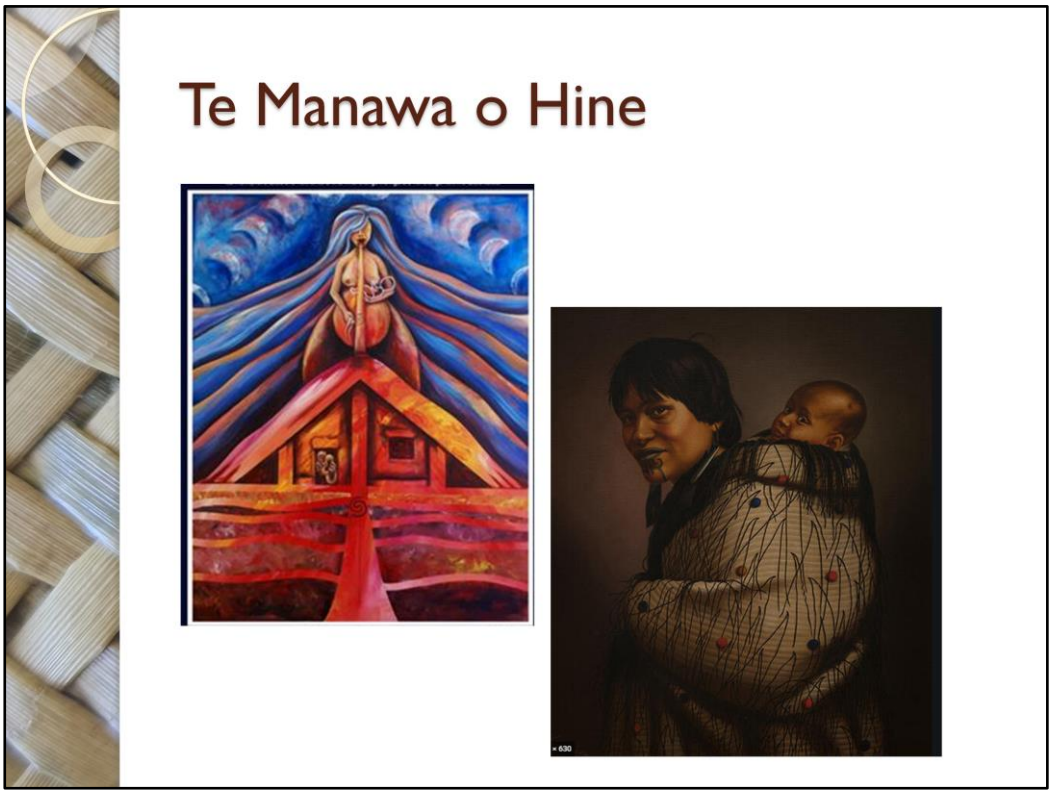
- ANTENATAL/INTRAPARTUM/POSTNATAL

LEAD MATERNITY CARER OBSTETRICIAN

- ANTENATAL/INTRAPARTUM (BUT COSTLY)

LEAD MATERNITY CARER GP

- ANTENATAL ONLY



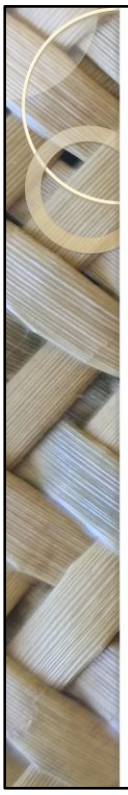
What Te Manawa o Hine means – its whakapapa
Cultural advantages to the model

Early engagement

What can we do within the organisation to support women cared for within a kaupapa maori model to feel safe and welcome within ADHB

In the past we have done some cultural safety training, planned for the new year:

- Hone Hurihanganui
- Culture in Practice – Training to be led by Koha Aperahama who will train our Māori midwifery staff to deliver the training ongoing. This will be available to all staff regularly next year and starts in February.
- Transformation of Tamaki – What could it be like? Could we transform the unit to be a more welcoming and respectful environment for whānau. Could cohorting our primary birthing Māori women to birth in a more culturally friendly and midwifery and whānau-led environment make a difference.



Commitment to Equity at 'Te Toka Tumai'

WE HAVE A COMMITMENT AT THE MOST SENIOR LEVEL IN THIS ORGANISATION

WE NEED TO SEE THAT COMMITMENT REFLECTED THROUGHOUT THE ORGANISATION-

KIA WHAKATŌMURI TE HAERE WHAKAMUA
(I WALK BACKWARDS INTO THE FUTURE WITH MY EYES FIXED ON MY PAST)