HAU TE KURA

nurturing our treasures

CULTURAL RESPONSIVENESS REVIEW OF MATERNITY SERVICES AT HAWKES BAY DISTRICT HEALTH BOARD FOR WHĀNAU MĀORI

Completed by Review Team: Linda Thompson, Judy Ann Cooze, Henare Kani, Moe Milne and supported by Mara Andrews

FINAL 23 FEBRUARY 2022

TE TĀURU

Kia hiwa rā! Kia hiwa rā!

Kia hiwa rā ki tēnei tuku kia hiwa rā ki tērā tuku!

Ngā Tukemata Ngā Pounamu o Kahungunu!

Whakarongo ake nei ki te tangi a te manu e tau nei i ngā maunga here tangata o te iwi

Ko Whakapunake ko Kahurānaki o Te Matau-a-Māui-Tikitiki-a-Taranga

Mai i Te Wairoa Tāpoko Rau ki Te Mata o Poroporo. Kia tū! Kia oho! kia matāra!

Ko te Tikanga Ratonga Whakawhānau Pēpi te kaupapa.

Tēnei ngā Kaiarotake te whakakakau atu nei, te pūrongo atu nei ko ngā kōrero whānui,

a ngā Māma, a ngā māreikura whakawhānau Pēpi, a ngā tātai kōrero o te rohe nui tonu!

He aue, he mamae! He ōranga, he kitenga! He aue, he mamae! He ōranga, he kitenga!

He wānanga tapu mauri ora te whānautanga mai o ngā Pēpi ki te whai ao ki te ao mārama!

Tihei Mauri Ora!

Be watchful be alert!

Be watchful to this place, be alert to that place!

Hear the call of the bird resting atop the binding mountains of Ngāti Kahungunu!

From Te Wairoa in the north to Poroporo the southern end of the great net of Te Huki

The Cultural Responsiveness of the Maternity Services at the Hawkes Bay District Health Board is the primary matter

The Reviewers now reveal and inform on what has been widely stated

By Māori mothers and whānau, Midwives, and relevant contributors

Expressions of distress and hurt, of wellness and insight

Consider traditions and the life cycle, that new babies may enter the world to claim the right to life!

HAU TE KURA

HAU TE KURA is a kaupapa associated with improving the cultural responsiveness and safety of maternity services in Hawke's Bay. The review is being undertaken that looks at ways to improve the experience of whānau so that every child is born in a safe and caring environment, and where Māori whānau particularly feel respected, listened to, cared for, and supported with their new pēpi.

PINEPINE TE KURA

Pinepine te kura, hau te kura,	*Little tiny treasure, treasure of renown*
Whanake te kura i raro i Awarua;	*The treasure who came from below Awarua*
Ko te kura nui, ko te kura roa,	*The noble treasure, the famous treasure*
Ko te kura o tawhiti na Tūhaepo!	*The treasure from afar off, the treasure of Tūhaepo*
Tēnei te tira hou, tēnei haramai nei;	*A strange visitor is he, lately arrived here*
Ko te Umurangi, na te Whatuiāpiti.	*He is Te Uamairangi descended from Te Whatuiapiti*
Nau mai, e tama, ki te taiao nei,	*Welcome o son welcome to this world of life*
Kia whakangungua koe ki te kahikatoa,	*You are to be ritually strengthened with the Kahikatoa*
Ki te tūmatakuru, ki te tara ongaonga;	*With the Tumatakura and the Taraongaonga*
Ngā tairo ra nāhau, e Kupe,	*These were the thorny obstructions that you o Kupe*
I waiho i te ao nei.	*bequeathed unto this world*
Piki ake, kake ake i te toi huarewa,	*Climb up ascend by the suspended way*
Te ara o Tāwhaki i piki ai ki runga;	*The pathway of Tāwhaki when he ascended on high*
I rokohina atu rā Maikuku-makaka,	*And there found Maikuku-Makaka*
Hapai o Maui, he waha i pa mai,	*Attended by Hāpai o Māui and greetings were uttered*
'Taku wahine purotu!' 'Taku tane purotu!'	*My beautiful lady, my beautiful man*
Kōrua ko te tau, e.	*A tribute for you two o loved ones*

THE REVIEW TEAM

- **Mara Andrews**: *Ngāti Kahungunu, Whakatōhea, Ngāti Raukawa:* Director/Senior Consultant, Kāhui Tautoko Consulting Ltd since 2000. KTCL works with health and social Government and community providers, across the country in the Māori Health area, particularly in strategy development; policy matters; service reviews and evaluations.

- **Moe Milne:** *Ngāti Hine:* Consultant NZPN, ONZM. Moe was awarded Officer of the New Zealand Order of Merit (ONZOM) for services to Māori and Health. She has addressed mental health issues in the Māori community in her roles as a psychopaedic nurse and as a general and psychiatric nurse. Moe contributed to Te Hau Mārire, the national Māori Addiction Strategy, and developed several education programmes. Moe's knowledge of Māori health, education and research is extensive. A fluent native speaker in Te Reo she is committed to ensuring her whānau grasp hold of the values and culture of their ancestors.

- **Linda Thompson:** *Ngāti Kahungunu, Te Atihaunui a Paparangi Whanganui, Tuwharetoa:* Consultant NZRN ADipN QCM was awarded the Queen's Commemoration Medal 1990 for services to the public and Women's Health. She is a founding member and life member of Te Kaunihera o Ngā Neehi Māori o Aotearoa (1983). Linda held the first management role for Māori health, as Director in the Manawatu Whanganui Area Health Board and went on to join the first Māori Health team in the Ministry of Health that set up Te Kete Hauora Māori Health Directorate under the Deputy Director General of Māori Health management

Judy Ann Cooze: *Ngāti Kahu, Ngāti Aukiwa* Clinical Midwife / Nurse Consultant demonstrates understanding of a Māori world view through her delivery of midwifery services and drawing on her whānau and hapū practices in this area to ensure safe, clinical and cultural practice in her field of expertise. Judith is an experienced Māori Midwife with a history of working in both hospital and the community in New Zealand and Australia – amongst indigenous women in both countries.

Henare Kani: *Ngāti Kahungunu, Rangitāne, Tuwharetoa:* Consultant spent time with Ngā Māia as well 2000 - 2019 in various roles. He has background experience in tutoring cultural competency for midwifery schools and midwives nationally 2006 – 2015. He developed Tūranga Kaupapa which is a reference and source of support for midwives, wāhine and whānau and was developed for Ngā Māia in 2006 to enhance Ngā Māia kaupapa and to provide cultural guidelines. Tūranga Kaupapa are guidelines for cultural competence that have been formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives.

ACKNOWLEDGEMENTS

The review team would like to thank the Mamia whānau for agreeing to contribute the photos in this report. Their koha is much appreciated.

The review team would also like to thank and acknowledge the following:

- Sponsors of this Review: The Chief Executive and Executive Management of the Hawkes Bay District Health Board
- Chairman and Iwi representatives of the Hawkes Bay District Health Board
- Hawkes Bay District Health Board: Executive Management representatives of the Hawkes Bay District Health Board, including the Māori Health Service Management and Kaumātua
- The stakeholders internally and externally to the Hawkes Bay District Health Board who included Ngāti Kahungunu Iwi Incorporated
- Past members of the Māori Relationship Board of Hawkes Bay District Health Board
- Waipatu Marae Representatives and Mamia
- Māori health service provider representatives located in Heretaunga and Wairoa
- Māori Midwives located in Heretaunga and Wairoa
- Midwives, past and current, of the Hawkes Bay District Health Board
- Hawkes Bay District Health Board services, community facing: Tuai Kōpu and He Korowai Aroha
- Hawkes Bay District Health Board Maternity Services: Management and Staff: past and current including from the service locations at Hastings and Wairoa
- Whānau whānui: ngā Māmā, me ngā Whānau i roto i ngā Taiwhenua o Ngāti Kahungunu ki Tamatea, Heretaunga, me Te Wairoa
- All who participated and contributed their perspectives to this review.

Appreciation must especially go to the Hawkes Bay District Health Board and the Expert Advisory Group for commissioning this important review. Without your perspectives and opinions - we would not have been able to complete this work.

Photo below: The review team (including one by zoom) with CE Ngāti Kahungunu Iwi Incorporated Chrissie Hape.

DISCLAIMER

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GLOSSARY

TERM	DESCRIPTION
Hapū	Sub-tribe, pregnant
Iwi	Tribe
Karakia	Prayers, incantations
Kaupapa Māori	Māori way of doing things connected to Māori philosophy, beliefs, and principles
Kōrero	Conversation, discussion
Māmā	Mum / mother
Mana	Authority
Mana Tangata	Power / status accrued through one's leadership talents
Mana Motuhake	Autonomy
Manaaki	To support, show generosity, empower
Mātauranga	Knowledge
Oranga	Health, wellbeing
Pāpā	Dad / father / partner
Pēpi	Baby
Tangata Whenua	People of the land, indigenous first peoples of Aotearoa
Tauiwi	Foreigner, person coming from afar
Te Ao Māori	The Māori world
Tikanga	Correct procedures, custom
Wāhine / Wahine	Women / Woman
Whakaaro	Thought/s, opinions
Whakapapa	Genealogy
Whānau	Family and extended family
Whanaungatanga	Relationships / bond

Recommendations

It is recommended that the Hawkes Bay District Health Board:

#	RECOMMENDATION
1	**NOTE** that this cultural responsiveness review of maternity services at Hawkes Bay District Health Board (HBHB) for whānau Māori has been completed and has included a review of HBDHB documents, a literature review and surveys / engagement with internal and external stakeholders including - 13 HBDHB maternity staff survey respondents - 8 Lead Maternity Carer (LMC) survey respondents - 43 internal HBDHB governance, management, and staff interviews - 13 external organisation interviews - 22 Wāhine Māori (some with whānau) who have used the maternity service.
2	**NOTE** that the recommendations below are organised by the two objectives of the review sought by the HBDHB
Review objective 1: Identify and recommend improvements to improve maternal and child outcomes for Māori parents and their pēpi who birth at HBDHB facilities	
3	**NOTE** that evidence shows in New Zealand, many Māori women face barriers in engaging in maternity care early and this is particularly so for Māori women aged under 20 years. Furthermore, evidence shows that LMC engagement in New Zealand is poor for non-European women including younger women; women in their first pregnancy; marginalised and vulnerable women; and women in lower socio-economic suburbs. Māori women are over-represented in almost all these categories
4	**NOTE** that results from the engagement process reveals that wāhine Māori and their whānau have highly variable experiences and outcomes from accessing HBDHB's maternity services
5	**NOTE** that wāhine Māori overwhelmingly rated the Wairoa maternity service as much better, culturally safer, and more responsive than those wāhine who had used the Hastings maternity service. The vast majority of wāhine from Wairoa prefer the Wairoa service and have negative impressions of the Hastings service with several asking that more specialist services be delivered in Wairoa to avoid them travelling to Hastings. Furthermore Wairoa (non-Māori) leadership was shown to be very understanding and empathetic to the needs of Māori and operating a very effective model of care. It was identified that despite Wairoa having fewer staff per women and lack of resources and equipment in comparison to Hastings (with access to more staff per women, more equipment, support of Obstetricians and other speciality services, larger facilities) – the service was overall better in Wairoa than Hastings.
6	**NOTE** that many wāhine and/or whānau shared stories of what they felt were discriminatory practices of their care and how whānau were treated at the Hastings site. Cultural needs were not consistently met, and several were reticent about having to use the Hastings service for future birthing.
7	**NOTE** that the Kaitakawaenga service is highly valued by wāhine and whānau
8	**AGREE** to actively embed Ngāti Kahungunu tikanga within the maternity services including in position statements, policies, and physical facilities (artwork, stories, bi-lingual signage, collateral such as posters, stories, waiata, physical design). This should include promotion of

<table>
<tr><th>#</th><th>RECOMMENDATION</th></tr>
<tr><td></td><td>the importance of whakapapa and whanaungatanga; honouring the whakapapa of the wahine and her pēpi; and keeping māmā, pēpi and whānau mana and mauri intact. A key focus should be relating any processes, collateral, or policies back to Pinepine te Kura and the regeneration of new life from māmā and pāpā and their role in protecting whakapapa. It is important that these are not just visual displays but that they centre the environment on offering a positive, nurturing and warming experience for all whānau</td></tr>
<tr><td>9</td><td>NOTE that several Māori midwives advocated for a community-based Kahungunu-centric birthing unit that could consistently provide culturally safe care for all hapū māmā. Based on annual volumes of around 800 Māori births per annum, it was felt this was a viable option for the area</td></tr>
<tr><td colspan="2">Review objective 2: Identify and recommend improvements to the understanding, practices, and behaviours of HBDHB towards responding positively and effectively to the cultural needs of whānau Māori</td></tr>
<tr><td>10</td><td>NOTE that several strategies, plans, policies, and guidelines were identified as very strong particularly when jointly developed with Ngāti Kahungunu iwi representatives – but more needs to be done</td></tr>
<tr><td>11</td><td>AGREE to work with Ngāti Kahungunu partners to update the following policies and strengthen Māori cultural content including updating references to Te Tiriti o Waitangi with the principles outlined in the WAI2575 claim findings:
HBDHB Policy Position Statement on Institutional Racism
HBDHB Policy on Child Abuse and Neglect
HBDHB Policy Guide on Maternity Wellbeing
HBDHB Policy on Child Protection and Alert Management
HBDHB Policy on Treaty of Waitangi Responsiveness – Assessment</td></tr>
<tr><td>12</td><td>AGREE to review all Job Descriptions and Performance Plans for maternity service positions to introduce and include Key Performance Indicators (KPIs) related to Te Tiriti and cultural responsiveness performance. This should ideally include a 360-degree feedback mechanism. Specifically, the goal for all maternity service staff should be to ensure that the short time in the birthing unit by māmā should be “free from all harm” through a high standard of service – without judgment, a clear birth plan and strong communications with community-based LMCs. Updated Job Descriptions could include the following format:<table>
<tr><th>1 Summary description of the Organisation and how the service aligns with this</th><th>2 Description of the Job / Position:</th></tr>
<tr><td>Kaupapa of HBDHB; and of the Maternity Services
HBDHB Vision / Mission statements
HBDHB Te Tiriti o Waitangi statement</td><td>Job identification, Job title and Job summary
General nature of the job.
Introduce related cultural competence for the role</td></tr>
<tr><th>3 Key performance indicators, or measures:</th><th>4 Relationships:</th></tr>
<tr><td>Major responsibilities and duties identifying measures of performance against each
Major functions/activities – linked with each identified performance measure</td><td>Internally – Reports to, Supervises, Works with:
Externally – as relevant, Outside the company, other key stakeholders</td></tr>
</table></td></tr>
</table>

#	RECOMMENDATION
	• Specify cultural competence elements and measures for duties / functions / activities • Specify Whānau / Hapū / Iwi relationships required in the role **5 Working conditions:** • Decision-making authority, Direct report / supervision, Budgetary limitations **6 Personal specifications and competencies** • What it takes to do the job successfully – in attitude, behaviour, competence – including personal, professional, cultural.
13	**AGREE** to include senior Māori midwifery representation on all Multi-Disciplinary Teams (MDTs) within the maternity service
14	**AGREE** to strengthen clinical governance guidelines, meeting standing agendas and policies with a specific and intentional focus on equity and cultural responsiveness
15	**AGREE** that the practice of searching files (commonly known as "flipping files" within the service) cease immediately. The practice of searching client files to actively seek background information on māmā to effectively use against them (and done without supervised authorisation) results in detrimental effects on māmā, pēpi and whānau. This practice must be thoroughly investigated immediately in the maternity service. Senior Executive management must give notice to this investigation and alongside Human Resource legal advice, act to eliminate the practice in this service.
16	**NOTE** that whānau and staff have reported incidents of 'cruelty' in the way some wāhine Māori are treated particularly where they are young. This includes clinical trauma from receiving conflicting advice from medical and nursing staff (Doctor tells them to do one thing and Nurse tells them to do something else). Some wāhine also become fearful about their own privacy from over-hearing discussions by staff (particularly at nursing stations) about other wāhine and whānau in the unit. These incidents and behaviours have created fear, uncertainty, and frustration for many wāhine and their whānau and has led to mistrust in the service.
17	**AGREE** to more aggressively promote meaningful actions to implement and monitor the HBDHB Policy Position Statement on Institutional Racism. This should include making provision for an independent complaints or whistle-blower process that is safe for staff (and clients including wāhine Māori) to report incidents of racism within any service. Complaints within a service should NOT be reported to or managed by line managers within that service. Such complaints should be analysed by ward/unit and by site and trends be placed on the HBDHB Risk Register. Also consider a non-Māori trainer for non-Māori staff on confronting institutional racism and addressing their conscious or unconscious behaviours
18	**AGREE** to increase the number of Māori midwives working more actively in the Hastings maternity service so that at least 30% of midwives are Māori – including in leadership positions
19	**AGREE** to increase availability to staff of cultural supports, training and mentoring in Hauora Māori and regular cultural supervision
20	**AGREE** to improve the knowledge and understanding of HBDHB maternity staff to external Māori provider services and supports, to encourage referrals to services that can support hapū and new māmā on discharge

#	RECOMMENDATION
21	**AGREE** to review resourcing for the Wairoa maternity service to find further ways where more specialised services can be provided there (including telehealth) for hapū māmā to avoid trips to Hastings during pregnancy (e.g., scanning, contraception, managing gestational diabetes including telehealth options). This was particularly emphasised as a potential cost-savings to avoid charter planes of specialist staff to travel to and from Wairoa.
22	**AGREE** to improve confidentiality and privacy of wāhine and whānau by conducting handovers between midwives in private areas (not in public spaces such as nursing stations or at bedside in shared rooms)
23	**AGREE** to establishing a Māori reception/Kaiāwhina position for Waioha reception to provide a more welcoming culturally responsive entry to the service for all whānau but particularly for Māori who are more at risk of dis-engaging from health services
24	**NOTE** that Tiriti partnership relationships of the former Māori Relationship Board were identified as insufficient to represent a true partnership and that members who were interviewed felt their advice was either ignored or lacked influence to change or improve services [it is noted that a new Iwi Māori Partnership Board is being formed within the health reforms and will operate with the new Health NZ structure from 1 July 2022]
25	**NOTE** that several staff were unaware of 'client rights' as outlined in the Health and Disability Commission material, and therefore are not ensuring that all wāhine Māori are advised of these rights. Refresher training is required in this area
26	**AGREE** to update organisational linkage charts for maternity services to demonstrate the relationship with the DHB's Māori Health Services
Focussed workforce-related recommendations	
27	**AGREE** to a focused Māori Midwifery Recruitment and Development Strategy for Māori Midwives. Māori midwives and the HBDHB Māori health services must play a leading, consultative, and monitoring role in the collaborative planning for workforce recommendations to ensure the maternity services act cohesively for meeting the needs of the service in the future and work to eliminate the gap between current (workforce) status, to where the service needs to get to. This collaboration should provide co-development plans to bridge the gap, identify how to ensure the gap closes, and implement the actions.
28	**AGREE** to develop a focused Mainstream Midwifery and Maternity service staff Cultural Competency Development Strategy. This should include all Maternity service staff currently employed and those recruited from 2021 onwards. *(HBDHB Workforce Strategy 2019).*
29	**AGREE** to continued participation by all maternity staff in cultural safety training and competence. This must be coupled with the equivalent responsibility for all mainstream midwives and maternity staff to also undergo a planned and performance-measured programme of cultural competence, commencing with cultural safety training and Tūranga Kaupapa training. This training must then be followed up with the ongoing process of performance measurement in cultural safety to practice and applied in the annual staff performance appraisals for all staff in the DHB maternity services
30	**AGREE** to review recruitment and Human Resource processes to ensure they have the appropriate alignment with the HBDHB Te Tiriti o Waitangi Statement, policies, values, and

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	vision. Māori clinical, midwifery, and cultural expertise must be inclusive of these processes to demonstrate proactive recruitment of Māori to the maternity services.
31	**AGREE** to privilege Kaupapa Māori processes and skill base for positions in maternity services. This should be instituted as appropriate and acceptable where positions with direct and/or leadership contact and influence are congruent with the Māori population and client base in the maternity services
32	**AGREE** that the role and expertise within the Māori health services of the DHB and Māori clinical and midwifery expertise be included in the review and revamp of job descriptions, interview processes and panels, and scoring system for selection of appropriate candidates. This is particularly to strengthen inclusiveness of cultural competence alongside clinical competence for selected midwifery / maternity service roles including service and line management roles.
33	**AGREE** to establishing a system of facilitated, negotiated, relationship building between service leadership and management, and clinical staff in nursing, midwifery, obstetrics, and gynaecology. The ability to execute this needs to be a key performance indicator for any service management role in maternity services. Executive and service management must demonstrate leadership skills to address safety, equity, and the elimination of racist behaviour towards staff in maternity services
34	**AGREE** to create a system for supported clinical and cultural supervision and/or counselling of health professional staff to enhance their competency - clinically and culturally. Service line budgets need to be explored for inclusion of internal supervision costs (clinical and cultural) for maternity staff
35	**AGREE** to initiate mandatory maternity staff training in specific areas of: Te Tiriti o Waitangi – Articles and Application; Structural Analysis of institutional power sharing; Health Equity Assessment Tool (HEAT) applied to maternity services; Kahungunu History; and Cultural Safety - Tūranga Kaupapa
36	**AGREE** to review and improve the existing processes for complaints and mediation in maternity services by establishing a formal system for staff to make complaints; be provided with advocacy services if required; have their complaint acknowledged with a resolution for their complaint. Ensure the system keeps records that demonstrate robust management of risk and quality improvement that involves oversight and monitoring from both the human resource department and the quality improvement department of the HBDHB
37	**AGREE** that the system of improvement must have clear mechanisms that enable the workforce to uphold their professional ethics and codes of conduct. The system must be enabling of staff to invoke the Bullying and Harassment Policy of the HBDHB; the organisational Institutional Racism Policy; and there must be a clear pathway to escalate these processes to and through the Health and Disability Commissioner, and/or the Ombudsman.
38	**AGREE** to strengthen Māori leadership in maternity roles. The service must turn some attention to: • Development of a proactive recruitment policy of Māori leadership into maternity services

#	RECOMMENDATION
	• Apply the HEAT process by setting out a renewed pathway of reducing Māori health inequities in the maternity workforce with a monitored approach in achieving maternity workforce goals for increasing Māori midwifery in maternity services • Engage Iwi, Hapū and Whānau networks in the Heat process so that Kahungunu workforce goal setting is partnered with DHB goals in achieving this strategy. • Provide access to mentoring for Māori clinical leadership described as - *"..... like Te Ara Mana Pou, you need that tree to lean on until you grow yourself"* The proactive recruitment policy of Māori leadership into maternity services is most appropriately applied when Māori representation in the "hierarchy" of managing maternity services is actively sought AND every recruitment interview panel engages Māori representation from the outset of developing the role and job description; the criteria for appointing suitable candidates; the decisions on the appropriate candidate for the job, taking into consideration the cultural imperatives for the role and the population from which the maternity service client base is derived
39	**AGREE** to review the 'stop, start, more, less' feedback from staff (received from staff survey) as part of a quality improvement workshop and implement agreed actions from that framework: There are things we need to **STOP** doing: • Tolerating poor behaviour or violence towards women or staff • Discharging mums of babies in SCBU • That culture of discrimination based on where women live i.e., from Wairoa. Be better at introducing ourselves to all the whānau. Be genuine about finding out where they are from. • Antenatal clinic facilities are totally inadequate This has been flagged numerous times • Being judgmental. Providing care by tick box Things we need to **START** doing: • Valuing staff. • Providing more Māori and Pacifica midwives. • Providing seamless collaborative care with more communication with Obstetrics and Gynaecology specialists • Having well trained staff, educational days, Cultural and Clinical Quality care. • Quality focus Evidence based practice. Culturally appropriate care. • Have regular hui to kōrero about how we can make our service a safe place for tangata whenua where they feel at home. • Better support and coordination of social complexity e.g., accommodation for Wairoa families. • Providing options and support around personal, cultural decisions in the maternity journey. • Use Te Reo and pronounce names of baby, māmā and partner appropriately. Mandatory Tūranga Kaupapa one day course for all employees working at HBDHB.

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	• More antenatal visits in home for women. More te reo language and other cultural languages. • Provide all māmā with a support person who can stay 24 hours a day with them. Whānau rooms for family. Respect and cultural understanding when a baby is stillborn around the rites of what is important for the parents and whānau. • A physiotherapist on postnatal ward who is specialized in Birth injury and trauma. This is a huge area in inequity in Hawkes Bay and does not qualify for ACC. Things we should do **MORE** of: • Empower women to be active in their own health decisions. • Encourage waiata, karakia and other spiritual practices. Have a garden where we grow plants to aid healing - learn more about rongoā. • More interaction of those strong in Te Ao Māori within the unit. More obvious use of and teaching of the Meihana model. More use of Te Reo. More available chances to learn Te Reo. Facilitation of mihi whakatau for the arrival of new medical staff every 3 months to our unit. • Becoming more family/whānau orientated. We need to provide/support better whānau support and wrap around for our precious young mums and those families who are particularly vulnerable. I would like to see a better understanding of why some woman and families don't engage with us. What are their barriers, and can we help to mitigate these? • Consistent approach to violent language/behaviour better valuing of individual knowledge and skills • Better staffing levels. More education for existing staff to support around family violence, substance abuse and supporting social complexity. • I would like to see more time to process an emergency transfer to Theatre decision. A pause for timeout, to say a karakia. • I think there should be more learning opportunities when women, whānau and midwives can learn together. E.g., karakia, flax weaving etc • Time for one-to-one care with all women, not rushing from room to room… • Provision of the best care we can in challenging circumstances • Māori Midwifery Consultant, Wahakura, muka ties, some displays and posters supporting Māori culture and Te Reo. Breastfeeding support specific to Māori Whānau friendly practices. • Māori midwifery advisor. • Provide as much information as we can to keep women and their babies safe. i.e., safe sleep, becoming smoke free. Increasing the use of Te Reo in our workplace. Things we need to do **DIFFERENTLY:** • Better care planning for complicated cases with clear care plans around partners who can and can't stay etc.

#	RECOMMENDATION
	• We need to stop being so black and white in what we do and look at providing more individual care to the woman based on their needs rather than the unit as a whole...to do this we need more staff. • More social work supports. • Better breast feeding supports. More beds to accommodate longer stays • Better coordination and communication between LMC and DHB staff to put woman in the centre of care. • Listen reflectively and be ready to offer the services of Kaitakawaenga if the māmā feels shy about talking to me. Trust needs to be earned. Sitting quietly in the corner and waiting for her response may be all she needs before she has articulated what she wants from me. • Increase the number of obstetric and scanning clinics in Wairoa so women do not have to travel out of district for secondary care. • Make them all feel knowledgeable, empowered, and ready to head home. Not asking people to go home when we need their bed space.
Other Findings	
40	**NOTE** that: (a) although not within the scope of the review, the child uplift incident of 2019 remains a source of trauma for many of the stakeholders that were interviewed. As a result, several interviewees raised the incident and its impact on them personally and professionally. Since the matter was raised so frequently, that kōrero has been captured to honour the voices of those who shared their whakaaro. (b) Supervision or alternative healing support should be offered to staff impacted by that incident as the trauma has cultural consequences on the care provided to wāhine Māori
41	**AGREE** to institute a debrief policy and process for all staff involved in any adverse events or traumatic situations (including still-born births) and offer ongoing supervision, counselling for any staff who require it – not just for wāhine and whānau, but for involved staff as well. This is in response to the kawa that a whakawātea process is needed to make it 'noa' for those affected
42	**NOTE** that many internal and external stakeholders believe that "not much has changed" since that incident and the ensuing reviews, and that more must be done to improve the perception and confidence of staff and external stakeholders in the HBDHB maternity service and its interface with Oranga Tamariki. In fact, despite there being an uplift policy, our stakeholder engagement appears to show that interpretation of that policy has been variable by different leaders in the maternity service.

Executive Summary

Pinepine te kura, hau te kura, Whanake te kura i raro i Awarua

Context

The Hawkes Bay District Health Board (HBDHB) maternity service provides care to expectant parents throughout the pregnancy journey (prenatal, labour, birth and postnatal). The care provided can have a lasting effect on whānau. The maternity services are provided for parents residing in Hastings, Napier, Central Hawke's Bay and Wairoa through Lead Maternity Carers (LMC's) who are Midwives and Doctors, General Practitioners. Hospital and community settings are provided as venues for the birthing facilities for māmā, pēpi, and their whānau (mothers, babies, and their families) or they may choose to birth at home.

The ability to respond to the cultural needs of whānau, as well as their clinical needs, is imperative to ensure a positive experience and the best possible outcomes for māmā, pēpi and whānau. The cultural responsiveness review of HBDHB maternity services seeks to ensure the cultural responsiveness of maternity services to ensure the services are meeting the expectations of whānau Māori and the organisation. The work has been prioritised by the HBDHB and an Expert Advisory Group as a response to whānau feedback and following other independent reviews of a 2019 attempted uplift of an infant by Oranga Tamariki from the maternity services at Hastings Hospital.

The Review

The key objectives of the review are:

- To identify and recommend improvements to improve maternal and child outcomes for Māori parents and their pēpi who birth at HBDHB facilities, and
- To identify and recommend improvements to the understanding, practice, and behaviour of the HBDHB towards responding positively and effectively to the cultural needs of whānau Māori.

The findings of this review are therefore categorised to reflect and inform these two objectives.

In May 2021, an Expert Advisory Group (EAG) supported by the HBDHB to commission an independent cultural responsiveness review of maternity services delivered by the HBDHB. The review is overseen by the Expert Advisory Group comprised of Māori researchers, midwives, and Ngā Māia, as well as the HBDHB cultural and nursing advisors. The HBDHB supported and funded the review, and it is a high priority for the Board, Chief Executive, and management.

The Terms of Reference for the review specify that the findings will contribute to the "Population Health goal of improving the quality of care and cultural experience of women and whānau who use maternity services in Hawkes Bay".

Methodology

The review was conducted in the June to November 2021 period. The processes for the review were informed by Kaupapa Māori qualitative research methodology privileging whānau and Māori participants' lived experiences of maternity services in the HBDHB maternity service. The initial phases of the review

comprised of a Literature Review and Document Review, both of which were to inform the questions for the engagement phase, to provide opportunity to text or explore findings from those reviews. Stakeholder engagement included an online survey option for Lead Maternity Carers (LMCs) and HBDHB staff; face to face interviews (one-on-one and in small groups) and zoom/phone interviews with 22 whānau who had birthed in the HBDHB facilities in the prior two-year period; 43 HBDHB governors, Māori Relationship Board partners, managers, and staff, and thirteen external Iwi and community provider participants. A total of 78 interviews were conducted.

Raw data was analysed, and themes produced which were then categorised into themes aligned to the two key objectives described above. The Reviewers that conducted the engagement then reviewed the final analysis to develop a shared perspective and agreement on the findings, and to shape recommendations.

Experiences of Māori parents and their whānau who birth at HBDHB facilities

The maternity service environment for whānau

Some studies differ about the timeliness of Māori women engaging early with health services for maternity care. The literature confirms that they can immediately meet barriers from their first health service contact that can then lead to avoidable delays for them accessing a seamless maternity care pathway. Notably, maternity health professionals are not necessarily the first point of contact for the younger under 20yrs old Māori women seeking pregnancy confirmation tests. There is a lack of sufficient and appropriate information and support particularly for this younger population group of Māori māmā.

Another study found that timeliness of LMC engagement in New Zealand is poorer for non-European women, younger women, women in their first pregnancy, and women living in more socioeconomically deprived areas. It is agreed across these studies that overall improvement of the timeliness of LMC engagement for these groups of women has the potential to reduce inequalities in maternal and child health outcomes. Other barriers to accessing maternity services exist and these emphasise the service acceptability, cultural appropriateness, and colonialism of particularly, mainstream service provision. A positive alternative for consideration and implementation is the clinical and cultural fusion of culturally competent understanding and adherence to Te Tiriti o Waitangi (Kāwanatanga, Tino Rangatiratanga and Ōritetanga) combined with Kaupapa Māori and Mātauranga Māori within services delivered to Māori.

Vulnerable Populations

According to studies in New Zealand and internationally, marginalised, and underserved populations present concerns to many countries for their vulnerability to social, economic, and political disadvantage. Of particular concern are women generally and more specifically, those who are of child-bearing ages. Disadvantaged pregnant women and their infants are highly susceptible to, and suffer more from such areas as:

- Poverty and related issues
- Lack of culturally appropriate care and time constraints
- Health care providers and their routine practices sometimes posing additional barriers
- Insufficient communication skills or judgmental care delivered
- Not being given options/choices, information

All these factors were found to influence whether, women will access and/or utilise the full course of maternity care, or (in New Zealand) – the maternity continuum. Access to, and timely engagement in maternity care is shown to improve maternal and child health outcomes and is an important element of

healthcare performance measurement. This is also supported by feedback from mothers about their satisfaction with maternal care and was considered an essential component of quality (maternity) care.

This care provided by midwives also mitigates economic effects, e.g., income on postpartum depression, possibly through the social support system that midwives are able to provide and to help mothers build these support networks for themselves, sharing information, and allowing for longer periods of time to form relationships with their care providers can be effective in minimizing the effects of other disadvantages on pregnancy outcomes for māmā and their pēpi.

Midwives have an important role to coordinate and refer mothers for further support clinically such as utilizing appropriate interventions from mental health nurses, and other health care providers, or Lead Maternity Carers (LMCs) who can themselves offer home visits that minimize costs associated with transportation, childcare and other factors identified earlier as barriers to care, which can be critical tools to improving outcomes.

The literature affirms the need for increased integration of evidence-based resources, programs, and interventions into formal health care networks to demonstrate there is more seamless access and referrals for primary care providers and their clients that is advantageous for māmā and their pēpi. Organisationally, social policies that support integrative and holistic models of care, including those provided by midwives, and primary care nurses, are useful and can be supported and utilized as integral components of the health care system for all – including those who continue to face various forms of social disadvantage.

The experience of whānau

The overall findings from the engagement process are that hapū wahine and their whānau have highly variable experiences and outcomes from accessing the maternity services of the HBDHB. In some areas the service was noted as very good, with whānau feeling the midwives and staff were responsive, accessible, caring, and supportive. This was especially so for the Wairoa-based maternity service and the team there received multiple accolades from wāhine for their work. The experience of hapū wāhine accessing the Hastings service however was markedly different. The level of compliments for the Hastings service among Māori māmā was outweighed by stories of a poor experience, and many shared stories (māmā and their midwives) of māmā and whānau being subjected to a myriad of discriminatory practices that specifically target wahine Māori. This has significantly impacted their view of the HBDHB (Hastings) maternity service.

Māmā felt that the support for themselves and their circle of whānau during their pregnancy and birthing experience, was lacking. Some discussed the lack of information on their rights, the processes and decisions made about them and their baby with the whānau, and not being communicated with appropriately. Cultural needs were not consistently met – not just for Māori but for other ethnic groups as well such as Asian, Pacific, and Indian women. Many discussed the gaps that exist in cultural supports and referrals. Overall, there are significant variations between the HBDHB's Hastings and Wairoa services for wāhine and their whānau, resulting in variations of experience and outcome for whānau.

Among many of the Māori midwives, there was support for an independent Māori birthing unit that could serve the wahine living within the Kahungunu rohe.

Understanding practices and behaviours of HBDHB in responding to the cultural needs of whānau Māori

The literature review help to provide context on what is best - and poor - practice that impacts on Māori utilisation and experience of maternity services, and also that of other indigenous peoples as a

comparison. To complement the literature review findings, the review of DHB policies and procedures that was undertaken also highlighted a number of gaps.

Cultural Responsiveness

The literature confirms that best practice for cultural responsiveness is possessing the ability to be a culturally safe person who is delivering care. This person is described as one who has self-knowledge and self-identity, and who behaves respectfully when delivering their services to people who are not from their culture. Studies have also confirmed five possible domains of achievement of cultural competence for organisations that are focused on Māori. Whānau hapū and iwi are at the centre of these domains. These are in:

- Leadership and having a Māori decision-making presence at this level
- Accountability and having Māori consumers who have a voice in these forums
- Practice and having the workforce trained within the locality and focus of whānau hapū and Iwi
- Relationships and having members of whānau, hapū and iwi who are involved in decision making
- Workforce – and having Māori staff numbers in the organisation that are proportionate to the percentage of Māori population within the region or boundaries of services delivered by the organisation.

As the Māori population is nurtured and raised to be Māori in their own whānau, hapū and iwi kāinga, this will require a workforce that is equally equipped to serve this future client base. International literature presents measures for cultural competence that detail behaviours, attitudes, and values at the furthermost end of the continuum i.e., what a destructive incompetent practitioner / or organisation displays - through to the other end of the continuum i.e., what a proficient and safe practitioner / or organisation displays in behaviour, attitudes, and values. Ultimately, research has determined that institutional racism is often present and has been created by systems such as the health system, and it must be identified. It must not be ignored but eliminated because it is a health threat and an inequity that Māori suffer the most from.

The maternity service environment for Māori midwives

The Māori midwifery workforce is seen as another group of predominantly women, who themselves may experience their own inequities within the midwifery workforce and in services delivering maternity health care to Māori māmā', their pēpi and whānau. They are in severe shortage in the region (as well as nationally) and the Hawkes Bay District Health Board sees this recruitment area as one with particular challenges.

Review of HBDHB policies and plans

The review team assessed a range of documents including governance and management plans and strategies, organisational policies, maternity service and workforce policies and clinical policies. While some documents were very positive and affirming, there were several gaps identified. Some documents were explicit in their responsiveness to Māori with Tiriti clauses and whānau commitments. Other documents were generic and lacked any acknowledgement of Māori. There were no major flaws in the documents reviewed, but rather areas for review and improvement:

a) overdue dates for internal review on some of the documentation
b) updated language needed and reference to MOH Te Tiriti o Waitangi Framework (updated after Wai2575 findings) for the Treaty of Waitangi policy (and subsequent integration of this into Ngākau Ora training

c) overdue review date for the Multi-disciplinary Team Policy on Child Protection
d) some outdated plans

Documentation in governance and leadership was mainly a positive representation of the HBDHB commitments to Māori health, the Treaty of Waitangi and cultural responsiveness. There are gaps however in the policy guidelines that are implemented proactively to assess and review the status of child protection across the maternity services. Linkage to Māori Health services was not explicit.

There is well written documentation of maternity reports and plans submitted for review. These are updated and inclusive of Ngāti Kahungunu kōrero – on values, vision, aspirations, tribal hauora concepts, tikanga and cultural responsiveness. This is inclusive of both Māori authored and HBDHB service authorships. This indicates high involvement and engagement of iwi, hapū and whānau in the directions for the DHB services at strategic, planning and hauora Māori levels.

Job / or position descriptions were reviewed and there were varying levels of inconsistency throughout the job descriptions which lacked cohesion and standardization of common statements. The use of KPIs for cultural responsiveness is inconsistent across positions and should be applied to all employees. No currently active Risk Register documentation was reviewed from the maternity services, but templates were requested and supplied.

Positive feedback documents were provided from the staff training recently held in 2021 for the Ngākau Ora Staff Cultural Responsiveness Training; the COVID-19 lockdown impacts on Māmā and their whānau; and reports that included consumer comments and feedback in the services directly.

Findings from the engagement process on HBDHB practice

Engagement themes revealed significant variation despite commitment to provision of a culturally and clinically safe service for hapū māmā. There were challenges both for many Māori health staff within the DHB and for Māori providers and midwives working with the DHB maternity service – to support embedding more kaupapa Māori approaches that support hapū māmā. A culture of institutional racism was evident throughout the Hastings service, evidenced by many stories from whānau having experienced discriminatory behaviour. The Wairoa service however received a number of compliments, and most concerns were when the hapū māmā has to be transferred to the Hastings site to birth. There is inequitable representation of Māori at the management level of maternity services. There is also a lack of consistent inclusion of cultural supports, environments, training and mentoring around kaupapa Māori approaches to care, including insufficient referrals to kaupapa Māori services that could support hapū māmā.

The model of care at the Wairoa site was overwhelmingly supported by the midwives and team that work there, while several elements of the model of care operating at Hastings were concerning. Variations in provision of appropriate care that meets the cultural and clinical needs of wahine, mean that wahine receive a compromised service in Hastings that frequently subjects them to harm.

There have been vehement declarations made through not only staff responses to this review, but sadly with māmā responses as well. The Māori māmā that are meant to rely upon and trust the maternity services, have been subjected to a myriad of discriminatory practices that specifically target Māori women, from violations of privacy to targeted harassment.

These unjust practices have plagued Māori māmā and negatively impacted their view of the HBDHB maternity services and has resulted in them being actively fearful of falling pregnant again due to past traumas suffered and not wanting to relive their experiences.

Strengthening the workforce to provide culturally safe care

There is also a lack of consistent clinical and cultural supervision for staff with some saying they have never had either. The workforce urgently needs support in this regard, and this should be addressed immediately.

The HBDHB maternity service data indicates that 42% of women that give birth in Hastings are Māori, however the number of Māori midwives is vastly disproportionate. There are not enough Māori midwives able to cater to the Māori community. This problem extends beyond HBDHB and is recognised across the nation. Māori midwives bring to the table an understanding of culture, whānau structure, and manaakitanga for wahine Māori and their pēpi.

It was affirmed through the review interviews that the position of a Māori midwife cannot be undervalued due to their dedication to wahine Māori and cultural connection to the profession. The pattern of responses from the Māori midwives that have worked in the HBDHB maternity services has indicated that this institution has failed to aid and support them to conduct their work in a way that made them feel safe – both culturally and professionally. There is a demonstrable lack of insight into the values and practices of Māori culture that Māori midwives are trying to incorporate for the benefit of the māmā that they are caring for.

From June 2013 the proportion of Māori employed by HBDHB steadily increased from 9.9% of total staff numbers to 14.3% by June 2016 and as a stretch target was providing significant challenges to the DHB. No reports on this progress were sighted from 2017 up to 2021.

One of the aims of the HBDHB Midwifery Draft Maternity Leaders Workforce Strategy 2021-25 is to – *"Provide for equitable recruitment within a culturally safe working environment*." This involves a two-pronged approach that should be implemented to meet outstanding challenges that continue to face the DHB maternity services. There were inconsistencies and variabilities in where the responsibilities and accountabilities for Māori cultural responsiveness lay in each of the role descriptions plus, what these elements of responsibility were.

There was lack of cohesion and standardisation of common statements most job descriptions in DHB organisations tend to have. For example, Northland and Auckland DHB's, and the Ministry of Health document a Te Tiriti o Waitangi / or Treaty of Waitangi statement on their role descriptions and when advertising jobs especially of a senior, or prominent service position. These statements are usually in the front of the JD's and not buried amongst the task schedules or person specifications and provide a good indication of the kaupapa and stance the DHB wishes to portray to potential employees.

Some job/position descriptions reviewed had modifications made to them on the initiation of this review in August 2021. It is noted that job descriptions however minor the alterations or modifications, need to be alerted to any incumbent holding these roles and consultation must be entered into with the staff concerned before changes are made in their position documents. Some roles were noted to have appropriate key performance indicators or measures, other roles did not.

The majority of staff surveyed on their views about improving the maternity services highlighted there was definitely a need for improvements in maternity services. Feedback from both LMC's and staff generally in the maternity services indicates the lack of an adequate system for addressing and resolving issues of deep concern, from staff being bullied, feeling unsafe, being patronized, and judged.

Only one senior leadership position is held by a Māori midwife, and Māori staff who were interviewed expressed discontent with this.

A concern expressed by numerous staff members during the review was that the skills of Māori midwives were not fully recognized by the HBDHB Maternity Service. Rather it was felt that Māori midwifery positions were being used to "*create an appearance of diversity and equity to appeal to the Māori community*". For (Māori) staff, this indicated that the organisation showed a lack of commitment to improve pathways to leadership for Māori employees, particularly Māori midwives. It was also reported that Māori who were appropriately qualified were not being considered for promotions or higher-level positions.

The Māori midwives expressed concerns about the wellbeing and safety of the sole midwife with the senior leadership role at the HBDHB due to the lack of collegial support that was available. Although, having the position did improve experiences for whānau because it alleviated fears among whānau for reprisal over real or unresolved issues. The Māori LMCs unequivocally supported and collaborated with the sole midwife within the system. Furthermore, the most senior leadership within nursing and midwifery acknowledged that the lack of Māori leadership within the maternity service is a serious problem that needs to be actively rectified.

Other Review Findings

Impact of child uplifts by Oranga Tamariki on HBDHB maternity services

Although not a specific area of focus for this review, the media and public prominence of the 2019 attempted uplift of a newborn from a Māori whānau at Hastings Hospital, meant this issue repeatedly came up during the engagement process. The incident was mentioned by whānau (some of whom had experienced an uplift themselves), from LMCs, HBDHB staff and midwives and from external stakeholders. The matter has had a significant impact on everyone's perceptions of the maternity service and the HBDHB's perceived collusion with Oranga Tamariki to target newborns of whānau Māori. For these reasons there is a chapter in this report which captures this feedback to honour those voices.

Methodology

Scope of Review

Hawkes Bay District Health Board (HBDHB) maternity services provides care to expectant parents throughout the pregnancy journey (prenatal, labour, birth and postnatal), and the care that they provide can have a lasting effect on whānau. Services are provided in Hastings, Napier, Central Hawke's Bay and Wairoa. The ability to respond to the cultural needs of a whānau, as well as their clinical needs is imperative to ensure a positive experience and the best possible outcomes for māmā, pēpi and whānau. HBDHB commissioned this cultural responsiveness review of maternity services in order to ensure the cultural responsiveness of maternity services is meeting the expectations of whānau Māori and the organisation. This work has been prioritised as a response to whānau feedback, and the recent attempted uplift of an infant by Oranga Tamariki, that aligns with HBDHB policy.

To ensure the review considers and is responsive to the needs of Māori, this work requires partnership with, and input from, appropriate stakeholders who have expert knowledge that would contribute to the review process.

Kaupapa Māori approach

The review intentions were to examine how the HBDHB measures its cultural responsiveness utilising the three articles of Te Tiriti o Waitangi with an emphasis on

- Kāwanatanga – development, consultation and appropriate implementation and delivery of maternity services to Māori in the HBDHB setting.
- Rangatiratanga – will be explored and questions asked about what means of engagement of whānau, hapū and Iwi in the consultation and implementation processes exist? What level of control and governance do whānau, hapū and iwi have in the Maternity services space?
- Ōritetanga – how does the HBDHB measure its equity for Māori and when there is recognition of inequity what action plans are put in place to address these inequities from a Safety and Quality perspective? What is the timeline of review and target dates for completion of agreed action plans? How is accountability communicated up, and to whom?

Cultural and tikanga advice from cultural consultants Moe Milne and Henare Kani – who were key members of the Review Team – was essential to ensure an authentic and Tiriti-compliant process was applied in the review.

A Ngāti Kahungunu tikanga approach

The essential contribution and strong reflection of the Ngāti Kahungunu locus in which this review was carried out was provided by Ngāti Kahungunu Iwi Incorporated. This provided the emphasis for the review team to remain whānau-focused throughout the process:

> ***"Kōrero Mai Whānau"*** *– ".....is a way in which we can re-invigorate Te Parikārangaranga o Kahungunu; the echoing reverberating calls of our people to each other. Through Kōrero Mai Whānau, we have been able to talk to whānau about their aspirations, their dreams, their hopes but also about some of the trauma that they have undergone over the past few decades. For some, even further back into the past. We want this to be a continuous rumble of kōrero, of sharing the highs and the lows, as we reach all corners of our iwi, like we used to in the old days without cell phones and social messaging. Even though we now have the internet, Wi-Fi, Instagram and Facebook, there are still a lot of our people who are isolated.*

Kōrero Mai Whānau is a way in which whānau can come and talk to each other, talk to their peers, talk to their whānau, to their hapū and to their iwi and share in our own future. The soaring hawk was again a metaphor for our communicators who stood on the mountain tops and called to each other, with paua shell or Te Mata flint from which they were able to send signals to each other. Parikārangaranga is a gap between Kahurānaki, Te Mata and Kohinerākau. The echoing cliffs had actual form in those days, so when it was a clear calm day, you could hear each one calling. Te Parikārangaranga o Kahungunu: we need to hear the calls of our people, especially those who are in the shadows. We need to bring them out and hear their call". Ngahiwi Tomoana (p3)

"What is evident is that when our most vulnerable whānau (whānau pounamu) engage with government agencies, these systems and its application can severely impact on their wellbeing and that of their tamariki, increasing levels of vulnerability and trauma. In the worst of cases this practice can tear apart the ties that bind us and that is our whakapapa. Whakapapa is a fundamental central tenet for whānau whānui o Ngāti Kahungunu. Good health for whānau includes the physical, spiritual, and cultural well-being as individuals and collectively ensuring strong, healthy, and vibrant whānau, hapū and Iwi." ` Chrissie Hape, CE, Ngāti Kahungunu Iwi Incorporated

Literature Search methods

The research and review of broad literature topics were sourced through known websites and search engines: namely, Google.com; Google Scholar; PubMed Central Google Scholar; Amazon.com and SAGE.com, for clinical (maternity) and cultural needs. Further searches from these sources also provided ease of mining for equivalent indigenous and global contexts to our search words, terms, and concepts, such as: service access needs and gaps; maternity service provision and the clinical (maternity service) environment; cultural responsiveness, competence, and safety; Vulnerable populations, marginalized groups, and underserved populations; and impact of children removed from whānau by the State.

This extensive search resulted in a compilation of the references for each of the themes of the review. Information that was reviewed was sorted into four key themes:

(1) Maternity service provision and the clinical (maternity service) environment. Review of maternity services information was an essential link for determining the HBDHB cultural responsiveness in the maternity services across the Kahungunu rohe. These particular reviews were designed to assist our search in finding out what the HBDHB expects should happen within the organisation based on the policies it has set, and the procedures it has developed.

(2) Cultural responsiveness and understanding competence and safety. This included Information on (Māori) perceptions and experiences of health and disability services, particularly maternity services, and Oranga Tamariki services. The searches incorporated patient/client experiences of care, satisfaction with care, perceptions of care, the health of vulnerable population groups, and Māori health. Cultural Research Publications and Media: The following sources were identified: Cultural research/publications, youtube.com, NZ Television Documentaries (e.g., Marae, Hui), NZ Government websites and utilisation data from researchers with attention to the Ministry of Health and Oranga Tamariki research data were accessed. The literature provided information on (Māori) utilisation, perceptions and experiences of health and disability services, particularly maternity services, and Oranga Tamariki services. The searches incorporated patient/client experiences of care, satisfaction with care, perceptions of care, and health of vulnerable population groups, and Māori health. Additional to the published literature, related data, and information from acknowledged Māori experts, Māori researchers, Theorists, Authors,

Academics, and contacts of the Consultant Consortium, were duly sourced and are an ongoing exercise throughout the review process for any additional key trends and patterns

(3) Vulnerable populations being the marginalized groups and underserved populations. This included Information on Māori consumer experiences of disparities and inequities as Māori are identified as having greater and more persistently unequal access to appropriate health services than their non-Māori counterparts. The searches incorporated the timeliness of engagement of pregnant Māori women and their full use of the existing maternity education and care pathways for their hapūtanga. The literature provided information on areas such as: The social impacts of inequities in maternity care on marginalized groups of women in New Zealand and abroad; the influence of midwifery on birth outcomes; and strategies that successfully minimize or lead to the elimination of inequities in maternity care.

(4) Taken Children and the role of the delegated health authorities of Aotearoa New Zealand. Major existing and published Inquiry Reports were viewed as important to inform, but not to duplicate, so much as reinforce and/or enhance this review. The cultural responsiveness of maternity services has relevance to the colonial practice of taking children from their families, including newborn pēpi, when they are deemed by the Ministry for Children to be at risk of harm. The literature searches in this area included an historical overview of other jurisdictions who practiced this method as a process of colonisation, namely Australia, America, and Canada. The information on this was clear and although it eventually was included in New Zealand's history of colonisation, the forcible removal of children was not practiced to the same level as in other countries. However, this did not absolve New Zealand's other abusive and violent historical practices such as the removal of the native language, culture, medicines, cultural practices, and lands of the Māori.

It was evident from the literature that all of these practices duly and devastatingly affected Māori in the exact same way that it did other indigenous nations. Suffering affected the individual and collective whānau – with feelings of loss of identity; their tinana – with suffering higher levels of poor health and socioeconomic outcomes; their hinengaro – with high rates of depression, anxiety, post-traumatic stress, and suicide; and their wairua – with disproportionately higher levels of domestic abuse and violence. The New Zealand delegated authorities for the social wellbeing of Children (Ministry for Children, Oranga Tamariki); and for health (Ministry of Health and District Health Boards) have regulated and unregulated systems of high-level scrutiny (one example: the Simpson Report 2019) on their current practices to ensure standards of health, wellbeing, safety, quality, cultural competence, and overall public accountability are being sustained. The literature also includes sentinel changes that are afoot in both these areas where Waitangi Tribunal Reports (Wai 2915, 2021; and Wai 2575 2016-18) and Legal (Ombudsman Report 2020) and Commissioner (Children's, 2020) opinions have recognised that Rangatiratanga for whānau, hapū and iwi must definitely come closer to within their grasp, and the Crown partner must remain on notice to improve its responsiveness and (cultural) competence.

Document Review Methods

Documents were provided by the Hawkes Bay District Health Board that outlined and described strategic and operational functionality of the DHBs processes and planning for delivery of their health services. The documents were sorted into three categories that include:

1. Governance and Leadership in relation to cultural responsiveness

2. Workforce and Service Documentation; and
3. Maternity Services and Quality (inclusive of both Maternity and Māori health models and systems for delivery).

The full list of documents that were reviewed can be found in the appendix.

In order to assess documented expectations of the maternity staff and services, an array of documents were reviewed in three categories: governance and leadership; workforce and clinical review of maternity services. The review included documents such as internal policies, reports, governance papers, templates, and surveys. In total 51 documents were reviewed, and a full list of all documents can be found in the appendix. A tool was developed with criteria that was used to test each document. The criteria sought to understand the cultural responsiveness of the document by checking the:

- Strengths: where commitments to Māori and Te Tiriti o Waitangi were explicit
- Weaknesses: where there was limited recognition of commitments to Māori and Te Tiriti o Waitangi

An assessment was then made as to any improvements that could be suggested. The documents were read and summarized to identify alignment with the aims of the review and any not considered relevant to the goals of this review, were then identified, and removed from the more thorough review.

Those documents that were considered relevant were then identified for strengths and weaknesses and an overall conclusion drawn on the appropriateness of the document to support and guide the DHB's capacity, capability, and responsiveness particularly to Māori whānau in the maternity services.

Each document was reviewed to identify its strengths, weaknesses using the following analysis:

Strengths	Weaknesses	Assessment
Identifies whether the documents are culturally responsive by acknowledging: - Status of whānau, hapū, iwi as tangata whenua - Te Tiriti o Waitangi - Māori cultural practices; and - Encouragement for opportunities to be flexible to respond to the needs of Māori.	Identifies any absence of, or limited recognition of, cultural responsiveness for Māori within the document content. For instance - some documents may be too generic and lack specific recognition of Māori needs.	Comments are offered from the review of strengths and weaknesses and suggestions made for where improvement can occur. Reviewers also looked for consistency in statements / commitments across documents

Stakeholder engagement Methods

Design of questions and collateral

Proposed questions to draw out information to respond to the objectives were developed, including questions for two surveys to LMCs and HBDHB staff as well as questions for interviews with target participants. The review team were interested in speaking with all staff willing to take part in the review, however due to time limitations and clinical obligations of the staff, online digital surveys were developed to capture feedback from as many maternity staff as possible. The questions were informed by the previous document review of HBDHB policies and documents, and the literature review. Questions explored what was being done in practice to compare with what was expected to be practiced or applied from a clinical, cultural and consumer perspective. The subset of questions was developed in the online

surveys to determine organizational culture, values, and systems to gauge where the organization was in the present day. Further to examining organizational insights, motivation, and willingness for change.

An Information Sheet for participants and Consent Form were also developed. These were reviewed by the Expert Advisory Group (EAG) as well as the HBDHB. It was decided to "name" the project Hau Te Kura in order to market the surveys and produce a poster that would encourage people to complete the survey and/or participate in the project. The Information Sheet and Consent Form were reviewed internally within the HBDHB for ethical alignment. See appendices: Appendix 1 (All Maternity Staff Survey HBDHB) Appendix 2 (LMC Survey external) Appendix 3 (Hau te Kura Flyer). The surveys could be accessed by the use of QR Codes, or by handwritten versions of the online survey, or emailed links.

Once approved these tools were used to begin the engagement process.

Engaging Stakeholders

Two methods were employed to engage with the target audiences – the online survey for Lead Maternity Carers (LMCs) and HBDHB maternity staff, and a face-to-face interview process. The poster was distributed in both the Wairoa and Hastings sites to encourage survey completion and recruitment of participants. The review team developed a schedule of target stakeholders that could be engaged in the period 20 September to 1 October in Hawkes Bay. Appointments were organised with the assistance of a Coordinator at the HBDHB including facilities for zoom hui where Covid impacted travel, or timing prevented face to face meetings.

Engagement with internal and external stakeholders (including whānau) utilised the pre-approved questions to guide all interview conversations. Participants were assured anonymity through the consent process and that no names would be used throughout the process.

All interviews were recorded (with consent) and transcribed into word documents verbatim. The recordings and transcriptions were saved into a secure (password) Dropbox file for use by the review team only. These files are now held by Kāhui Tautoko Consulting who also now hold the signed consent forms. To privilege the voice of whānau and the participants, as many verbatim quotes are used as possible to support key themes.

Participation Levels

At the time of the review there were 47 available FTE (Full time equivalent) Midwifery/Nursing workforce employed by the Maternity Services Hawkes Bay District Health Board (no. of vacancies unknown).

Surveys

The review team received a total of 13 responses to the HBDHB maternity staff survey with 10 responses being from non-Māori and 2 of the 12 being from Māori. One did not identify.

Figure 1: Ethnicity of HBDHB staff respondents

The review team received a total of 8 responses to the LMC survey with half of them being from Māori. All responses were from Hastings-based LMCs and none from any other Hawkes Bay areas responded. At the time of the review there were 53 Lead Maternity Carers in the community, so this was a relatively small sample (15%).

Figure 2: Ethnicity of the Lead Maternity Carer respondents

Interviews

Internal stakeholders who were interviewed included (n = 43)

- **Strategic Governance Leadership**: Internal DHB key informants from HBDHB Board, representatives from the DHB's former Māori Relationship Board, CEO and senior/executive management, service (maternity) management and operational leadership
- **Executive Operational Directorship**: The executive management levels of the HBDHB were selected for interview. This included Operations, Māori Health, Finance and Commissioning, Health, Quality and Safety, Clinical Maternity and Midwifery Leadership and Cultural Leadership
- **Lead Maternity Carers and Midwifery staff of the maternity facilities**: Midwives, Nurses, Managers, Kaitakawaenga

External stakeholders who were interviewed included (n = 13)

External stakeholders were drawn from the range of organisations, individuals, providers, and groups (Mainstream and Māori, Government, and non-Government) from across the Hawkes Bay DHB catchment areas of Te Wairoa, Ahuriri, Heretaunga and Tamatea. This included:

- **Iwi, hapu:** Ngāti Kahungunu Iwi Incorporated (NKII) organisation that represents Whānau, Hapū and Iwi,
- **Providers / NGOs:** Waipatu Marae – Mamia; Whanake Te Kura – Antenatal birthing wānanga; Tuai Kōpu – HBDHB; He Korowai Aroha – Kahungunu Executive; Plunket Society / Nurse; HBDHB Maternal Mental Health service; Smoke free Public Health Service; Wairoa Young Achievers; Teen Parent Unit at Flaxmere College; Te Taiwhenua o Heretaunga – Leadership and Services from Tamariki Ora, Te Whare Pora; Whanake Te Kura, Family Start; Te Kupenga Hauora – Family Start, and MDT membership – all the Provider Managers, Coordinators, Team Leaders, Midwives, Nurses, Social Workers and Support Workers

Whānau: Māori Service Users / Māmā and whānau (n=22):

The target was top achieve a sample of 25 whānau who have birthed at the maternity services in the last two years. These were randomly selected by the HBDHB from its database, and HBDHB staff then sought consent from the sample whānau to have them meet the Review Team. Times were arranged for appointments at Hastings or Wairoa when the review team was scheduled to be on site. This process deliberately privileged Māori māmā and whānau voices and was based on a brief analysis of the Māori population distribution across Central Hawkes Bay, Heretaunga, Hastings, Napier, and Wairoa.

The Review team suggested a sample of 25 whānau who have birthed at HBDHB in last 2 years that would be randomly selected (all Māori). Based on a brief analysis of (Māori) population distribution across Central Hawkes Bay Heretaunga, Hastings, Napier, and Wairoa. The table below shows the planned whānau numbers and the actuals completed:

Figure 3: Target and actual whānau participants

2018 Census	Total population	Māori population	% Of total Māori population	Target whānau sample	% Of sample	ACTUAL PARTICIPANTS
Central HB	14,142	3,351	7%	2	7%	2
Hastings	81,537	22,269	50%	12	50%	8
Napier	62,241	13,800	31%	8	31%	6
Wairoa	8,367	5,493	12%	3	12%	6
TOTAL	**166,287**	**44,913**		**25**	**100%**	**22**

A final number of 22 whānau from across the region were interviewed in their homes, at Wairoa hospital, in Hastings at Waipatu Marae, Mamia (where whānau were also in support of participants), Napier Plunket Rooms, in Tangoio, Raupunga and at Te Taiwhenua o Tamatea in Waipukurau. Although the records show 22 individual whānau, there were several māmā and whānau members at the Mamia site visit, who participated in the kōrero. Their views are captured in this report.

Other whānau/māmā were also interviewed in various forms of communication with the rest of the Review Team by zoom, and phone calls. Reviewers travelled to wherever whānau were comfortable to meet with them and share their stories. Community Lead Maternity Carers (LMCs) also referred māmā that had expressed a desire to speak to the review team on their experiences of cultural responsiveness when accessing the Maternity service at the HBDHB.

Analysis and Reporting

The results from the literature review and stakeholder engagement were analysed against the main domains of the review specified in the terms of reference. Data and notes have been aggregated for this report.

The results from the engagement process documented in the surveys and the transcriptions were sorted into (a) whānau interviews (b) external stakeholder interviews and (c) internal HBDHB interviews. Information was mapped to the two main objectives: whānau experience and HBDHB practices, and then themes from the questions were developed to identify the main findings. The survey data was analysed and has been included with the interview data. All information was then sorted to align with the two objectives, and common themes from all interviews and surveys grouped around these themes so that comparisons could be made across different stakeholder groups.

The draft report was presented to the HBDHB and EAG in person on 14th January 2022. After feedback was received from the HBDHB and EAG, the final report was completed on 21st February 2022.

Limitations of the review

Delays receiving full documentation early in the project

The primary challenges experienced during this process included delays in receiving documentation from the HBDHB which then meant most document analysis was done simultaneously with the start of the engagement process. The team's original review plan expected to have completed the document review well before the engagement process, in order to inform the questions so that the findings could be fully tested during interviews with stakeholders. While questions to stakeholders did in fact cover the

application or knowledge of strategies, policies and guidelines, a specific link could have been developed if the document review could have been completed before engagement began.

Survey responses

The review team was disappointed with the response rate on the LMC survey and despite extending the date and undertaking more promotion through the HBDHB contacts, the numbers did not increase markedly. There was also some anecdotal feedback that some LMCs were reluctant to complete the survey and in fact some had approached their Union to check whether they were obliged to complete the survey. Promotion and showcasing of the review was somewhat limited as feedback was that some staff were not told about its availability. This further delayed completion of the survey.

Maternity service provision in NZ and the clinical environment

Ko te kura nui, ko te kura roa, Ko te kura o tawhiti nā Tūhaepo!

A picture of the current maternity system

Maternity services are delivered predominantly by midwives in the New Zealand health sector who are identified as Lead Maternity Carers (LMCs). Some General Practitioners are also chosen by women as their LMC. The Midwifery Council of New Zealand, Te Tatau o te Whare Kahu, conducted a Midwifery Workforce Survey in 2020 which revealed that:

- There were 3,274 midwives who held an annual practising certificate in 2020
- The midwifery workforce was almost completely female, and their overall average age was 46.65 years old
- The midwifery workforce was predominantly European/Pākehā making up 84.79%.
- Midwives identifying as Māori were 6.72% (220) and midwives who give 'New Zealand Māori' as their first, second, or third ethnicity was 10.26% (336).
- The average time midwives stay in the workforce is 14.97 years.
- 38.15% of midwives (1,249) reported case-loading as their main work situation
- The majority of these were self-employed / independent LMC midwives (1050) who make up 84.07% of the case loading midwives and 32.07% of the overall midwifery workforce.

There is a significant deficit in the number of Māori midwives who can care for Māori women. The Ministry of Health pledged a $6 million package over four years to help increase recruitment and retention of Māori and Pacifica midwifery students. This is one of several areas of reform needed to support Māori women and their whānau.

The New Zealand Public Health and Disability Act 2000 has some key objectives that relate directly to maternity health care and service provision[1]:

- Improving, promoting, and protecting the health of people and communities. This relates directly to maternity health care and service provision to Māmā and their pēpi.
- Promoting the integration of health services, especially primary and secondary care services. This relates directly to services provided by primary care and hospital Midwives and other lead maternity carers.

The National Maternity Monitoring Group (NZ Ministry of Health) identifies specific standards that should underpin maternity service provision:[2]

- Standard 1: Safe, of high quality, and achieve optimal health outcomes for mothers and babies.
- Standard 2: Ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage, and

[1] https://www.health.govt.nz/new-zealand-health-system/

[2] https://www.health.govt.nz/our-work/life-stages/maternity-services/national-maternity-monitoring-group

- Standard 3: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately, ensuring there are no financial barriers to access for eligible women.

HBDHB Profile

Hawke's Bay DHB funds and provides services for nearly 165,000 people living in the Hawke's Bay region. The DHB currently employ 3050 people: 16.9% Males; 83.1% females. The majority of the workforce for the HBDHB in age bands are in the: 45-55yr olds at 26.3%; followed by the 55-64yr olds at 24.2%. Lower proportions of the workforce are seen in the 25yr olds (2-.2%) and the 35-35yr olds (17.7%). The largest occupational group in the workforce are Nursing staff, 51.0%; Allied Health staff, 18.2% and Management and administration staff, 15.6%. The Medical and non-clinical staff make up: 9.1%, and 6.1% respectively. Ethnicity positions and proportions for the HBDHB workforce are shown in the table below:

Figure 4: HBDHB Workforce Ethnicity

Ethnicity	Positions filled	% of Total
NZ and European	2404	71.6
Māori	506	15.1
Pacific Islands	47	1.4
Asian	240	7.1
Other	115	3.4
Not known	48	1.4
Total	3360	100.0

Source: Hawke's Bay District Health Board Annual Report 2018/19 p.5

The Māori Health Plan for the HBDHB 2016/17 noted the general intention in Hawke's Bay to increase the Māori workforce across all government agencies, and a district priority for Health Services to increase Māori staff representation in the health system. As of June 2013, the proportion of Māori employed by HBDHB was 9.9% of total staff numbers. This was increased incrementally to 14.3% by 30 June 2016 and as a stretch target, is still providing significant challenges to the DHB. It is a challenge the (HBDHB) are up for and are focused on increasing Māori staff representation in Nursing and Allied Health. (*P.23).*

The process of birthing at hospital

Lead Maternity Carers (LMCs) provide care to women within maternity facilities under a generic access agreement under Section 88 Notice[3]. The maternity facilities provide a certain level of service to women birthing in the facilities and a certain level of support to the LMCs. Most primary maternity facilities and all secondary and tertiary facilities employ midwifery staff, who provide core midwifery services to women in their facility (and who are often referred to as 'core' midwives). This includes 24-hour care to women and babies in the facilities and working in collaboration with LMCs. The Health Quality and Safety Commission provides reassurance over the safety of New Zealand maternity care[4].

[3] https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/

[4] https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/news-and-events/news/2654/

If a woman chooses to birth at a hospital or her overall health and wellbeing of herself and her baby would be safer birthing in a hospital environment, then she will be admitted once she is in established labour. The LMC attends the labour and birth and fulfils obligations to the woman for her birth plan and obligations to the DHB outlined in a '*schedule 3 Access Agreement*' between the facilities and the lead maternity carer. However, the LMC will at some point hand over care if she exceeds the hours to safely continue to be the lead maternity carer and she either hands over to her LMC partner or the core midwives while she goes home to rest.

After the LMC partner has exceeded hours for safe practice or the woman has birthed, care is handed over to the Core Midwives usually in the post-natal period. The woman is supported by the core midwives to learn how to breastfeed. Core midwives support women with changes after birth and encourage rooming in and attachment and bonding for mother and baby. During this time the core midwives take shift-by-shift observations of mother such as blood pressure, heart rate, oxygen saturation levels, maternal temperature, monitor PV blood loss, and provide education on how to care for herself and her newborn in the immediate post-partum period. The midwife conducts observations on the neonate checking heart rate, temperature, respiratory rate, tone, and colour to observe baby's transition to extra-uterine life. Most plans of care are made in partnership with the woman, LMC and the core midwife. And discharge from the facility is discussed with the woman, her whānau and support people usually in the antenatal period with flexibility to modify plans based on acuity of mother and baby.

Barriers to equitable maternal health in NZ

In a report on barriers to equitable access to maternal care[5] the writers identified six integrated factors:

1. Physical Access
2. Political Context
3. Maternity Care System
4. Acceptability
5. Colonialism
6. Cultural factors.

They noted that the structure of the maternal health system in New Zealand, which includes free maternity care and a woman-centred continuity of care structure, should help to ameliorate inequity in maternal health and yet does not appear to. A complex set of underlying structural and systemic factors, such as institutionalised racism, serve to act as barriers to equitable maternity outcomes and experiences. Initiatives that appear to be working are adapted to the local context and involve self-determination in research, clinical outreach, and community programmes.

It was determined that the combination of these six social determinants is specific to New Zealand; creates a unique set of challenges in addressing inequity; and those localised solutions have potential to further maternal health equity.

[5] 'Barriers to equitable maternal health in Aotearoa New Zealand: an integrative review': http://creativecommons.org/licenses/by/4.0/

Other countries also experience similar challenges with achieving equitable access to their indigenous Maternal and Child Health services. For example, in a 2019 report from Queensland Australia[6], three key priorities were identified by Aboriginal women, which reveal the desire for improvements in care:

- Priority 1 "We want a say in how maternity services are designed and delivered"
- Priority 2 "We don't want to keep telling our same story to different people
- Priority 3 "We want more of our people providing our maternity care

Another study in Western Australia[7] surveyed the corrosive effects of institutional racism on indigenous women in the Maternity Care system. Referring to organisational policies and procedures that further marginalised Indigenous women then in turn, contributed to poorer health outcomes beyond the perinatal period. Interestingly non-indigenous participants in the Australia study did not widely recognise institutional racism but cited many examples of stereotyping, negative stories and systemic practices which 'appeared' to discriminate against Aboriginal women. There is a plethora of research citing the importance of empathy, reflective practice and supporting Women's choices. Although this is recognised world-wide women continue to report negative experiences in Maternity Care.[8]

There has been little discussion in the literature about handover of maternity care. In a study in the Netherlands[9] women surveyed reported hospital clinicians had less of an understanding of factors impacting the individual when entering into the hospital care system. Further, participants surveyed reported that reluctance existed with hospital clinicians to contact the continuity of care provider in order to clarify information to continue care in the hospital setting. Participants reported feeling disadvantaged by this reluctance.

The need for fusing clinical and cultural practice

New Zealand researchers[10] debated the need to forge innovative models and strategies and their study explored the inequities in current maternal infant frameworks. They framed their study around the 3 articles of Te Tiriti o Waitangi, Kāwanatanga, Rangatiratanga and Ōritetanga and presented the values of mātauranga Māori and Kaupapa Māori to the maternal clinical environment, thus offering the fusion of clinical and cultural practices harmonising and balancing the appropriate maternal care and support to māmā and their pēpi, particularly in the immediate post-partum period.

Defining cultural competency, responsiveness, and safety

Cultural responsiveness is a set of behaviours, attitudes and policies that come together to enable a system or professional to work in cultural situations[11]. Cultural competence goes far beyond the golden rule – treat people as you would prefer to be treated. that works only when someone wants to be treated the same way as you[12]. Family and Community Services (FACS) New South Wales[13] further published a cultural capability framework under the following domains:

[6] Growing Deadly Families" Maternity Services Strategy (Australia) 2019 – 2025
[7] Thackrah, Wood, & Thompson, 2021
[8] (Swordy, Noble, Bourne, Van Lessen, & Lokugamage, 2020)
[9] van Stenus, Poorthuis, & Boere-Boonekamp, 2020
[10] Stevenson, Filoche, Cram, & Lawton, 2020
[11] Aragaw, Yigzaw, Tetemke, & G/Amlak, 2015
[12] Patricia Santiago-Munoz MD Obstetrics and Gynaecology 2019
[13] Family and Community Services FACS, 2017
https://www.facs.nsw.gov.au/__data/assets/file/0007/592234/Aboriginal-Outcomes-Strategy.pdf

- Clear accountabilities throughout the organisation, led from the top
- A mandatory program of online and localised face-to-face Aboriginal cultural capability training for staff across FACS.
- A mobile app to share resources and facilitate staff engagement and relationship building with Aboriginal people and communities.
- Measures to increase Aboriginal staff in FACS, improve Aboriginal staff retainment and make FACS a culturally safe place for Aboriginal people to work.

The Aboriginal Cultural Capability Framework was developed to facilitate (FACS) staff to better develop their understanding of Aboriginal cultures and assist staff to build strong relationships with Aboriginal people, organisations, and communities in their districts. *(p.10)*

Māori cultural responsiveness has been defined as "*an awareness of Māori cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds.* In this MidCentral District Health Board report[14] notes that "Māori cultural responsiveness is about the acquisition of skills and knowledge to achieve a better understanding of members of other cultures – citing Durie, 1997p9. Professor Sir Mason Durie noted that a failure to appreciate the impact of culture on clinical realities has often led to misdiagnosis and mismanagement among ethnic minorities. Māori cultural responsiveness is central to improving Māori health and require a commitment by primary health care providers to ensure culturally responsive health care practices. Further to this is the development of the DHB's Māori Health Responsiveness Framework, T*e Ange Aroturuki Hauora Māori.* The framework is intended to enable a strategic approach to Māori health development that supports informed planning, policy development, service purchasing, service delivery, and monitoring.

A 2015 Australian study[15] proposed a cultural responsiveness framework for healthcare organisations to deliver culturally responsive services to cultural and linguistically diverse (CALD) clients. They strongly recommended a move away from cultural competence and towards cultural responsiveness, due to the variability of definitions, the complexity of its dimensions, and the different levels of understanding of the term across the health sector. They believed it enabled a less technical, more concrete method of responding to (CALD) patients at both a relational and institutional level. It also enabled the addressing of broader social determinants of health and that the cultural responsiveness framework was sufficiently broad in scope to address the tacit and overt nuances at both the individual level and the systemic level. These dimensions are reflected in the following diagram:

[14] http://www.midcentraldhb.govt.nz › documents PDF

[15] https://diversityhealthcare.imedpub.com/developing-a-cultural-responsiveness-framework-in-healthcare-systems-an-australian-example.php?aid=1830 . Gurjeet K Gill[1*] and Hurriyet Babacan, 2015

Figure 5: Cultural responsiveness framework

Figure 1 Cultural responsiveness framework in healthcare systems.

Cultural responsiveness is often identified as a strategic means of responding to people within the context of their own cultural background (see Figure above). It is intended to be more responsive than cultural competence because it encourages response to situational applications of cultural knowledge and is less technical in nature. It has emerged as a challenge in person-centred planning processes, and incorporates diverse elements, including relationships, self-awareness, safety, and identity[16]. Cultural responsiveness includes cultural safety, which is defined as '*safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need'*, where there is '*shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening'*[17]. Overall cultural responsiveness is a highly reflective learning process that aims to bring about behavioural changes and practice improvements. Incorporating different dimensions of culture into healthcare, it can be used as a framework for a political response to marginalisation and addressing health inequalities[18]. The writers built on the National Health and Medical Research Council[19] model and the framework of others[20], and extended it to include cultural diversity and propose the following definition:

> *"Cultural responsiveness is an outcome of an organisation's ways of managing cultural diversity by achieving cultural competence through relevant policies, procedures and resources"*

The writers further state that in order to deliver culturally responsive healthcare, health services need to create and maintain a particular kind of organisational culture that features well-resourced cultural diversity management systems and practices, a culturally responsive workforce, culturally responsive service delivery systems and informed clients.

The Bay of Plenty District Health Board in partnership with Te Rūnanga Hauora o Te Moana (the mandated Te Tiriti partner) seized an opportunity and developed a whole of system transformation to improve the well-being of Māori within their district through the Te Toi Ahorangi strategy[21]. The

[16] Williams, 2007
[17] Williams, 1999, pp. 213–14
[18] Johnstone and Kanitsaki, 2007
[19] NHMRC 2006
[20] Werkmeister-Rozas and Klein 2009
[21] Keelan & Porter

strategy encompasses five determinants of – Toi Ora, Mana Atua, Mana Tupuna, Mana Whenua and Mana Tangata that underpins their worldview. It aims to support whānau to exercise their mana, which will enable their mauri to flourish. *Te Toi Ahorangi* utilises wayfinding to nest their strategies giving clear direction and timelines that they intend to achieve this transformation. Te Toi Ahorangi acknowledged its challenges and has prioritised and named them Te Oranga Mokopuna, Toi Oranga Ngākau, Toi Oranga Ake, Toi Oranga Whānau and Toi Oranga Tikanga.

Domains in developing cultural responsiveness

Cultural responsiveness in its inception is reasonably easy. In its development it requires commitment and accountability from the frontline to the most senior positions in health. Literature suggests five domains for consideration in the development of cultural responsiveness

- *Leadership*[22] – Māori are recruited to senior decision-making positions in the organisation and non-Māori leadership partner with whānau, hapū and iwi to improve outcomes for Māori. Leadership has a critical role in changing culture and implementing reform. The decisions they make, what they attend and ignore are mirrored throughout the organisation
- *Accountability*[23] – Organisation's report to whānau, hapū and iwi on how they are performing against a mutually agreed key set of indicators. From their frontline to their Executive
- *Practice*[24] – All staff regardless of role engage in local cultural capability training and report the organisation compliance monthly
- *Relationships*[25] – Members of whānau, hapū and iwi are involved in decision making processes. Consumer engagement at every level
- *Workforce*[26] – Māori staff are targeted proportionate to the percentage of Māori people accessing the service. Measures are implemented to increase Māori in Management and Executive streams

A Cultural Competence Continuum[27] is proposed by Cross et al:

- Cultural destructiveness: The imposition of foreign and damaging systems, actions, and policies (e.g., reservations, industrial schools, etc.) with the intended outcome of disruption or destruction of existing cultures and structures.
- Cultural incapacity: The ongoing withholding of recognition and respect for the cultural structures of the client or the client's community or population.
- Cultural blindness: The deliberate act of development and delivery of programs and services in a manner that pretends that "culture does not matter" or that seeks to treat all clients "equally."
- Cultural pre-competence/cross-cultural care: The recognition that culture does matter and that the culture of a particular client or community may be different from that of the service provider.
- Cultural competence: Awareness of one's own culture and the culture of clients and communities, and how these will impact the health and healing relationship being developed. Culturally competent care will be as congruent as possible with the culture of the client under consideration.

[22] Stevenson, Filoche, Cram, & Lawton, 2020
[23] Tupara & Tahere, 2020
[24] Tupara & Tahere, 2020
[25] Keelan & Porter
[26] Tupara & Tahere, 2020
[27] Adapted From the National Center for Cultural Competence); *T Cross et al 1989 & PowerPoint presentation. http://www.diversityRx.org. 2002.*

- Cultural safety: Complete congruency between the culture of the person seeking services and the services provided. This would be seen as a goal for all health systems and all clients but, for the most part, would be a continuous and iterative process to be striven toward and not necessarily an end result in and of itself.

An overarching concept necessary for the creation of cultural safety in health services and systems is the willingness of health care professionals to develop, implement, and internalize the idea of cultural humility. Cultural Humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. It can be seen as the driving force in moving health and health care services further toward culturally safe care and is based on a specific and ongoing commitment of service providers, administrators, policy developers, and decision makers. It relies on recognition of the fundamental inequalities that permeate the "traditional" patient-professional relationship and that these inequalities have a significant impact on the health outcomes of clients and communities.

Mauri Ora[28] defines cultural competence in the following way:

> *"Individual values, beliefs and behaviours about health and wellbeing are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation and occupation. Cultural competence in healthcare is broadly defined as the ability of health practitioners to understand and integrate these factors into the delivery of healthcare practice."*

Another definition that attempts to capture this more contemporary complex understanding of cultural competence comes from the Medical Council of New Zealand[29]:

> *"Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:*
>
> - *that New Zealand has a culturally diverse population*
> - *that a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship.*
> - *that a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding."*

Māori wellbeing in becoming a mother

Dr A Graham in her thesis[30] explains how she explored young Māori mothers' experiences of wellbeing around the birth of their first tamaiti, in Aotearoa. Through kaupapa Māori methodology, grounded

[28] *Mauriora https://mauriora.co.nz & http://www.gpcme.co.nz/pdf/WS%20179%20Jansen%20-%20Cultural%20Competence.pdf*

[29] *https://bpac.org.nz/bpj/2011/august/cultural_comp.aspx*

[30] Aria Waiariki Graham. A thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy, Victoria University of Wellington 2018

in a kaupapa Māori and mana wahine theoretical framework, the research captured the voices and stories of ngā māmā, and reveals important components to their wellbeing within their lived realities (p234). She states it is an area that has had little exploration, particularly the transition from the 'voice' of Māori mothers that not only needs to be heard and included into the politicisation of their own wellbeing, but to that of a kaupapa Māori, wellbeing, strengths-based and emancipatory approach that resists the deficit theorising of young Māori mothers.

> *"I grew up in Waipatu with my whānau close by, which is a settlement where many families have lived in intergenerational homes. Waipatu provides kāinga (homes), wai (water), kai (food), a place to live and learn, to be well, to karakia (pray/prayer), to be sick, to die, be mourned and be buried. Babies were born there and the whenua of my cousins were returned to a special place under the plum tree. Tūpāpaku (deceased body) of our loved ones lie in our homes and on the Marae (meeting place) at Waipatu, and our whānaunga (relatives) come here to say goodbye. This is home, our whenua, our tūrangawaewae." Aria Waiariki Graham*, (P.iii).

From a te ao Māori perspective, Dr Graham noted that "*we are all connected*…… *'all Māori are related'* and that "*this is indeed true from a celestial and social perspective, as we as Māori have an origin founded on systems of nurture and whakapapa.* (vii). Dr Graham also noted that the terminology for young mothers has often been loaded or deficit, but from a Māori worldview, particularly through a mana wahine perspective, wahine Māori (Māori women) and mothers are deemed strong, powerful, autonomous, and purposeful[31].

> *"From a Māori worldview, identity is inherent to our identity in our whānau, such as mother, father, daughter, cousin and so forth. Te reo Māori embellishes a Māori worldview of whānau, by embodying our sense of interconnectedness to each other and to our cosmological origins". (p5)*

Other key findings from the research were:

- Within the whānau setting, young Māori mothers are experiencing wellbeing around the birth of their first tamaiti and thriving. (p235).
- The success of young Māori mothers within environments of supportive whānau, extends to their success in social, health, education, and employment opportunities.
- There needs to be further exploration and consideration regarding how the power of significant women can be raised and enhanced to influence the outcomes of wellbeing for young Māori mothers.
- In the absence of significant entities in the wellbeing experiences of young Māori women and mothers, determined efforts to replicate such beneficial entities of stability guidance and empowerment within the context of a Māori worldview, is paramount.
- Essentially, developing whānau wellbeing and sustainability is the ultimate goal and most pragmatic solution for ongoing revitalisation.

The research affirms that there is a dichotomy that exists between what young Māori mothers value, and what a dominant society imposes.

[31] Tomlins-Jahnke, 1997a *(Referenced in Dr Aria Graham. Thesis….)*

- This research indicates that the success and ability for young Māori mothers to thrive is possibly due to their innate strength, whānau support systems and connection to know and practice ways of being from a Māori worldview, and whilst these successes are lacking in mainstream systems and society, they are taking place in spaces cognisant of te ao Māori.
- It would be advantageous to make a concerted effort within the mainstream health care system of developing more Māori nurses, doctors, midwives, and health professionals with a strong kaupapa Māori understanding and application to practice, as would greater cultural competence and application of te reo Māori across all disciplines.
- Additionally, the Māori community requires more ability to determine, explicate and exercise their needs as the 'experts' of their wellbeing, based on a kaupapa Māori perspective and Māori worldview.

Within the health sector there is evidence of lack of culturally safe practice:

> *"We hope we are ……. moving to a stage where racism will not be tolerated, equity will be demanded and that critique of the role the health system plays in creating or maintaining inequities will become the norm. To achieve this, anti-racism and pro-equity activities can no longer be the work of the fringe but must become a priority and core work for the entire healthcare service"*[32].

Health care experts also make a clear connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities[33]. Further afield, there is a global context in which Aotearoa New Zealand is also a participant and contributor:

> *"Of all the forms of inequity, injustice in healthcare is the most shocking and inhumane, because it often results in physical death*[34]*."*

Cultural responsiveness is described in the literature as having cultural safety at its core. Cultural responsiveness is a commitment to becoming aware of one's own behaviour (individual or organisational) and self-knowledge. To incorporate that self-knowledge and engage in genuine dialogue with the community it serves to transform care to achieving, maintaining, and governing cultural safety[35].

Broadly in the (NZ) midwifery workforce there are no compulsory recertification (i.*e., for Annual Practicing Certification*) requirements for cultural competence and therefore the professionals are reliant on employer requirements[36].

Culture as a lever to address health inequalities

In a Native American presentation[37], it was noted that in Native American tradition, the medicine wheel encompasses four different components of health: physical, emotional, mental, and spiritual. Health and well-being require balance within and among all four components. Thus, whether

[32] Tamatea et al 2019
[33] J.R. Betancourt. 2002
[34] Martin Luther King Mar25th1966: https://quoteinvestigator.com/2015/10/22/mlk-health/
[35] Indigenous Allied Health Australia, 2021
[36] Tupara & Tahere, 2020
[37] https://www.ncbi.nlm.nih.gov/books/NBK201298/ *Leveraging Culture to Address Health Inequalities:* Examples from Native Communities: Workshop Summary. Commissioned paper prepared for the Institute on Medicine. Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities by James Knibb-Lamouche. Seattle, Washington November 14, 2012

someone remains healthy depends as much on what happens around that person as on what happens within. *Leveraging Culture to Address Health Inequalities* was a forum aimed at addressing the broad role of culture in contributing to and ameliorating health inequities.

For a majority of the history of modern medical science, health was viewed primarily as the absence of disease or defect. While this viewpoint achieved many victories and some spectacular successes, its weaknesses have become more and more apparent. For instance, there are staggering costs for developments in medicines, technologies, and their use such as costs for prescription drugs, a primary cost driver in the modern health system. There is also over-reliance on, and belief in, the scientific method as the sole source of information and the directing force for innovation. But a large blind spot emerges in which the medical model has nothing, or little, to contribute when considering the individual as anything other than a collection of parts. Treating individuals as human beings with minds, emotions, and spirits is not something this approach does well, and this has resulted in the denigration of systems or viewpoints that attempt to address these facets. Medical and scientific establishments have looked down upon treatments and technologies not developed by their methods. For example, in both Canada and the United States, traditional Healers and Elders have been prevented from providing ceremonies and other healing interventions—in some cases through punitive and legislative methods—and as a result, medicines and treatments developed over the centuries were denigrated as superstition and quackery.

> "*Every disease has two causes. The first is pathophysiological; the second, political*.[38]"

There exist non-medical and non-physiological aspects to the health of individuals, communities, and populations that has come to be called the "social determinants approach." This approach recognizes that there are a great number of inputs to both individuals' health and the systems (environments, families, communities, nations, etc.) to which they belong and which impact on health at the individual level as follows:

- income, social support networks,
- education, employment,
- social and physical environments,
- coping skills and resilience,
- childhood development, biology,
- health services, and gender.

This list is far from exhaustive, but it gives us a glimpse of the complexities that arise when considering the deceptively simple question of why particular individuals or groups of individuals (i.e., minorities, immigrants, Native American communities, etc.) are less likely to be healthy than others in society. In considering these issues, the World Health Organization stated[39]:

> *"Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. Within countries there are dramatic differences in health that are closely linked with degrees of social*

[38] Ramon Cajal, 1899 *(referenced in 39)*
[39] *https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf p.iii of 356*
Closing the gap in a generation Health equity through action on the social determinants of health

disadvantage. Differences of this magnitude, within and between countries, simply should never happen".

Curtis et al[40] identify that eliminating indigenous and ethnic health inequities requires addressing the determinants of health inequities which includes institutionalised racism and ensuring a health care system that delivers appropriate and equitable care. They note that there is growing recognition of the importance of cultural competency and cultural safety at both individual health practitioner and organisational levels to achieve equitable health care. Some jurisdictions have included cultural competency in health professional licensing legislation, health professional accreditation standards, and pre-service and in-service training programmes. However, there are mixed definitions and understandings of cultural competency and cultural safety, and how best to achieve them. They conducted a literature review of 59 international articles on the definitions of cultural competency and cultural safety. They found that health practitioners, healthcare organisations and health systems need to be engaged in working towards cultural safety and critical consciousness.

To do this, they must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others. The objective of cultural safety activities also needs to be clearly linked to achieving health equity. Healthcare organisations and authorities need to be held accountable for providing culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity. They concluded that a move to cultural safety rather than cultural competency is recommended. We propose a definition for cultural safety that we believe to be more fit for purpose in achieving health equity and clarify the essential principles and practical steps to operationalize this approach in healthcare organisations and workforce development. The unintended consequences of a narrow or limited understanding of cultural competency are discussed, along with recommendations for how a broader conceptualization of these terms is important.

The Importance of culture In Patient-centred Care

There is growing recognition of the need for culturally safe, patient-centred care in improving the health outcomes of minority populations, particularly Native American populations[41]. The health status of Indigenous populations is well below the national average both in Canada and the United States[42]. The experience of many Indigenous populations with the mainstream health care system has been negative, often due to cultural differences. Frequently, cultural differences and the inability of health care providers to appropriately address these differences have contributed to high rates of noncompliance, reluctance to visit mainstream health facilities, and feelings of fear, disrespect, and alienation.

Arriving at an understanding of the concept of cultural safety is a journey of self-awareness on this continuum. According to Irihapeti Ramsden, the Māori nurse and educator who developed the concept in her doctoral thesis in 2002[43], cultural safety is the ultimate goal in a learning process,

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[40] Why Cultural Safety Rather Than Cultural Competency Is Required to Achieve Health Equity: A Literature Review and Recommended Definition: *Elana Curtis1* , Rhys Jones1, David Tipene-Leach2, Curtis Walker3, Belinda Loring1, Sarah-Jane Paine1 and Papaarangi Reid1 Curtis et al. International Journal for Equity in Health (2019) 18:174. 14Nov2019. https://doi.org/10.1186/s12939-019-1082-3*

[41] National Aboriginal Health Organization, Analysis of Aboriginal Health Careers Education and Training Opportunities.2003 *(referenced 39)*

[42] https://www.ncbi.nlm.nih.gov/books/NBK201298/ *(referenced 39)*

[43] *R*amsden I. Thesis 2002; Papps, E. & D Wepa, ed., 2005; & Brascoupé and Waters Cultural Safety *(Referenced 39)*

starting with cultural awareness of a patient's ethnicity and, in culturally safe practice, growing concerns with "social justice … and nurses' power, prejudice and attitude." In other words, Ramsden turns the focus of cultural safety away from the cultural understanding and knowledge of the health care worker and onto the power inherent in their professional position. She seeks to redefine cultural safety from a transformative point of view of the Aboriginal person receiving care; the determination of success is by the recipient, who defines the care received as culturally safe, or not.

Institutional racism and bias in the health system

Researchers[44] have presented the so-called "triangle of racism" that shows hate crimes are at the active end of a continuum and that the extreme tip is held in place by a large underlying passive acceptance of the denial of racism and white privilege[45]. Tamatea (2019) describes racism as an organised system that operates at multiple levels both at a structural and personal level with various pathways to health. Talks of inaction in the face of need as a hallmark of institutionalized racism[46,47] has shown that active individual level racism is a determinant of health and ethnic health inequities in Aotearoa.

Health impacts for Māori mean that health inequities are the result of both active discrimination and passive inaction and racism will not be removed from society without dedicated and directive effort, hence ignoring racism is not an option if we wish to achieve health equity[48].

Dr Donna Cormack[49] says that evidence shows health (social and education) providers have racist assumptions, stereotypes, and beliefs about Māori (patients) across a range of conditions. It has to affect the quality of the healthcare interaction as well as health outcomes for Māori. For example, Māori get prescribed different medications. for antidepressants, Māori are more likely to get second generation medications which are older, tend not to be seen as effective and have more side effects than new medications. The whole system is designed to work for Pākehā and against Māori. As uncomfortable as it makes people feel if we're not prepared to call out racism in the health system it will never change. Cormack believes it's time for the Government to respond to racism and declare it a public health crisis. The research also captured the way Māori responded to racism. "Māori are not passive victims. They react and act. Māori resist by talking back, 'calling it out', raising their voices, making complaints, or taking their business elsewhere," researcher Dr Tinirau stated. Māori also found refuge and respite from daily encounters of racism with their whānau and in "Māori spaces", where they could talk honestly and discuss their experiences. Feel safe to do that and supported for saying so[50].

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[44] *Tamatea et al (2019) & Kristen Drury on February 14, 2017*
[45] *Jade AU Tamatea, Nina Scott, Hemi Curtis. NZMJ Vol 132 No 1492: 29 March 2019*
Penmen W, Cloud D. 2019 *(references: editorial 1. Multi-researcher list)*
[46] Jones 2000 *(references: editorial 1. Multi-researcher list in 46 & 47)*
[47] Harris et al (2019) *(references: editorial 1. Multi-researcher list 46 & 47)t)*
[48] Paradies et al (2009) *(references: editorial 1. Multi-researcher list 46 & 47))*
[49] https://scholar.google.co.nz/citations?user=YPDwKIIAAAAJ&hl=en Dr Donna Cormack & Tamatea
Call for action on equity from three angles. Jade AU Tamatea, Nina Scott, Hemi Curtis NZMJ 29 March 2019, Vol 132 No 1492. © NZMA www.nzma.org.nz/journal
[50]https://www.stuff.co.nz/pou-tiaki/300259105/survey-reveals-mori-grief-and-anger-at-daily-experiences-of-racism Dr E Tinirau

Vulnerable populations

Defining vulnerable populations

Marginalised groups and underserved populations are defined as: Individuals or groups who are exposed to conditions and processes in society that prevent them from full participation in social, economic, and political life. For instance, poverty is both a consequence and a cause of being marginalised[51]. People can be marginalised due to multiple factors, sexual orientation, gender, geography, ethnicity, religion, displacement, conflict, or disability.

The core factors that determine who or what groups are marginalised and what the barriers are that prevent them from being reached are:

- Political discrimination which may marginalise some ethnic groups, migrants, or particular regions of any country.
- Social discrimination and marginalisation which can impact on a wide range of groups on the basis of age, gender, sexuality, language, disability etc.
- Economic marginalisation which can prevent equal access to basic services, income opportunities and access to jobs.

By "underserved", Mauri Ora Associates (2009)[52] say this means identifiable groups of people who are more vulnerable than the general population,

- achieve poorer clinical outcomes,
- suffer a greater burden of disease,
- receive lower quality care,
- suffer a greater proportion of medical errors and adverse effects, and/or
- have more limited access to appropriate services.

Impacts of vulnerability on health

Research[53] has identified that some of these health problems are the result of different levels of contact with risk and protective factors by the underserved group compared with the most advantaged groups in New Zealand. Some are clearly heavily influenced directly by patient behaviours, such as cigarette smoking, nutrition or a lack of physical activity which can contribute to a greater burden of disease. Some health problems, however, are unrelated to patient behaviour and instead reflect barriers or inequalities associated with the healthcare system. Examples of underserved groups in New Zealand are Māori, Pacific peoples, those in rural areas, the poor, the disabled, and other groups who do not affiliate with the cultural majority.

Evidence from both New Zealand and abroad demonstrates that these underserved groups experience significant disparities in access and outcomes in virtually all areas of the health care system, including preventive care, primary care, hospital services, mental health services, and specialist care. These disparities are not randomly distributed but arise from a whole range of factors that differentially affect the most vulnerable of our society.

[51] Social Science & Medicine 2019
[52] Mauri Ora Associates, 2009 pp8-12
[53] Mauri Ora Associates, 2009 pp8-12

Māori health inequities

Influences on health inequities

Researchers[54] have reported that persistent inequities in health experiences and outcomes are observed for Māori compared to non-Māori in Aotearoa New Zealand, and note that Māori consumer experiences of health services were based on health inequities related to:

(i) the socioeconomic and political context.
(ii) socioeconomic positioning; &/or
(iii) intermediary factors that increase exposure to health-compromising conditions.

Palmer et al 2019[55] view the improvements of consumer experiences as mapped to policy directions on unequal consequences of illness (individual interaction); risks of exposure to health-damaging factors (community) and (public policies); and mitigating effects of socioeconomic and political stratification (environment). The research conclusions were that Māori consumer experiences of health services and programs are an important informer of variables that impact health inequity. Strategies to tackle health inequities informed by Māori consumer experiences can be drawn from existing empirical research which abounds in the New Zealand health sector literature.

The Ministry of Health[56] has identified addressing the poor health status of Māori as being of the highest priority. While Māori still have lower life expectancy, greater morbidity, and higher rates of disability, they have less access to health and rehabilitation services than do non-Māori. The Ministry noted that the perceptions of Māori consumers can contribute to understanding how the health system is or is not facilitating their access to health care. Māori demographic profiles of health and social determinants precedes their various journeys in and through the health system of Aotearoa.

Reid and Robson[57] have provided a plausible pathway to the birth of racism in Aotearoa and its impact on the health of Māori as the indigenous people. They reason it is impossible to understand Māori health status or intervene to improve it without understanding New Zealand's colonial history. Furthermore, they say we must never assume that colonisation is something confined to the past. This is because health impacts for Māori from racism in the health system has resulted in Māori experiences of consistent, comprehensive, and compelling disparities in health outcomes, exposure to the determinants of ill-health, the lack of health system responsiveness and the underrepresentation of Māori in the health workforce.

Persistent and marked inequity is observed for Māori at all levels of health[58], education, social and justice areas in Aotearoa New Zealand[59]. Whereas non-Māori have life expectancies approximately 7 years longer than Māori, attain higher educational achievement in secondary and tertiary education, and are incarcerated at markedly lower levels[60]. In primary and secondary health care, non-Māori patients are prescribed more effective medications[61], and are referred more often to specialist services and experience higher quality hospital care[62]. Non-Māori patients experience persistently

[54] Suetonia C Palmer et al 2019, Reported Māori consumer experiences of health systems and programs
[55] Palmer et al 2019
[56] Ministry of Health (2005)
[57] Reid and Robson (2006)
[58] MOH 2012
[59] DOJ, MOE, Exploratory report. 2007
[60] MOH 2012
[61] Metcalfe S et al, 2006-07
[62] Davis P, et al 2006

lower rates of preventable diseases that lead to avoidable hospitalisation and unmet need in primary care[63].

Māori experience inequitable access to health services throughout the life course leading to higher rates of disability and multiple morbidity [64] and are more likely than non-Māori to cite cost as a barrier to accessing primary care. In addition, nationwide quality improvement programs in Aotearoa New Zealand worsen inequity by differentially improving access to services for non-Māori[65].

Impact of social inequities in maternity care on marginalized groups of women

Many review studies have highlighted health inequities for socially disadvantaged pregnant women and their infants and increasing access to affordable quality reproductive services as a pressing concern in many countries[66]. The researchers examined this problem and gave recommendations to address it, primarily focusing on high-income countries. Special attention was given to the role of midwifery and community-based programs in reducing poor health outcomes among structurally marginalized women facing multiple social inequities. They noted that in the past few decades there has been a resurgence of interest in the social causes of health inequities among and between individuals and populations.

- The social determinants of health approach aims to identify not merely how these factors individually impact health within a population, but also the reasons why there are variations in health outcomes and how these differences are shaped by an individual's unequal access to key resources
- Deficiencies in social and economic resources contribute to unfair and unjust differences in health among groups in the population, known as 'health inequities'
- Although often conflated, some argue that there is an important distinction between health inequalities and health inequities
- Health inequalities are linked to genetic, biological, social, and other factors that result in differences in health status which may or may not be unfair, whereas health inequities refer to avoidable and unjust "social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society"
- Health inequities can be worsened by stigmatizing and discriminatory policies and practices that result in exclusion from social structures such as social networks, social institutions, and broader political and economic structures. Exclusionary processes, including legal sanctions against midwifery and allied professions and fee-for-service costs for reproductive services, contribute to health inequities
- Enhanced inclusion in social structures and participation strategies can improve health outcomes for socially excluded groups by reducing health inequities
- Some scholars have gone on to argue that certain social determinants are more 'fundamental' than others because of their direct and enduring influence on a range of health inequities
- *Link and Phelan* argue that socioeconomic status is the most important factor determining health because access to key resources such as money, power, prestige, and social connections

[63] MOH 2015
[64] HQSC 2019
[65] Dalbeth N et al, 2018; Loring BJ, et al, 2019; Metcalfe S, et al, 2019
[66] Smith & Benoit 2021

appears to trump all other determinants (e.g., having money and a broad social network can minimize certain health disadvantages related to age, geographic location or ethnicity).

- *Benoit et al* make the case that gender is an additional fundamental determinant for it too influences one's access to these important social resources. At the same time, they argue these fundamental determinants need to be investigated as interconnected and "intersecting" axes of discrimination with no particular determinant, such as gender or class or race, being privileged over the other
- As *Kozhmannil et al.* state these fundamental health determinants "pattern in inequitable, unjust, and unconscionable ways the access to and quality of care that pregnant patients and their infants receive."

The research has established that various barriers to adequate maternity care for marginalized women and their families persist in high-income countries, even in countries that have publicly invested in universal healthcare coverage for their respective populations, which has included comprehensive maternity care. Key findings were:

- Marginalized women decide whether or not to access antenatal care through a process of '*weighing up and balancing out' personal issues and circumstances within their social context, and in the context of the care provision they anticipate and encounter*." Further, if they make the decision to access care, those with social risk factors are more likely to experience care that is paternalistic and does not meet their needs in the perinatal period
- Among socially disadvantaged women, there are a number of personal circumstances that influence accessing appropriate care, often interacting, and intersecting with broader structural or institutional barriers. The barriers structurally marginalized women face during the perinatal period can have serious consequences on their health and well-being during early parenthood.
- Socioeconomic status is one of the most frequently discussed barriers to accessing maternity care. Poverty and related issues impede women's ability to find maternity care that is accessible, reliable and of adequate quality. In fact, poverty has been singled out as the most significant factor predicting inadequate prenatal care
- A common financial barrier is paying for transportation to maternity care services. For women without an affordable and reliable method of transportation, initiating and maintaining consistent antenatal care can be difficult to achieve. When financial barriers impede women from accessing the appropriate maternity care needed, their health and that of their new-borns is compromised.
- Similarly, poorer health outcomes were found for mothers who are less educated, have lower household incomes or live-in neighbourhoods characterized by lower socioeconomic position.
- Indigeneity and minority ethnicity status often intersect with economic inequities in antenatal care seeking. Women in New Zealand who identified as Māori or Pacific Islander were six times more likely to initiate antenatal care later in the pregnancy, compared to those of European descent or other ethnicities. In the Canadian context, indigenous women are significantly more likely to have received inadequate care than non-indigenous women and to have started prenatal care after the first trimester. Ethnicity has also been shown to impact health inequities for pregnant women and their new-borns.
- Cultural concerns were particularly impactful when interacting with health care institutions, as a lack of culturally appropriate care and time constraints limiting the development of this care caused additional barriers to timely access of care; even more difficult were language barriers between health care seekers and providers.

- Characteristics of health care providers and their routine practices sometimes pose additional barriers to appropriate or quality care for women who are socially disadvantaged. Insufficient communication skills or judgmental care can lead to avoidance or non-compliance. Experiences of discrimination linked to low socioeconomic and other marginalized statuses led some women to avoid antenatal care in the future or withhold disclosure about potentially stigmatizing information with health care providers in future encounters.
- Incomplete knowledge about the options when seeking out maternity care results in a scenario where groups most at risk to inadequate maternal and infant outcomes due to economic hardship have access to the least appropriate models of care.

While many of the studies cited above have clearly identified troubling discrepancies in access to and quality of maternity care for marginalized women and their infants, much of this research has also identified important interventions for how to improve care for these populations and enhance maternal and infant health.

At the broadest level, the fundamental right of all pregnant women to have control over the decisions related to their own bodies and health care should be guaranteed by national governments in all countries. Work needs to be done to expand the care options for rural and remote women who are obliged to give birth in distant urban centres under official 'evacuation' policies. Furthermore, actions need to be taken to support health care providers in being educated in 'cultural safety' care practices. Fenton and Jones[67] describe cultural safety as –

> *"About empowering people and facilitating the achievement of positive outcomes by recognizing cultural identity and the impact of personal culture on Midwifery care, "have a responsibility to play a role in dismantling racism through self-education and a shift in perception and practice. Clinical efforts to improve the quality of care must stand on a foundational belief that clinicians wield power, privilege and a responsibility for creating equity in obstetrics.*"

This focuses on the holistic well-being of pregnant women and their families, and includes emotional, social, and cultural well-being, is particularly effective for those who are facing intersecting disadvantages.

Important aspects to access and utilisation of maternity care

Access to maternity services

In terms of maternity care in Aotearoa New Zealand, Bartholomew et al[68], report that timely engagement in antenatal care improves maternal and child health outcomes and is an important element of healthcare performance measurement. This research looked closely at the timeliness of lead maternity carer (LMC) engagement amongst pregnant Māori women and aimed to identify the factors associated with timely engagement. The *Growing Up in New Zealand* longitudinal study enrolled a diverse sample of pregnant women during 2009 and 2010. Timely engagement was defined as before ten weeks gestation.

These same sentiments were echoed by a midwife in Tanzania[69] (Rose Mlay) who fought for the right to safe motherhood for her people and led the push for improved working conditions for midwives, and better health for mothers and children in Tanzania. A common thread in her work was to ensure

[67] http://dx.doi.org/10.15640/ijhs.v3n1a2 Catherine Fenton1 & Dr Linda K Jones 2015 p24
[68] Bartholomew et al 2015
[69] Personal communication Rose Mlay, Sept 9, 2011

safe motherhood for all women in Tanzania. She believes this is something they deserve, saying "*it is the right of every woman to receive care by a qualified healthcare provider who can save the life of the mother and the life of the baby*." She says: "*Life is a human right that nobody should deny," "When women are denied this right, it is unfair*."

Client satisfaction with maternal care

In another study in southern Mozambique[70], client satisfaction was seen as an essential component of quality (maternity) care. In this study, health system factors, processes of care as well as mothers' characteristics influence the extent to which care meets the expectations of mothers and families. The focus specifically aimed to address the mothers' experiences of, and satisfaction with, care during childbirth. Most mothers (92.5%) reported being satisfied with care during childbirth and would recommend that a family member to deliver at the same facility. Specifically, 94.7% were satisfied with the cleanliness of the facility, 92.0% reported being satisfied with the interaction with the healthcare providers, but only 49.8% felt satisfied with the assistance to feed their baby. Mothers who had negative experiences during the process of care, such as being abandoned when needing help, disrespect, humiliation, or physical abuse, reported low levels of satisfaction when compared to those who had not had such experiences (68.5% vs 93.5%). Additionally, they reported higher levels of dissatisfaction (20.1% vs 2.1%).

Analysis revealed that mothers who gave birth in primary level facilities tended to be more satisfied than those who gave birth in hospitals, and having a companion increased, on average, the overall satisfaction score, with 0.06 in type II health centres (CI 0.03–0.10) and with 0.05 in type I health centres (CI − 0.02 – 0.13), compared to − 0.01(CI -0.08 – 0.07) in the hospitals, irrespective of age, education, and socio-economic background.

This study concluded that childbirth at the primary level facilities contributes to the level of satisfaction. The provision of childbirth care should consider women's preferences and needs, including having a companion of choice. We highlight the challenge in balancing safety of care versus satisfaction with care and in developing policies on the optimum configuration of childbirth care. Interventions to improve the interaction with providers and the provision of respectful care are recommended.

The Hapu Ora Report[71] indicated that Māori women experience inequalities in access to maternity care services and reported lower levels of satisfaction with maternity services than most other women from other ethnic groups (in Aotearoa NZ). The report aimed to identify research priorities for the life course of Māori with a specific focus on wellbeing at the early stage of life. It was crucial in highlighting what affects early physical, social, and cognitive development of Māori babies.

It is well known in NZ that Māori babies suffer disproportionately from low birth weight, pre-term birth, stillbirths, and neonatal mortality than most other ethnic groups. Improving the support services provided in the early stages of life will help prevent negative outcomes later in life – the Associate Minister of Health, stated at that time[72].

[70] Aug.2019, BMC Pregnancy and Childbirth
[71] SHORE, Whariki, Nov.2013
[72] Hon. Tariana Turia 2013

The research report identified three key priorities for further work which included addressing societal conditions, supporting the mother and her baby and the whānau and improving services to ensure best practice maternity and new-born support for Māori mothers, their babies, and families.

> *"We need to do a better job of meeting the needs of Māori mothers and their families by identifying and supporting not only their physical needs but also their mental health and well-being. Anyone who has been through pregnancy and childbirth understands and knows not only the absolute joy of a new-born in their lives but also how stressful this journey can be at times – we need to do everything we can to understand and reduce these pressures on Māori mothers and their families," says Mrs Turia.*

Influence of midwifery on birth outcomes

In a Canadian study attempting to establish if and how midwifery-led care influences birth outcomes for marginalized women in particular, McRae *et al*[73] showed a statistically significant reduction in odds of negative health outcomes for infants born to women of low social-economic class receiving antenatal midwifery versus physician-led care. In another study by Benoit *et al*[74] found that postpartum depression scores of pregnant women receiving continuous midwifery care were similar to those of high-income pregnant women in continuous physician care, despite the authors' finding that lower income was linked to depression in the postpartum period. This suggests that the care provided by midwives was able to mitigate the effect of income on postpartum depression, possibly through the social support that midwives were able to provide disadvantaged women in their course of care.

Other successful strategies include:

- Utilizing interventions such as midwife-led continuity models and programmes that provide an opportunity for building social support networks, sharing information on a broad variety of topics, and allowing for longer periods of time to build relationships with their care providers appears to be effective in minimizing the effects of this disadvantage on their pregnancy outcomes.
- Community-based maternity programmes for women facing intersecting forms of disadvantage are another opportunity for minimizing inequities in maternity care.
- Providing access to mental health nurses for additional support beyond primary care and building self-efficacy led to a significant decrease in depressive symptoms. Home visits that minimize the costs associated with transportation, childcare and other factors identified earlier as barriers to care, can be a critical tool to improving outcomes

[73] Daphne N. McRae et al: Population Health, Volume 3, December 2017
[74] Benoit C, Westfall R, Treloar A, et al. Journal of Mental Health 2007

Experiences of Māori parents and their pēpi who birth at HBDHB facilities

The following section summarises the themes that were identified during the engagement with project stakeholders related to the experience of whānau who birth at HBDHB facilities at Hastings and Wairoa. Feedback includes perspectives from whānau, Iwi and governance partners, HBDHB governance and management, maternity service, and midwifery services (including staff surveys) and community providers.

Supporting wahine hapū and her whānau

Mana of wahine hapū and her whānau is paramount

A key theme from all interviews was that whānau are important to the wahine hapū whether they are partners or ex-partners who are co-parenting, mothers, other children, grandmothers, or siblings and yet on several occasions māmā felt that their whānau was excluded or barriers put up to their inclusion. It was also felt by some, that more attention should be paid to caring for the whānau that are supporting the wahine hapū such as offering them a kai, cuppa tea or somewhere to sleep. Additionally, for wahine hapū resident out of town such as Wairoa, there was a desire not to have to birth in Hastings and separate them from their whānau and any other children.

"This time around I am back with the midwives, and I am trying to convince them can I just have it here (in Wairoa)? Just because it is just shit going down to Hastings and they make you go down prior. And because I have got other children, and because I am a very clingy mum. I have too much weight on myself"

"Because my children's father - we are not together but we do co-parent - he was able to come down and we were alternating in SCBU because you are only allowed parents in there. So, we would do four hours each"

"It was good. First time I think one was a student midwife. And there was another midwife. They actually took my first son for a few hours so me and my partner could get some sleep. I think it was the first night. That was pretty good because I didn't know what to expect. It was so tiring. I think the only downside for him was that he didn't get meals in there. And yeah, he had to go out and get kai or sit there and watch me eat"

"There was no offering of a coffee to my mum or anything like this. It was just everyone just ticking boxes coming in and not even noticing she was there or acknowledging her. Is that what they call manaakitanga?"

"She [mother] came and she stayed because I was like, "Can you stay? I haven't been good. I've been crying every night. I haven't been getting the care that I need." So, she stayed. They couldn't offer her anything, she's not a small woman. They gave her two chairs, just little steel armchairs and she put

one back here and one along there, and she slept like that. There was nothing to offer her or anything. So, she got up and laid on the ground. I said, "Oh, no mum. I don't care, no." So, I rang my cousin, she lived nearby, and I said, "Can you please bring a mattress for mum? I don't care what they say, she needs somewhere to sleep. Then I told my mum, it was like 12 o'clock at night, "Tell them to let my cousin in to give you a bed." Because stuff this. So that happened, and we didn't realise that it was going to be so traumatising

"The first one he had a comfortable sleep. It was a nice suite. He had a little bench seat thing he could lay down on with a mattress on it. But with this one, because I think we were the only ones in Waioha when he was born, and there was only, I think, one midwife at the hospital, we had to get moved to the other side and…. my partner didn't have anywhere to sleep"

"After talking to another māmā who gave birth that same week in the hospital, but they were in the other room, the VIP side of it. When I heard their experience was marvellous, I thought, well, okay, this definitely isn't normal, what I went through. I should've spoke up. I didn't know. I thought it was just how it was. So, yeah. I mean, it's nearly three years on, every time I talk about it, I just get really emotional"

Some new māmā also noted the importance of support from other māmā that they connected with in mother's groups or coffee groups and how important it was to have those networks, so they didn't feel alone:

"Coffee group every now and then ...was great once you first had your baby because you're all in the same boat, so you can all message, or when we had caught up every now and then we'd, could all chat about what all the problems you're having and realize it's actually not just your baby, everyone's babies are like that, or things like that. I think it was great. That's probably the best thing that got us through, the mother's group"

Lack of adequate and appropriate information, education, and advice to wahine hapū

Many of the māmā interviewed, described situations of not being advised of their rights, not being listened to, not knowing why their babies were taken to the Special Care Baby Unit (SCBU), rationale for epidurals, induction, caesareans, and impact of gestational diabetes. Unless the wahine hapū had the confidence or courage to ask questions and press for answers that they could understand, most felt that decisions were imposed by staff without any ability to question or understand. In summary the maternity service staff frequently demonstrated a lack of or inability to observe and practice their legal responsibility to inform consumers of their rights and to provide full information without the need for any patient / whānau to request it. One māmā also said she was threatened with referral to Oranga Tamariki if she did not do what the service told her to do. In another example, a mother of one of the wāhine hapū said she was not listened to or given opportunity to have a mutually respectful conversation with the staff:

"He just turned around and looked at me and I said, "I'm her mother, and I've just heard everything you've said, and you're not doing it." And he came in, even though I said that - he came in and sat next to her and told her that he wanted to do it. And I said, "Were you not listening?" And then I was angry"

"Yeah. I was very mad. I didn't even get to see him (newborn baby of Māmā). Hadn't even laid any eyes on him. Before, see, they pulled him out. He went straight over to the monitor bay thing. And then, from there, they had made the decision, I could hear him. I just couldn't see him. They had taken him straight to SCBU. They told me, "We need to take baby to SCBU." I'm like, "Oh, okay." And I'm here and they're there. And then, all I seen was the back of the trolley going out. I didn't even get to lay eyes on him before he left. I was freaking out though, because I'm trying to get them to hurry up and close me up so I can get there. But, with this one, it forced me to get up out of bed within about three hours after surgery. I told my dad, "Go get me a wheelchair." He did and I was up, and he couldn't believe it. He couldn't believe I was sitting up. I walked ... got out of bed, walked to the wheelchair, and sat in it after three hours after surgery. Yeah. And you know what? That pain was a lot more bearable than it was when I was pregnant. Yeah. I was far less painful than being pregnant"

There was an assumption also that for māmā with multiple existing children, they would already know what was happening and therefore did not need explanations or information. These māmā felt that the service did not appreciate that each birth is a different experience and that they are not always the same as the last birth.

On the other hand, it was noted by some midwives that some whānau did not appreciate the importance of attending ante natal classes to receive information about their rights and planning ahead for their birthing experience as one community midwife noted:

"This part of the māmā pregnancy journey is really important in ante natal. But the [HBDHB] midwives don't tell them they have to keep coming back to these classes as it is where they get their information and support about what to expect and how to prepare for their birthing. This time and these services are just not valued enough amongst whānau. It's where they can learn about their rights, how to ask their questions, what to watch out for……There's a huge cascade effect from this…….it affects everything else that happens for them in their journey and helps the mum be in control of what happens to her further down the tracks. Birthing is different for everyone, and for every baby you have…. And once they know – have the information, then you can leave them to go on and have a satisfactory birthing experience. That's the value of coming to ante natal care".

Variations in care for wahine hapū and her whānau

Inconsistent approaches to clinical care putting māmā at risk

A few spoke about feeling there were different levels of care for different wahine with some receiving a better service than others. There were also occasions of mixed messages coming from different staff working with the same wahine hapū, causing confusion and stress for the wahine. Several discussed the impact of having to experience different staff who gave different instructions:

with one saying, "*it's like you never know what you're going to get – will it be one of the good ones or one of the mean ones?*"

"He walked in … and I was on the ball trying to move around, and he come in and he said, "You need to get off that ball, you're not allowed to be on the ball." And I said, "Pardon?" And I said, "the

midwife come in and told me I need to get active because I've been on the bed all day, and to start moving around"

The lady actually had the audacity to ask, "Oh, when are you guys leaving? I'll need you to go." In my head, I'm thinking well, as soon as possible, but yeah. I was struggling because no one checked me, and I had a lot of pain. It wasn't until about day five, when one of the midwives, I think it was the same one, she said, "Are you still here?" They'd been giving me painkillers. She goes, "Are you still not, right?" This is how she was talking to me. "Are you still not? Do you still have pain?" Well, yeah, I'm not making it up. Yes. She goes, "Oh, can I check?" This was about day four or five and she finally checked, and it turned out I had a massive haemorrhoid, and I couldn't even sit, which was affecting the way I was breastfeeding because I wasn't comfortable when I was trying to breastfeed baba. I wasn't even able to learn properly because I was in pain and so they realised it. She gave me some ointment and stuff"

"I had multiple midwives come in, so I never saw the same face because I was struggling with breastfeeding, I was taught ten different ways. I didn't even have time to adjust to one".

A community midwife also provided an example of inconsistent and inappropriate care putting māmā at risk:

"I was looking at a young Māori mum, she was about 17. She was highly anaemic, and they changed the system on how we booked antenatal appointments… and I said, "But we need this urgent iron infusion. She could go into labour any time now." And you know what? She didn't get that iron infusion before delivery. She ended up with two PPH's [Postpartum haemorrhage]"

Maternity and midwifery staff from HBDHB provided a wide range of views about the care provided for wāhine hapū and new māmā and their pēpi, especially those in more complex whānau circumstances:

"*There's lots that's been missed……lots and lots…….they go home after having baby, sore, infected, they are sick. This is also trauma they are carrying. They are sick when they go home, but there's been no care and attention to them, none when they get home either, no care, no follow up. That impacts the rest of their life. Low incomes, not engaged with any services that help them – but this is what we start working with, with them to try to build a safety net around them, for them. Lactation consultants – who can afford them? They are specialists, have to pay them like $350 an hour……even if you could pay that – lactation is a service you need now. The service has a proposal for funding for this. But it looks different to what was proposed, and referrals have to go through Plunket! But if the mums don't trust Plunket, then they won't be going anywhere near them*".

An Oranga Tamariki staff member stated that:

> "80% of the whānau that present in their early stages will be able to operate their own whānau with a level of independence. That's what a lot of our work in Oranga Tamariki is. Alongside of that, I know that lead maternity caregivers … provide that level of support with the engagement that they do.... It's called the Kaiarataki Service. The anchor is the whānau, maybe a whānau of a person that's in prison, that's due for release in the next eight months. And what has been missing in that piece is, how do you walk alongside whānau so that when this person gets released, they are here not back here? In reality … the maternity isn't equipped to provide that level of support"

A representative of Ngāti Kahungunu Iwi also discussed their family harm project (Te Kura) and how they aim to support wāhine and whānau:

"We're talking to the police about... Through the work we are doing with our Te Kura, to say where there is an issue with a... And likely to have children, please take your family hunting with you. Please be understanding, because we've had an incident where a mother and father were both uplifted and the children were left at school. No one at home - who was going to look after those babies? The school or… So, we've said to the police, that is not good enough. And it was only through the mother yelling and screaming, she managed to get a call to her sister, who had seven children of her own to go and pick up her babies so that Oranga Tamariki would not come in and uplift those babies".

"Unfortunately, with the gestational diabetes woman, the problem seems to be health literacy and access to those women in the community. I get a lot of, because I CC into all of the midwives' emails, so I get a lot of emails going around in circles about tracking women down, about education around the gestational diabetes, about getting people to use insulin. We've got funding for them ... what do you call those monitors that they wear all the time so don't have to think of product?"

Inconsistency in provision of culturally appropriate care putting māmā at risk

Some feedback was received about the inclusion of appropriate approaches to meet the cultural needs of wāhine Māori and whānau:

'When we went in for labour, but when we went to have the check of Waioha, I noticed a karakia on the wall. Like a poster and I sort of thought, oh that's oh great. They've got karakia on the wall. But you know, when we were in there, no one came and said, we've got this beautiful karakia. Why don't we karakia together with pēpi. I feel like it's tokenistic. I think like, yeah. I think that everyone realises that it's nice, but I don't think that they realise that it's a taonga.'

"I went in there and I wanted a muka tie. I don't know if this comes under cultural. I wanted a muka tie because I heard the health benefits for it. It was so good. So, I wanted to try it. I actually had time to find one here, but they told me, "Ask one of the midwives down there, how do we get them? Because they have them all the time down there. So, I did. I said, "Do you do muka ties here? One lady had no clue what I was on about. She goes, "What the hell is that?" And I go, "For the umbilical cord." She said, "No, it's a clamp." And I said, "No, it's not. It's a flax." So, then, I was angry with her. And then, I said, "I'll get one of those. Leave it".

This sentiment was repeated during midwives and staff interviews when questioned about knowledge of the maternity service staff on awareness of Māori health inequalities and how this should influence the cultural aspects of care that is provided. As one midwife stated *"it is questionable. They pretend to understand but they have no idea, and most don't see the point."*

"I ended up getting overwhelmed. I ended up taking it out on my children's father, because by then he was allowed in there too. So, I rang my midwife, told her what was happening. I said, "Can I leave?" Because I'm stressed out, I haven't seen the girls in two weeks because of the rules, the COVID rules. I just want to get home to my babies. And she said, "You can leave." She said, "They cannot hold you there against your will." She said, "But let me vouch for you too. Give them my name." So, I did that. And even after I told them that I'm leaving, they were still trying to convince me to stay, that it was in my son's best interest. But I knew something was up. Ended up catching up with midwife three days after. She rang me and she goes, "How did you feel about that? When all

that was happening in SCBU?" And I said, "I felt like they were keeping me captive. Like I did something wrong." I felt quite racially discriminated against"

A HBDHB Māori health service team member described one of the cultural approaches they were implementing to better support Māori patients and in particular hapū māmā:

"Tuai Kōpu and the maternity services should be joined up as a Papakāinga … we need to formalise it, resource it. Our Te Whare Pora pilot project money is ending in June – then what?? We are a weaving service in the antenatal space – the least threatening type of area that would not put our whānau off coming in to participate – we are the linchpin for these other services to wrap around, and we're losing the money for what we do. So, we're working with six providers within the Hawke's Bay space, so Wairoa down to Central Hawke's Bay. So, we're working with those six providers to look at, how can we do early intervention, intensive intervention, whether that's funded by Oranga Tamariki partnering for outcomes, or whether it's funded via MSD, to ensure that whānau, where they have the chance to have a level of independence and be kaitiaki of their own tamariki and their own whānau, how do we do that and how do we provide resolution so at that point, then they can build their ability to cope and their level of resilience?

Access issues with centralisation of specialist appointments to Hastings

For Wairoa women, the non-availability of some specialist services in the local maternity service, was identified as causing anxiety for many wahine. Wahine talked about not wanting to have to travel to Hastings for appointments and not wanting to birth in Hastings. The centralisation of some of these services was identified as a significant challenge for many whānau:

"As people in Wairoa, our dollar's not worth as much as everyone else's, so we have to pay more money to get anywhere. It's like you're penalized. They think you're penalized yourself because you're living in Wairoa, but years ago, the services were here. Now, some bugger's gone and centralized them all down in Hastings, and they haven't made up for that travel distance, at all, or their timeframe in getting to and from Wairoa down to Hastings. They haven't even changed their administration system. Appointments are not in sync with travel to and from Wairoa. I have one example of a māmā who had to go down. So, she had to ring up her brother to come up, drove up from Woodville, picked her up in Hastings, and drove her to Wairoa. Two weeks later – same cycle"

"They put Wairoa people on at the wrong end of the day because administrators don't bother to see that they live in Wairoa, or they don't bother to see they live in Central Hawke's Bay area"

"Two thirds of the māmā are assessed and at some point, during their pregnancy they will have to come to Hastings, or they'll present acute to Gisborne"

"Maybe some specialty clinics, all the bulk of your out-patient clinics everything else that's in that hospital should be moved to community / primary health. That's what I think. Because if you look from a hospital in-patient point of view, all the money has been diverted to those different sections and the in-patients are left floundering, just keeping their heads above water. Well, just cut the apron strings, give them that amount of money for the in-patient, put everything else out"

"The overwhelming one common theme was better access to the health service. That was the overwhelming thing. Hastings, I think probably, doesn't understand. They just think of Wairoa as Wairoa. They don't understand that Mahia is 45 minutes away or 50 minutes if you're out the peninsula, and Tuai is 45 minutes to go further up at the lake where the lodges and stuff like that"

"They're so concerned with Hastings, the mothership. They're working in so many different silos. They're not talking to each other. We're just this little thing but we have at the end. We have to keep raising our hand. What about us? They're only just starting to... I think the need is more apart from the cultural perspective, but also that they're virtually, literally running out of room"

Variable birthing experiences for wahine hapū and her whānau

Some birth experiences have caused trauma

Some new māmā also took some time to process their birthing experiences and carried different levels of trauma as a result. In some cases, they reached out to their midwife to discuss their views:

After some healing, I actually got in touch with [the midwife] …. she was the only person I could think of. I told her, "Hey, I struggled. It was really horrible for me." Then I learned later that I wasn't the only one"

"As soon as I came out and then once I healed a little bit for a couple months at home, I was looking for something online. That's when I reached out to [my midwife] but I was looking like, who do I talk to? I want to tell them what happened. And I waited and it wasn't until later, I don't know, it took ages until I got an email saying, "Your birthing experience here, blah, blah, blah." It was an evaluation form, but it was like ages, it was a long time after this. But I gave it, I just put everything in there, but I haven't heard anything …. It was just like a dead end. Just ticking a box"

"I'm grateful for all of this and that this review is happening. I'm sorry that I can't even think of something positive, but that's my experience. But I am still hopeful that the outcome of this [review] will be positive"

> *My second day in, one of the midwives came in and woke me up. Three o'clock in the morning and she said, "Hey, have a try at feeding baby." I was having trouble breastfeeding; I was sore and all the stuff. She said, "Have a go at feeding baby." That's all she said, and I said, "Okay." But baby was well asleep, to do with jaundice and stuff. And I was like, "Oh no, she's so peaceful. I'll let her sleep and I'm a bit tired too, so I'm going to go and have a sleep too. The midwife came back, six o'clock, three hours later and she goes, "How did it go?" And I go, "Oh, the breastfeeding?" And she goes, "Yeah." I go, "Oh, I haven't fed her yet." And she switched on the lights at six o'clock in the morning, swung the curtains open and yelled at me and said, "You need to feed her, what are you doing? You need to feed your baby." And she walked out of the room - and I was shaking and panicking. I started crying and I grabbed my baby, and I was like, "What the hell?" And she goes, "She needs to be fed. She needs to be fed." I was like, "I don't know what's going on. Am I killing her?" Then she obviously went away and calmed down, came back and then she said, "Did they not tell you? Didn't you know your baby's got jaundice?" I was like, "Yeah, I know she's got jaundice so what does that mean?" She told me, "You need to feed baba quite regularly." And I thought, why didn't you tell me that? So - it was horrible. Right off the bat I thought I was failing as a mother.*

Several wahine were also appreciative that this maternity services review was taking place and they were being asked for their opinions on their birthing experiences:

"Why can't it just be simple?" I know how to fix this, just manaakitanga. That's it. Why do we go off on all these tangents when all I wanted was manaakitanga? That's it. We do it at the Marae, we do it even in our own homes, what's the difference? I don't understand why is it so complicated?"

Yeah. Honestly, I appreciated your invitation that day because I just thought, "Oh." I felt like that was another window because it's not something that I share with everyone. I like to share it where it's going to make the most meaning"

"I don't want to whakaiti anyone else. That's why I really appreciated the invitation from you because I thought, this is where I can lay it down. This is where there is meaning. Well for me, even. Yeah, so. thank you"

A stakeholder from a local LMC stated "*the connections between our services and the DHB are less than satisfactory. Referrals, coordination with each other – there's nothing. Our scenarios are the mobster mums, living in garages, and sheds, no supports or whānau around them ... partners with no job, food, kids, everyday living needs not being met, every day … these are the mums who have the worst experiences in the maternity services, in hospital. But I've gotta go and pick them up and drop them off. I'm not a nurse … but we get involved because they won't go otherwise, or with anyone else. It's who they know and who they can trust*".

Maternity experiences differ between Wairoa and Hastings

Feedback from wahine Māori and whānau differed in relation to the service at Wairoa and the services at Hastings. Overall feedback from whānau was that the Wairoa team of midwives operate "as whānau and are available in person on text or messenger" and that they are all very helpful and responsive. For the Hastings service however, feedback from whānau was that some nurses and midwives in Waioha and Ata Rangi can be kind, while others can be extremely controlling and discriminating. Several whānau respondents were able to name specific staff who they felt mistreated them, and the names were fairly consistent across the respondents.

The Wairoa team of midwives shared a number of insights about their team, their approach, and their focus on culturally appropriate care for hapū māmā:

"We're more acutely aware of it because of the programme we had with whānau who are Korowai Manaaki Project - the whole basis of that was to try and look at a better model of care for Wahine. So, that's more face time with doctors, and providing free dental, transport, reducing the barriers for access. Pregnancy is not a disease. It needed a policy change. We paid out some of our $12,000 over six months, or eight months, and just travelled from Wairoa to the Bay. Scanning is a big one for Wairoa."

"I was working as an enrolled nurse from 1989 at the Wairoa maternity. So, that's where my initial journey to come towards the midwifery happened. The difference is I can tell you, is that it was very colonized. You did what you were told. The women that came in, they just went along with everything that was said to them. So, it was quite scheduled, everything had a time and a place, and was managed like that. Back then, you got to know who the māmā were. One of these young māmā that was there, she was given a hard time. She was pretty much coerced into doing what she was told. That was enough. I thought, "No. This can't happen. I'm going to be there for our family." So, that's the reason why I went to do midwifery. When I came back into their system, it was the same. It was a thing by doctors at those times. But then there was a change. The midwives came in, because that act became a name, so you could take responsibility"

“Now, our Wairoa women, I can say, is, especially our Māori, are quite strong in how they want things. If you look after them well, that's how we make good relationships. That's how things were way better than back then. One thing I did note about us as a team is, the continuity, which the College of Midwives brought in at that time. But whereas, Māori, making those connections. But what I noticed in our team was that if our wāhine were sent to Hastings Hospital, that's where your journey with them ended”.

“The ones I worked with that I couldn't go through to Hastings with them, we had made a connection, and that my thing with them was always so, when you get down there, if you don't understand what's happening, you ask them. You tell them, so that they can give you the information, that you are clear, and understand about that. But it wasn't like that all the time”

“As for the midwifery, as a team, I like working within my team. There were times when we didn't work very well together, but that came down to communication between us. That's why I say, as individuals, we need to take ownership for our ourselves. If there's a problem we need to walk forward and sort it between us, but in a respectful way. I want to say that I think our team here in Wairoa, we've got some really awesome, awesome māmā”.

“I see these babies now that are adults, and teenagers, and still know we know one another. I think that's what we need to work on is, more a connecting. Stronger. Then for a midwifery team itself, the hard thing about that is that we can't be 24/7 all the time. So, is there another way of building a strong connection with our team and Hastings? Building up the respect - So, how are we going to take care of her (pregnant māmā) once she comes away from Wairoa and goes to Hastings?”

“Working here definitely taught me how to practice from a rural aspect because you take all the external influences on being able to provide labour cares and looking after māmā rurally and everything that comes with that. Which includes getting to her, wherever she might be because some of our māmā live way up in the wop wops and areas that you've never ever been to. And areas where if you fell off the road, no one would know you've fallen off. So, those were the dynamics of working at home. What I did find there is that Wairoa, that community is a very, very tight knit community and everybody knows everybody or knows someone who knows somebody. Which is not always a positive. It could also work against you, as well when you're trying to engage with whānau. I’ve worked in the community for so long and know everybody and know all our birthing māmā, and the mother, and the grandmother, and the great-grandmother”

“When they got down there [to Hastings], they just wanted to know when they were getting back home. “I want to go back to Wairoa. I don't want to stay here." It was because when we talk to these girls, and what I got back from them, they didn't feel welcomed”

“When the whānau got there, they were pretty much like, "You're in our place now. You do what you are told." They would have different midwives coming on different shifts. That's how it was run. That's how the hospitals run because ... Like now the LMC are independent midwives, who do 24/7. The hospital midwives don't do that. There's a reason for that. Because of the skills that are needed. Most of us Māori midwives, we tend to have the same values. So, I try to see which Māori midwife is on”

“It's like they knew we're Wairoarians so you can see ... I just felt different from a Hastings person to a person from Wairoa and the young ones, a better, it's like, that's how I seen it”

Feedback from māmā who had accessed the Wairoa maternity service was overwhelmingly positive with several stories of feeling informed, supported, communicated with, and respected for their choices and decisions (despite impacts of Covid):

"For me, I, personally, two years, a lot older so I had a little bit more experience in ... You can put trust in other people to get you through a process, especially when they've trained for that process. As much as you want something to go a certain way, it's not necessarily going to happen that way so the moment you can get over yourself and trust the process, makes it a whole lot easier. Information, process, but she listened. She didn't force feed things down my throat. She wasn't telling me about her opinions on anything, she just listened to my anxieties, because they were mine. When I knew we were going in to be induced and I knew eventually, I'd have to get on that machine"

"Yes, I got clear information. I knew what was going on and I could ask. And there was support to be able to go to the Bay, petrol vouchers and all that, which is really like, it's not easy for some whānau to be able to just go, "Oh, yeah," and go to the Bay to get a scan. So, that support there as well, financial support, and just them supporting full stop. Like if I had any issues, if I was a bit not sure, they're there. … Yeah. It was nice and calming, but yeah. Nah, everything was all right. Actually, he was a good healthy baby and very fortunate because then I didn't want to go down the Bay where I wouldn't be able to see anything"

"So, my original birthing plan was to have my husband and my Mum there, but due to the restrictions we could only have one, so it was my husband. But the biggest struggle was when he left … and you're on your own. Yeah. And that's what really got to me was when he had to leave. And they did try their really best to try and drag it out, but rules were rules and he had to go"

"So, when I first got pregnant, I had a few midwives because I was all over the country. I settled here. And I think I just came to the hospital one day and [midwife] was there to take care of me. She just sat me down in the room and we filled out the paperwork, and then she said she'll keep in contact with me. She was good at keeping the communication, she was on Messenger as well as email. Because sometimes you really don't know what's happening to your body and all the bits and pieces. Yeah. She informed me a lot, she gave me pamphlets and if I had any questions, she answered them in detail"

"They were really great that staff in there, because after they did all the blood tests, they explained everything to me what was happening. And they said "We will write it all down for you, you must be so overwhelmed. You seem very alert, are you fine?" And I understood it all then. So, that was cool"

Desire for an independent Māori birthing unit in Hastings

Among many of the Māori midwives, there was support for an independent Māori birthing unit that could serve the wāhine living within the Kahungunu rohe. There was also mention during midwife interviews that the funding for the Waioha Unit was originally intended to support a Kaupapa Māori birthing unit but once Waioha was attached to Ata Rangi it became a hospital-based maternity unit. The Māori midwives who spoke of this have a desire for there to be a community based Kaupapa Māori birthing unit as was the original goal.

Some of the comments provided were:

"We have 17 Māori midwives in Kahungunu now who are ready to jump ship and to support a standalone Māori birthing unit in Kahungunu. And so, I've prepared a proposal with the support of Māori midwifery team, and we believe that we would be able to provide enough cover for three shifts

from 6:30 until 3:30, so three eight hours, that's two midwives per shift, plus on on-call Māori midwives who would be coming in for the labours and deliveries with our shift workers. So, we need 8 to 10 Māori midwives for the tree shifts, and then our on-call midwives working in the community, the LMC midwives. But we also believe that there would be opportunity to start our own midwifery training school. So, I've talked with the midwifery council, with AUT who suggest that yes, it would be possible to put Māori midwifery inside the birthing unit and they would do their practicum working alongside and being mentored by Māori midwives"

"The model is it not new. In Canada, they are already doing that, and so I believe that the process is not hard, and I think we have goodwill. I think that we are now at a time when it's possible that the funding would become available for such a pilot, and I think that especially when we're looking at workforce development and our Māori midwifery students are currently being denied access to DHB to do so practicums, I think it would provide a solution for workforce development, as well as providing safe places for our happy māmā to birth"

"I'd be looking really, really closely at the type of birthing service that can happen outside of wherever secondary care is, but honing in on a very, very much changed secondary service … then that secondary service care is every bit as culturally competent, and clinically competent, and sound as the other part of the birthing service, when you don't even need to have or worry about a hospital"

"I think in Hastings, you've got a good case for it. To have a standalone, with the number of Māori wards that you've got up here that's in their primary unit"

"It would be a kaupapa Māori standalone birthing unit that allowed our Māori midwifery students to learn midwifery inside the unit. It would be a place that is a standalone kaupapa Māori with a focus on hapū māmā, all of their antenatal, postnatal, breastfeeding, safe sleeping, Māori needs. It would cater for fathers, babies, mothers, teen pregnancy to have……. Everyone, all of it. It would also be a place where the tikanga could be re-established and redefined. It would be a place where all of our Māori midwives would be supported to be the best Māori midwives that they could be. I believe it needs to be acknowledged and resourced by the Ministry as well as the iwi to allow our Māori people to have this in every single community"

Kahungunu: Photo Credit – Wairoa District Council

Understanding, practice, and behaviour of the HBDHB towards responding positively and effectively to the cultural needs of whānau Māori

Nau mai e tama ki te taiao nei, Kia whakangungua koe ki te kahikatoa, Ki te tūmatakuru, ki te tara ongaonga, Ngā tairo ra nāhau e Kupe i waiho i te ao nei

Documents to guide practice, understanding and behaviour

HBDHB policies & position statements

The review team reviewed the HBDHB Policies and Position Statements; Organisational Structural Diagrams; and Strategic Plans, Strategies and Reports. More in depth summary of the documents is at Appendix 13. The documents identified that the position statement on institutional racism revealed a system for making complaints about racism in the organisation safely. The proposed process will need to be carefully monitored and ensure that appropriate reporting, advocacy, and cultural safety supports are in place. The HBDHB's policy on Treaty of Waitangi Responsiveness – Assessment and Procedure is also an affirmative policy and a strength that the HBDHB benefits from having in place. However, there is a need to update and revamp this policy as it was last reviewed in 2018. It should also reflect the findings of the Wai2575 claim to update the principles. The Hawkes Bay District Health Board Health Equity Framework – Mana Tangata Taurite is a strong planning and performance strategy for the DHB. This focuses on improving responsiveness to population need, consistently delivering high-quality care, and maximising system productivity. It requires a one-system approach that challenges the way planning and delivering services happens. It is suggested that more relevant equity measures be included that resonate with whānau Māori rather than the dominance of clinical indicators.

The HBDHB Policies on Maternity Wellbeing, Child Abuse, and Child Protection and the Child Protection Multi-Disciplinary Team (CPMDT) Guideline are also strong with the intent to have the best outcome for vulnerable pregnant women and their whānau. Whilst this outlines the role of a Multidisciplinary Team it is weakened by the lack of specifically identified Māori representation (senior Māori Midwifery presence and senior Māori cultural expertise) being present. The HBDHB Manual: Clinical Practice Guidelines and Child Abuse and Neglect Policy has a strong focus for Māori and Pacific intents, values, and recognition, however, it is considered that cultural expertise must be present in order for tikanga practices to be physically evident in the child abuse and neglect decision making process. Similarly, the HBDHB Manual: Clinical Practice Guidelines Child Protection Alert Management Policy needs to be aligned with the MDT guidelines and recommendations.

The HBDHB Policy on Care of Deceased is considered to be a strong and appropriate policy.

Several organisation charts were reviewed related to health services (October 2020) however none of these depicted or placed the Māori Health Leadership anywhere within the diagrams. Nor was the Hauora Māori Health Service identified – particularly where governance and executive were mapped into the structures.

HBDHB strategies plans and reports

The team reviewed the Hawkes Bay District Health Board Minutes, and Māori Relationship Board Minutes. DHB performance on national health targets are also evident in the Board Minutes. Often Māori and Pacific are grouped together in governance considerations because they share inequities. This does not recognise the unique place of Māori as tangata whenua and Treaty partner, which take precedence over any equity analysis. In fact, equity analysis should be embedded as one indicator of the Treaty relationship's effectiveness.

The HBDHB Workforce Strategy 2019 was reviewed and in particular the area relevant to the maternity service review related to the goals:

- Sustainable, Engaged Midwifery Workforce
- To deliver safe, equitable, culturally responsive quality care to support positive experiences and improved outcomes for wāhine, pēpi and whānau
- Recruitment NZ New graduates - Wrap around support for Māori and Pacific undergraduates
- Increase in Māori and Pacific graduates.

The goals are admirable but again join Māori and Pacific goals together instead of specifically targeting Māori under a Tiriti commitment (thereby implying partnership with Māori to achieve the goal) while addressing needs of Pacific under an equity commitment.

The HBDHB MAI Māori Health Strategy 2014-19 and HBDHB Māori Health Annual Plan 2016 / 17 were also reviewed, with particular emphasis on locating specific intentions around maternity services for whānau Māori. The strategy, developed in collaboration with Ngāti Kahungunu Iwi Incorporated and Māori communities, guides the district health sector in the pursuit of improved Māori health. A whānau ora approach is promoted. Goals appear to be relevant and inclusive.

The HBDHB Health Strategy Whānau Ora Hapori 2019 – 2029 provides the foundation for the planning, delivery and monitoring of services, to result in better health outcomes. This is a strong strategy developed with the Kahungunu Iwi goals in mind and in collaboration to provide Ngā Mātāpono (principles).

Stakeholder feedback on the provision of culturally appropriate care

Tiriti partnership has been ineffective in ensuring cultural safety for whānau

Several DHB Māori Relationship Board members made comments that indicated the ineffective relationship between the DHB and Iwi Māori, and how the partnership did not have the impact that it should have in ensuring culturally appropriate care for whānau"

"*I'm always dubious of the Crown setting the context for partnership. I think that the MRB has fallen within the gambit of the DHB control with the items that go on our agenda, the people who appear before us, the decisions we're asked to provide advice to. It's always seemed to me to be an incredible waste of the talent that sits around the table. I've never been sure about why the DHB board members sit on MRB ... the control is exerted by the DHB and that's through setting the agenda, controlling the agenda, sanitizing the minutes*".

"*The DHB itself is not necessarily best practiced or evidence-informed in terms of the reduction of Māori inequality or inequity, which is always a dreadful shame*".

"If I'm thinking as a Board member, I get very frustrated that there's a lot around our provider in the hospital. Whereas primary, most of the activity happens outside of the hospital. But the four walls of the hospital consume so much energy, time, commitment, risk, resource, data reporting, money hungry. It will. So, it's inefficient. And its old buildings carries huge risk. And some of our progress is quite stagnant. And the utilization is mainly us. Particularly maternity services. And I wouldn't know how responsive we are. We get stories."

> *"That kind of set the scene for engagement with maternity services, that we would hear back from people that those in the health system who came and presented to the MRB were picked on, challenged, not wanting to come and see us. So, in a sense, there was an easy out for people not to come to us, and no accountability. Where we sat, our advice fell – no one did anything with our advice. So, all we'd hear is just little presentations from maternity, and then just the bad experiences that Māori consumers were having, but Māori whānau were having bad experiences throughout the hospital. A grave reluctance to do anything about it, and I made the mistake of appearing at Māori Health at one point for the morning karakia and chat to find that they talked about whānau just as bad-mouthing ... bad-mouthing whānau just as much as anyone else. They've got this kind of ethos that whānau are to blame for their own circumstances. But without that, governance doesn't work, even in MRB space, without some sense of accountability. The whole thing about inequity - in terms of inequity, it just thrives on racism, which is essentially founded on hatred, and no one's doing anything to shift people out of it, or only just minor moves to make people accountable and trying to change culture"*.

Another local iwi member raised concerns about the relationship with the DHB:

"And when I've challenged it in DHB, Sometimes I've been really clear that, thank you for your comments, Crown. We'll put that in that box but let's listen to Māori as part of this relationship. You influence the rest of the people that the Crown have got authority over, but don't come and make out that you can sit in both fences, because you can't. But the whole design of the DHB is based on their world view, not actually the people that are out there. They take on that paternalistic role; we know what's good for you. We get told, our whānau, they're pretty dumb."

HBDHB Board perspectives provided were:

"I think we've been through quite a bruising time. If I can speak from the staff perspective, where we've had a chief executive with his eyes firmly fixed on the bottom line. And there's been a fallout from that. I think you squeeze a service so far, and people tip over. This is back to your values … that's the foundation for everything that you're doing. Because that has been such a core part of our new way of thinking, our transformation, and caring for staff and what we're wanting to care for staff, there's been a change with our CE, being safe, being valued. I do believe that".

"The Māori Relationship Board advises us, too. A lot of the plans are supposed to go through the Māori Relationship Board, and they put their lens overtop of it before final decision-making".

MRB members also provided some more positive or aspirational comments about the relationship with the health system now and into the future:

"Yes. Māori as a whole and our Māori health team is certainly strengthened. So that's very positive. Maybe just a little bit messy with the new entity coming on board, the Māori with the Iwi Partnership Board from going to transition we're all supporting it like that, but we don't really know who those appointees are coming on board and there's a little bit of a - who are they? Are they ready? Or ……will be ready. Some aren't."

"As a Māori relationship board, we are reporting back up to the HBDHB Board. It's always been very respectful from other board members, incredibly respectful. And at times I've been frustrated that we - as the Māori Relationship Board – we haven't taken enough actions and recommendations. Lots of wide-ranging discussions, but actually it's up to us to say ABC, to demand, but it's taken a while to ask for that. Yeah, I can relate to that, but I also think that's our responsibility to gain those teeth. And I have never had a pushback from the DHB Board members about any actions, any recommendations, they've always been endorsed. Okay. So, the flip side of that is, well MRB, we need to take up concrete recommendations and they will be mandatory."

"We have been transitioning through the Māori Relationship Board into an Iwi Māori Partnership Board where you might just try and go straight to that but depending what sort of setup our region ends up with. Fortunately, NKII did a really good job when he was in there, so you can't throw the baby out with the bathwater. PSGEs are going to be in there, and probably some representation through the Ngāti Kahungunu Incorporated, because they have, whether we like it or not, developed a good system of working out there with communities and developing health strategies over the interim years".

"There are just new mandates in the district. Ngāti Pāhauwera, always said that only Pāhauwera would speak for Pāhauwera. So, we didn't have a seat at the table. Kahungunu is there (NKII). That's fine. But only Pāhauwera speak to Pāhauwera, and at the table would be Rongomaiwahine, Te Wairoa"

"Regardless of the DHB, remembering too, that DHBs will be gone, Health NZ and localities will remain and potentially they might be the same staff, but you'll have the Māori Health Authority that will have our commissioning role and a monitoring role as well as the Iwi Māori Partnership Boards. So, we'll move forward with that, with our level of intention, because what we've always done is moved with intention. And we have worked with our sites here, both Hastings and Napier and with Oranga Tamariki regionally, and nationally to intervene in that space. We have this reference group called Te Tumu Whakarae o te Wero it is made up of all the Kaupapa Māori providers within the social sector. They have all their CEs at that table. And government representatives sit at that table. The providership created Pou Amo, which is an external, they - Oranga Tamariki, would call it Iwi external facilitation of FGCs. But Pou Amo for us is a whānau hui that's facilitated by a provider. So, we've intervened within that space where we can, when babies, prior to babies being born that Pou Amo will run a whānau hui to determine whether there is any risk"

The practice of providing culturally safe care

Several staff provided examples of occasions when they felt that provision of care and treatment was not prioritised over staff judgments about certain whānau as patients. These staff felt that often the staff used their power to refuse care because they could not see past a stressed patient who may be swearing for instance. Such an example came from one of the Māori Health staff:

> *"ED runs very similarly, and we had ED nurses that called me to and what they had is a guy that came in, he said, "I can't f..king breathe. I can't f…king breathe." And they said, "Hey, watch your language." And he said, "Get me some f…king oxygen." And they said, "Look, read that sign we will not serve anyone that swears - respect our space." And he said, "Oh, f--k you." And he was sitting there, they couldn't get his name... In the end the triage nurse came out and said, "We're not going to serve you,*

you need to go." They got the security guards, they told him to go. This is what they do … He did come back, 6 hours later - dead. He had a respiratory attack. And you know what? Our Māori nurses sat here and watched it, and as much as we tried to intervene, they were told, "You are only junior, get back to your ward, they need you. Get back to your space." Our people sat there and watched that. So, I called a hui. All of them, and Māori nurses. Security came from ED. I said to them what are you here for? Oh, I work in security. I really hate that job … because [you are] sitting here and watching what happens to our people. I can look at ED on the camera and I can see who's on the screens [staff] in the ward, and if it's in ED I can look at it and I know "we're gonna get called out here tonight. We basically sit there because if certain staff are on, as soon as that someone looks a bit unkept or that might seem like they're gonna be aggressive… they escort the patient off. I said, " How are you going to stop the racism because obviously they're identifiable to the security guards, how are you going to stop the behaviour?" Who is doing this to our whānau? This guy is dead…our people are dying because somebody is not triaging because they don't speak the language and look like you"

As one staff member said "*I get it, we don't want people swearing at us for sure – but if someone is screaming for oxygen and cannot breathe you sort that first – and then talk to them about their language when they are calm. It's the principle of save the life first – then talk later. But I think because it's a Māori who doesn't look too flash – they get judged straight away and the power is used to exert authority over them*."

It was noted by another staff member that some DHBs do better with prioritising the care of Māori patients such as Auckland DHB who have "*made it a policy never to cancel surgery for a Māori or Pacific person, because they know that the person who's coming in for surgery, who's probably had to plan their life around their job, their children, their education, that the day they've planned for is probably the only time they've got in the next three months. Never cancel their surgery. So, they haul long-waiters off surgical waiting lists. System responses are possible*".

An MRB member added "*What they get is people who are full of judgment and dislike for them (Whānau/Māori) because of their poverty, because they have hard lives often, they're hypersensitive, because hypersensitivity is a predictive mechanism. They know when someone's judging them*". This person added:

"*There's no excuse for not practicing this way. We want you to be clinically competent and culturally competent. We need an accountability system that either retrains you or shuffles you out the door.*

It's not hard. What whānau want is for the person who's at the bedside of baby to be able to pronounce baby's name. Practice until you can pronounce it. Write it phonetically so you can pronounce it. I've spoken with Mums who have got babies in NICU on death's door who don't get offered Māori health, don't get offered a karakia. What whānau want in a maternity service is so small"

"*There is also the area of unprofessional behaviour in the maternity service – you know – young staff, talking loudly and disparagingly about the patients, the māmā and whānau……. I went in then. Talked to them about their loud, judgemental remarks on Māori mums about their inability to look after their bubba's*"

One senior Manager agreed the DHB could do much better stating "*Our final legacy is what are the building blocks that we want to put in place this year to make those experiences - access, experience and outcomes - different than the ones that they're receiving now, and kind of set it up as a method of thinking about it and then working on it so that it sets it up for more than maternity. There's a legacy mainly about the fact that there's never been a better time for us to dig into what's systemically wrong with the mainstream system and turn it over*".

Other senior leaders in the DHB added comments which focussed on improving performance for whānau now and in the future:

"We have an interesting structure in Māori Health Unit as both commissioner and provider. So traditionally within health services, Māori health is kept separately, reported directly to the CEO. It's not a part of the health service umbrella, but as you quite rightly say the whare, the Kaitakawaenga the cultural leadership support we rely on massively day in, day out. We need to start preparing for what the health industry system reforms are going to bring so, it's quite possible when Māori Health Authority, Health New Zealand the commissioner, Health New Zealand the provider split out. And we've got to be ready to receive it and do it justice. This is not about handing a whole lot of power to one group; it's about how a public service system becomes culturally safe for everybody who is seeking care within our system".

"*If we're talking about cultural safety, it's cultural safety for Māori, it's cultural safety for fathers, and I think what's really interesting about the te reo terminology. It's not whakamāmā, it's not whakapēpi – it's whakawhānau. And so, a big part of the cultural response in this piece is how do we recognize that maternity is unique in our health setting, in that we're not dealing with illness. This is not a response to illness; this is responsible to predominantly well people who are about to have a life changing event that could establish and set bedrock for their whānau for the next 50 years*".

"*So, I see some signals that as an organisation, all the things that we did wrong at that point we have learned from, but it's not embedded. This [uplift incident] was so horrific that it had to come straight to me, and we went and dealt with Māori Health. Could we say that the organisation would be trying to respond to that way? Not yet*"

"One of the things that I was frustrated about was that I heard the narrative that you're hearing that our maternity services are not culturally responsive. And our complaints and feedback data show a different picture and that's all the service would say. And so, obviously we are not even open enough to have an honest loop of feedback with people to get their experience because it was evident there couldn't be this amount of noise. And then I think we've got to look at how, we are not best positioned to get that feedback. But then we've got to rely on others in our community to be able to give us what we need to hear"

"I think some of this is about saying "How do we move more services out into Kaupapa Māori models of care and do that in an appropriately resourced way?" And then where that is difficult because the amount of resource within a bucket, even when you give the full resource is if you deliver it in a community setting on day one, it will end up costing that entity more. How then do we give that control away while sharing responsibility for the financial impact?"

Challenges integrating Kaupapa Māori approaches within maternity services

There were several comments made about challenges with integrating kaupapa Māori approaches within the maternity services with one Māori staff member stating "*We have struggled with maternity*

services … maternity services is a key and vital part of what we do in Māori health. The CHAT service, ka pai it is a service that's needed but we also need it for Māori māmā. They tell us they cannot get more Māori involved. I said this service has not been designed for Māori, by Māori. This is 2021-22, and it is not acceptable anymore. There needs to be more effective thinking at the tēpu going into these areas for service provision to Māori".

It was also noted that a Māori Midwife advisory consultant position was put into the maternity service and funded from Māori Health for some time before the maternity service began funding it as described "*Māori health funding that went to purchase the Māori Midwife Advisory Consultant position. This funding came from Māori health budget, not maternity. We funded this for the past 2-3 years and have turned it over to maternity to now fund. They tried to push back but it does seem like an isolated position. Maybe the clinical part should be funded by maternity and the cultural quality part by Māori Health? This is another missed opportunity for the Māori programmes linking with maternity services".*

Māori health leaders have been concerned about services for Māori māmā for some time as evidenced by the statement "*there are troubling areas in maternity for Māori māmā … we escalated feedback received from the māmā. Aue, te pouri me te mamae. We gave the reports … like it was critical that some action and follow up happened for the māmā whose stories were held by us. But the action had to be taken by maternity – not us. These are our whānau. They are our people….and for it not to go anywhere? Not get addressed. They just said "Thank you for this. But nothing was done*."

"*Why shouldn't the Māori Birthing Unit be Waioha? That's what it should have been. Waioha Kaupapa Māori Birthing Unit. There's been so many missed opportunities. They are rowing their waka in a different direction. There are so many inconsistencies. It seems we're a 'nice to have', not a 'have to have'. Our concerns – ngā mea Māori – are negotiable. They can pick and choose. But when it comes to clinical……oh that's not negotiable*"

"Accountabilities are not in the right place. Monitoring and measurements for Māori health are still needed"

"Across Paediatric services – the Special Care Baby Unit (SCBU) and maternity services. There is a feeling that these services could do better in the way that they work for Māori. The 'Wairoa mums' – they get pretty anxious being in the Hastings maternity. I have seen how they get treated, yes. They are away from home, the rest of the family. They get 'handed over' to other Midwives who they do not know. The midwife who was with them is not involved anymore once they have to come to Hastings. Then they are passed from one different midwife to another, it's not always the same midwife they are dealing with".

"*Whānau love Waioha – it's comfortable, a place for whānau and partners to sleep, have karakia, and space of their own. Ata Rangi is quite different. More clinical, medical, it is hospital, not maternity for more normal circumstances, and not whānau orientated. There's nowhere for whānau to stay. They have to sleep on the floor. Mattress on the floor*".

"But the hospital service has a responsibility to be culturally safe and culturally responsible and be staffed by Māori and led by Māori, and Māori leadership, Māori management, Māori kaimahi. And I said this to (DHB colleague), he is a good guy, but he has this thing that everything's a catastrophe and we need more security, and I said, "I tell you what, we don't need more security, we need more uncles, aunties and cousins, they are your best security."

"And like Nan … she is your security, both whānau and you actually, kaimahi a tauiwi. In a situation a security guard came straight over the top [of the Nan] - she had that situation under control, and it

was a safe environment ... the security guard comes and she's in the middle of a kōrero and he just barges on in. So, they don't see, they see you're emotional, getting out of control, you're a risk to me. You're a risk to me and my reputation, and that's why they bring another approach."

The general feeling about the staff who work in the maternity service is that they lack cultural understanding from the top leaders to the bottom. One staff member stated "*what they need to do is listen to what the whānau feedback is about them and their service and take it all on board as a way to help them improve their service. That's the only way they can do better, take the feedback as improvement opportunities and not be negative or ignoring what whānau are telling them*".

"*There's no assistance post-natal. Some of this stuff whānau are saying – they don't get any help with their babies, no assistance to breastfeed, bath baby, you know – basic parenting. Or it's the opposite – they come and take the baby away to do the bath or something. But leave the māmā there – don't take her with them and get her to do the (bathing) and watch her to assist her. There's none of that happening in there"*

The Kaitakawaenga cultural support was identified by several staff as a valuable service. It is offered in Waioha and Ata Rangi but not the delivery suite where the actual birthing takes place. An incumbent in the position stated, "*as a Takawaenga, I feel safe enough going into maternity because I have this Māori health unit – got my back, but if I was on my own – nah – I wouldn't feel safe with them*".

SCBU was noted as "quite different [to the maternity service] with comments from staff such as "*absolutely awesome. Less clinical, more inviting. The Kaitakawaenga role is valued by SCBU. māmā and whānau get well treated too. The Chief Nurse/Midwife – she was awesome too*".

A pattern of institutional racism

The responses from several interviews generated a theme of patterns of what participants often referred to as "*institutional racism*". Some of these comments are as follows:

"There's a lot of white privilege in the system"

"We just published a paper on pre-term birth, and we talk about who the system is privileging. Basically, it's privileging whiteness.

It's really clear. The last CE would go to the U.K. and recruit people in senior management, he'd go and recruit people just like him and bring them over. So many of the midwives are from the U.K. We were saying, I have no problem with international recruitment in health, but my understanding of the U.K. is, it's ethnically or racially diverse. Why is it, every time …... everyone who comes from the U.K. is white?"

"The HBDHB maternity service has been rooted in racist and discriminatory practices – a given due to the fact being established by pakeha, and now as they embrace and try to practice Māori traditions, they lack real conviction and care for both Māori culture and people"

"In a very inappropriate way, try to lift out our taonga from us in isolation of Te Ao Māori and place it in their world, which really disrupts our identity. So, that's what's happening now. So, they suppressed it and hated it before, now it's a whole different transformation and we don't want you, we just want your Taonga. We just want your ipu-whenua. We just want your greenstone cutting cord thing… And by acknowledging that we want this stuff for ourselves, makes us culturally appropriate"

"Some get it, which is great, and then some just go back to their natural way of doing things, which is how they were, I guess how their world informs them how to engage, which is not our way, so they still struggle with that. You've got some clinicians who connect with that and then you've got some that just say they are, but underneath it all there's ... you know, racism, and that's all that's driving them."

"I always see this, because this world likes to be evidence based, so for three years I've been saying evidence has told us if we don't address racism, Māori health improvements will never happen"

"There were internal perceptions of our whānau that placed the blame for their circumstances squarely with them – all expressed without any sense of accountability"

"The whole thing about inequity - it just thrives on racism, which is essentially founded on hatred, and no one's doing anything to shift people out of it, or only just minor moves to make people accountable and trying to change culture."

"I've been hearing some of the women have had experience. I remember this one story, it was years ago, and I still remember this woman telling me this. She said, "Yeah, I understood that my baby got hurt [at the hospital] because of the processes or what happened." She said, "But all I wanted was for someone to say that they were sorry."

"I think you can see it, it's a formalized racism and anybody that speaks out against it, you are chopped out whether you are Māori or non-Māori. I know many of my friends over there would speak out and they just got chopped."

"So, when I would go in there as a midwife, I would almost... The anxiety, you know. The anxiety, I was just so frightened all the time that I would do something wrong. Down to what I would wear. If I turned up in the middle of the night in my hoodie, I was questioned, I was interrogated, "What are you doing in here? You're not a midwife." You know?"

"And, because you speak up, because you advocate for people that the mainstream doesn't think have the same rights as us, you are considered difficult. Yes, and if I had to do it again, I would do it again"

"And the communities that don't have that equality are not confident enough to make a complaint, for a lot of migrant communities. And I know, me coming from South Africa. I am appreciative of that. So, if one person treats me badly, I am not going to make a complaint. And, number one, I don't know that I can make a complaint. Number two, I don't know how to make a complaint. Most of all, I'm so grateful that I'm getting this treatment"

Māori advice not being heard

Several participants discussed being in situations where they would provide Māori advice on how they thought things should work to benefit Māori – but more often than not, they were not heard, or nothing changed as a result:

"Where we sat, our advice fell – no one did anything with our advice."

"So, all we'd hear is just little presentations from maternity, and then just the bad experiences that Māori consumers were having, but Māori whānau were having bad experiences throughout the hospital."

Tokenism

Māori midwives expressed dissatisfaction with current attempts at showcasing Māori culture, lacking both depth and actual care into these attempts. All attempts of integrating Māori culture has still been done through a colonial lens, rather than deep engagement with Māori on every level.

"All the images on the wall are Pākehā interpretation of what Māori looks like."

"There's a karakia on the wall – but it is never used or offered to ngā wāhine"

"It is undeniable that HBDHB has attempted to incorporate Māori taonga into their practice. However, this brings into question of how well they actually achieve this goal"

"……. prior to my arrival and some people, I wouldn't say racist, but certainly I would have to assume that there was good intention for the establishment of a MOU and the creation of a Māori Relationship Board between Kahungunu and their District Health Board. But both parties would agree that a mandated but non-resource allocated advisory board only can go so far."

"There's a metal sculpture that resides at the front of the unit – lacking any korero about the meaning behind it – just put something up with no wairua, no life"

"Disingenuous consultation of the Māori midwives for their opinions on the building of Waioha primary birthing unit. Instead of consulting the Māori midwives for guidance on how to artfully, and respectfully, encapsulate Māori culture into the building, they were instead asked arbitrary questions on which colour of paint they would prefer"

"They had an opportunity to do something wonderful and really embrace the whakapapa of this Iwi here. It's a place of birth, and all they cared about was the colours on the wall. The pastel colours."

There were several accounts by Māori midwives reflecting on their time as employees of the HBDHB Maternity Service and Māori LMCs in the community when Waioha Primary Birthing Unit was in its design and building stages. The disharmony with the end result was evident throughout the review.

"I would've put a whole heap of artwork up in here ages ago that was representative of whānau".

"It wasn't relatable, it was not representative of our community. It actually seemed like something that belonged in maybe the North Shore DHB".

"And then you add an unwelcoming staff member and you've got a really uncomfortable space".

"No, I think even just that reception area as whānau come in, it reminds me of cinemas in Westfield, where it's like they purposefully removed all those seats to stop people from sitting there. And that's a business, I get that, but whānau are coming to be a part of a really important event".

Judgement of Whānau

Several Māori participants raised concerns about staff who have pre-conceived ideas about Māori and act, behave and communicate accordingly in inappropriate ways:

What they get is people who are full of judgment and dislike for them (Whānau/Māori) because of their poverty because they have hard lives often, they're hypersensitive, because hypersensitivity is a predictive mechanism. They know when someone's judging them"

"We've got this hypervigilance on Māori and what you've got ... You've got the sink of maltreatment here, and this sink of abuse over here. But neither works. So, what's the solution?"

"When you come from an inherent belief that we [Māori] are the problem, they're always going to see us as the problem. Even when they've worked with us, they still look at you as the problem. You might give them a tool, but they still inherently believe, and its racism to the core, that we are the problem. They might put on a fake smile, but they're still, their whole sense of understanding us is, "You're the problem." And our side, we look at them like, "You're the problem." And so, we get this friction."

Stereotyping

Building on the previous comments there was also feedback from the interviews about stereotyping of Māori whānau:

"The thing is that stereotyping because there's more to a person just with what you see. And that's the thing about these, with our gangsters, whānau, but there's more to them, that's just a part of them, that's not all of them. In fact, I'll say, the ones that came in, and they called them their babies, their pēpi. Oh, they're bloody awesome. And one father when he caught his boy being born, he was amazing. And that's the thing with these men, is they have their own mana"

"They might have gang connections and tatts, but they love their wāhine and their babies. That aroha is not different – but they get judged the minute they walk in the door as bad parents"

"I know our whānau are amazing birthers, and if anything, what we have as a positive is that our māmā do have really good birth outcomes. Even though that's a minute part of the whole picture, that's something that needs to be celebrated, not making it harder for them. They had a block of a motel type of accommodation for whānau to come and stay, and they only had to pay $10 a night. The 'but' was, to make sure that she had a partner who was not associated with any gangs. Straight away, it's like you're stereotyping them before they even walk through the door. It's like, "Okay, and if she does have a gang," which is highly likely that most of our Māori at home do, especially if he's not got it visible"

"Even moms who have had a history of drug and alcohol abuse, you have to know that there's a story behind that. There's a story behind that, and we have to honour that and respect that. But judging people, or moms, on what they are doing, what choices they make, is not ideal. I get very passionate when I talk about that"

"Even people from the gang. ….so many kids that we would not allow the dad to stay overnight. And I have advocated for the dads to stay overnight"

"Without even looking at the person, "Oh, he belongs to a gang so he cannot stay overnight because of security reasons." But he hasn't done anything. I will tell them, "He has been so respectful to me throughout the pregnancy. He's a dad that cries at the birth of his child. He's a human before he is a gang member."

"Because it wasn't about me. It was about the people that I worked with. And I think us judging them, or people that judge people, not from gangs, drug, and alcohol abuse, they sense that judgement and that's what gets them up. Because we already acted differently, you know? And our body language says that we are judging you. The way we talk to you says that we are judging you. The way we put you in a box, basically, are judging you. But whereas, if you leave that judgement at the door, you'll find that that energy coming back is so different, that respect coming back, because you have respected that person to not judge them"

Micro-aggressions

Some interviewees commented on the day-to-day micro-aggressions that they and their wahine face:

"Sometimes, for me, as working in Māori ways, that there is something there that they're questioning about my skills, about my ability to do my job. You feel it"

"It can be a simple questioning your practice, like you don't know what you are doing, making you doubt yourself - that's the kind of nice racism, the micro-aggression that I feel, and our whānau, every day, whether it's in the supermarket, face every day, and then they come into this system of healthcare, and it continues. Yeah, so it's huge."

Foreign Midwifery Leaders In the service

Several comments were made raising concerns about maternity leaders recruited in from other countries and their absolute lack of respect for tangata whenua and judgment of Māori as somehow a "*lesser people*":

"I know. It's shocking. It's nothing short of abuse. And I believe personally, the reason why has been because most of the maternity services around the country are run by overseas midwifery leaders, and they have no idea about caring for Māori, they don't understand their legal rights and the illegal approach to the Treaty of Waitangi, and they have no wish or no desire to improve services for Māori"

"They [staff from other countries] think we're under-serving and they think that we are the bottom of the barrel, and we're nothing but trouble. And you see it in their faces when you walk into delivery suite, they look at you with contempt. And that's at us, we're midwives. That's how they treat our families as well, with contempt."

"So, I believe the only solution is to set up our own standalone Māori birthing units funded separately from the (mainstream) so we can get on and do our own thing and have proper care, and be respected for our knowledge, and look after our own in a way that we believe they need to be cared for. And I believe, like this oranga tamariki stuff, no matter how many reviews we're going to do over the next 20, 30 years, nothing's going to change for our Māori people. As soon as they access mainstream services, they are treated like animals. And I don't believe any number of reports and reviews will ever change the way they feel about us. We are nothing but undeserving people, that's how I believe they see us. "

"Went for an interview for Waioha … the primary birthing unit. Had all of the experience of running a birthing unit, and we were interviewed by a Canadian, an English, a British, and a South African midwife. One of the questions they asked – me a Māori midwife with huge experience - what did they ask, something about the treaty, these overseas midwives? She couldn't even say the word properly, and we are looking at them, these four overseas midwives. I wrote a letter of complaint to the DHB, said they have treated us appalling"

Euro-centric approach impacts more than Māori whānau

There were comments made about the impact of what was termed a euro-centric approach to maternity services, on other ethnic groups. Examples were given of the impact of the one size fits all approach on women and whānau of other cultures:

"The service does not encourage Māori, Pacifica, Asian. I mean, physically, yeah, things may have changed, but if you look at our maternity unit, it does not encourage Māori. It does not encourage the Pacifica. It does not encourage migrant communities".

"I have been told, "No, Mr. Singh cannot stay overnight because he sleeps all night and he doesn't help," right? Culturally, Mr. Singh would not even be at the birthing room, he would be pacing outside. But he is there. It's a big change. It's a big, big, big, change in this generation. We are getting men who would never traditionally have been at the birth here. So how do we support them the best that we can instead of expecting them to be like Mr. Smith who has grown up seeing his mom changing nappies, his dad changing nappies, has gone to antenatal classes, has that mindset that, "I will be doing 50% of the work."

"It's not only about the language - It's about learning the culture, as well"

"So, yeah, as I was saying, it's not only to just to respect that this is what's going to happen. Just because it may be different from what I believe, but this is what that person's culture is"

"I know there's this whole thing about Indian women being very drama queen, can't take pain, and they say, "Oh, we're just going to put them in water," or "I'll stand out here in the nurse's station and I'll wait for her to start pushing before I go in because woman will be screaming." Now, you take yourself and you transfer yourself to Japan, where people do not speak English. They don't understand you. They don't understand your culture. You have newly married. You don't know your husband that well, because a lot of them are arranged marriages, and you're expected to birth"

"A lot of migrant people come to New Zealand thinking that New Zealand has got this amazing health system. And, yes, I do agree that we have this amazing health system, because when I compare it to South Africa, it is an amazing health system in comparison, so we don't want to complain"

"A lot of research is based on white women, you know. That's the short answer. It's based on white women. And we're all very, very different. So, it's quite the opposite. And they've never heard of the different types of pelvises that each woman has"

"Don't let me get started about the growth charts. Yeah. Every Samoan baby is over the graph, it's over 90 percentiles, and every Indian baby and Asian baby is on the 10 percentiles. We have a framework that can be flexible. I had the highest episiotomy rate I've ever seen in my life. I had about a 13% episiotomy rate. But you're not looking at the demography of who I'm dealing with"

Perspectives related to the Model of Care

Perspectives of Māori midwives on providing appropriate care

A variety of Māori midwives (both HBDHB and independent) provided insights of their approach to their practice in working with wahine Māori:

"I think I love my job. And I love working in midwifery for all that it has to offer and for all my learning experiences. I love the wairua ... it's about being close to the whānau; it's about being close to the whakapapa. It's about being close to tipuna, and I value and cherish those moments. And for me, I think it's a special place that we have as Māori, where we are able to live and be a part of who we are. It's that time for me to remember the stories, and to be able to be a part of history. To be a

part of our whakapapa. And to be with our tipuna. I believe that when māmā becomes pregnant, she links with the tipuna".

"*I've had a lot of high-risk māmā, they come to me. And I was asked a few years ago because I would put on my scrubs … I would have 'Māori midwife' put on my scrubs. And I was asked [by another midwife], why do you put 'Māori Midwife' on your uniform? You know, this is why I've become a midwife. And I say it's because I am a Māori midwife. And she goes, "Yeah, but we're all midwives". And okay, yes, we are all midwives but I'm a Māori midwife. And she couldn't understand it. And she goes, "But we're all the same." And I'd say, "No. I'm a Māori." And that comes with being a midwife. So, I am a midwife, but I'm a Māori midwife. She didn't understand what I meant. So that's my whakapapa. That's my mark. That's what comes with me. My tipuna. My history, my teachings from my parents. Our teachings of my mother and father who have grounded me in these principles. Principles that they have been taught from their mother, their father. From living on the Marae. From living with whānau. From being whānau*".

"*I'll give you an experience of what mine and my māmā who have come to me, just recently, who has a history, of Oranga Tamariki in her whānau. And I believe that there's been an injustice to our people. And I believe that those things that our whānau carry, who are in problems, whatever they are in, because of the loss of their whakapapa. And I believe that if we as Māori believe in our whakapapa, then we must believe that we stand for our whānau who have had losses, who have nothing because it's been taken from them. And they are lost in this world of colonisation. So where do they go to? They are swayed by colonisation because they had no foundation".*

"*When I go to them and then I don't know them, I might go, "Oh kia ora what's your name?" We kind of know everybody in this area. And we try to connect to who they are and when we make that connection, then I am now able to talk to them and their whakapapa even though they don't know their whakapapa. And we want them to help and connect back to remember who they are. And as that māmā, you are the māmā of that baby.*"

"*And even though whatever their history is, it doesn't matter to me. It matters, and I have to be mindful because that's a part of her plan. That's a part of what she holds and what she comes with, but this is here and now. How do I help her to find herself in the situation that she is in? How do I help bring out her ability because that's who she is, she's the māmā wahine of that family? She is the foundation of that family. She holds that māmā within her that nobody else can hold. She holds that mokopuna within her, she holds the baby with her, which connects her to tipuna, her tipuna with her now and everybody else is with her now*"

"The processes with the hospital, they don't hear our voice, like with what happened with Oranga Tamariki, nothing has changed. Nothing has changed. None of the processes has changed, they had this multidisciplinary team that are meant to not have it there"

Service delivery designed to suit the system - not the whānau

There were several comments that related to the practices of the DHB raising concerns about the lack of connection and communication between services; scheduling of appointments that are unreasonable for whānau; and the lack of timeliness of information:

"Everyone in a hospital all works in these tiny little silos all the time. The patients got lost in the silos because they don't talk to each other. So, if you're a happy māmā and you are going to have a serious C-section, for instance, you might get appointments to see ……. first for your pre-anaesthetic.

For your ultrasound scan on the monitors, you're there to see the O&G specialist on three separate days in Hastings. The coordination of stuff is not there. It's very, very hard to have services that don't really talk to each other to try and bring everything together"

"The services don't talk to each other. We give out vouchers and stuff like that, but you've still got a four-hour round trip to get down there and back. If you've got three separate appointments on three separate days, it's just ridiculous. So, there's a lot of stuff like that that people are becoming aware of, but they haven't done anything about yet"

"The problem is that the DHB don't have the sonographers available to do those abnormality scans, because it's a very specialized field. To get the biggest bang for their buck, instead of sending a sonographer up here twice a month to do maybe five women each time, they just have them working constantly in Hastings. So, there's one problem that I think we can work around"

"Engagement is a massive problem. The health literacy stuff, yeah, is access, and all their health professional responsibility as well. Getting information, being timely about it, and making sure that language is being used so they understand as well"

Despite these concerns there were some signs of improvements being made:

"They've improved a little bit because they do try to make those appointments in the middle of the day, because we've got a minibus that leaves every morning at eight for people, to take people to their medical appointments. And then picks them up at three to bring them back. That's a free service within the community. The bookers try and make the Wairoa appointments in the middle of the day"

Strengthening whānau voice in their own care

Several staff commented on the need to strengthen whānau voice across the entire system and not just in maternity services, with a specific focus on utilising whānau voice to drive service improvement:

"I'd like to expand on something, it's the whānau put at the centre of our care - which I agree with, it's more like the whānau pool at centre of our care, because a lot of our providers, whether it's the DHB or NGOs or whatever, they've gotten into the business of health and not the actual care. We've started to move amongst whānau, and their story is very different to what they receive, and how they receive it and what they really want. And it's looking like, "Information, give me information, and I'll fix myself up, I can help with the journey in a more positive way, like the whānau model, they'll follow it."

"Whānau voice should be the designer of the service. Some of us went to Alaska more than once. When we went over there, and they have whānau voice at every opportunity. It's driven by whānau and that actually ultimately designs the service ... consistent whānau voice. The collection of satisfaction and improvement. Sometimes whānau voice isn't just about a complaint it's a service improvement"

"It's no good to go, "Oh well, we have a hui every year, and whānau ... I've invited uncle and auntie, happen to be my uncle and auntie, they're all good, I gave them a cup of tea and everything's fine," it's actually consistent whānau voice, that action of satisfaction and improvement. So, you've got to put the whānau experience into the quality improvement focus. Because at the end of the day, who is the service for, the staff or the client? And so whānau voice has to be part of a consistent continual collection of service improvement".

"There's one thing that we have to be mindful of too in terms of Whānau Ora that came up with Te Pou Matakana. What I'm saying is, they've left so many people out under their consortium, the voices of Te Wairoa, Tamatea, and I think we've got to, moving forward, in terms of this whole health reform, the whānau voices to be right at the forefront. When Dr Peter Sharples set up this whole concept around Taiwhenua, that was meant to be the start of whānau voice. What are our hapū saying there, what's our Marae saying there? So, let's have a member sitting at this level for Taiwhenua and then they were going to devolve all the services into that ……. So Kahungunu been in this space for a long, long time"

"If you think about business principles, it's about the customer first, but here it's about system first and the clinician and the staff. They've lost their way in terms of the value of the customer's experience. And I agree with you, you've got to have that as the foundation of any service."

Iwi representatives confirmed the need to focus on whānau and hapū voice:

"The structures and the frameworks that are in place need to uphold the aspiration that governance from a Kahungunu perspective is our whānau who maintain the kaitiakitanga themselves throughout whatever system they go through. That they are resilient and strong enough to dictate what it is that they have. What do we do? We just go straight up to my Chair and I we'll go straight on and ask for an answer and ask for system change. The project plan is the responsibility. What we do is we say, "No, this is not right. How are you going to address that inequity?" "Well, tell me, what are you going to do to change that so it can be done?" So, we'll just continue to advocate at the table for whānau"

The Wairoa Model of Care

The Wairoa maternity services team described a model of care that they felt worked very well for the māmā in their area, that included a strong continuity of care approach; good communications between team members; a strong focus on being responsive to hapū and new māmā, and a willingness to go the extra mile for whānau. There was also a concern raised about women with gestational diabetes and a desire to provide a better service for those wahine:

"This is the continuity of care model, it's a great model for wahine and whānau, because it's a small team. It's four midwives, and there's a strong desire and effort to keep continuity of care with the same midwife throughout the antenatal care and postpartum"

"Where possible, that midwife will be available for labour and birth, or sometimes, people do stay on call for whānau, but it's not something that is done regularly. The continuity of care is a great strength"

"It's great because it [roster] allows those four days off on our recovery. So, it's a sustainable model. Continuity of care, sustainable model"

"I think we have an amazing team that works very hard to be open, and welcoming, and engaging. We have a very open-door policy, so people will come, and we will see them. There's no concern about appointments. There're strengths of the individuals in the team. Other people have certain strengths. We have Māori midwives. We have a midwife who lives within the Māori community and has a lot of knowledge, has a lot of respect. She knows a lot of people. She has a lot of connection. We have people who've been here for a long time, and so they're known by the community, as well. That's kind of what comes to mind when I think about strengths of the team."

"It's a flexible model, in terms of seeing people, seeing women when they have a need, and having a warm, welcoming, inclusive sort of approach to whānau, as well. So, everyone's welcome."

"She did a pampering day as a reward for mums that had made some changes through their smoking practice. She organised a stay-away and one of our moms had a lot of involvement with getting involved and she was having depression and a lot of stress with history of postnatal depression. Well, in taking her out to (the "stay- away') for a whole day, giving her a relaxing outing - made a world of difference. We're still in contact with her now that she's moved out to Wellington"

"Even just for us, we run a raffle twice a year to get our women stuff like pumps, breast pumps, belts, stuff that should be basic stuff at the DHB really" "We are very fortunate in Wairoa that we have great collegial relationships with others. It's easy to get mental health support. It's easy to get drug and alcohol support, the district nursing input, a doctor. Because we're little, and we know each other, we can access those services for whānau very easily, and we do all day, essentially. So, people can be seen through promptly. I think that's a good change."

"I feel that while my work is with midwifery there's also other things that we don't do, that isn't part of our scope. So, we go look for Māmā. We spend quite a bit of time doing that or looking at other services that might be around her. So, the midwifery bit, in some ways, is quite easy. It's the other bits that you do that aren't captured in our job description"

"The other bit is that you're having a lot more women who are just gestational diabetics and having to do their blood sugars and go down to the Bay all the time, there's really no clinic up here for them. We've kind of asked to do a Zoom thing, to get that started"

"This is becoming our new normal, this gestational diabetes, so we'll mention that and say, "What do you think about these devices? And say, "Okay, we've got an endocrinologist, Jade Tamatea in Hamilton. Let's hook up a zoom. We'll get Leigh Duncan, our obstetrician from Hastings, and let's all sit down and have a face to face"

"There are some ways around helping women, too. Pricking your finger six times a day, for a Māmā with children, and working sometimes, it's really difficult. But there are devices out there that we'd like to be funded for our women, because they cost a lot of money. They would have to pay for themselves, and they just don't have that money. That, as a small group out in Wairoa, could we have funds to have those for the women?"

The Multi-Disciplinary Team (MDT)

Staff were questioned about their practices as part of testing the HBDHB Policies on Maternity Wellbeing, Child Abuse, and the Child Protection and the Child Protection Multi-Disciplinary Team (CPMDT) Guideline. Some of the responses were as follows and reveal concerns about exclusion of midwives (who develop care and discharge plans with hapū māmā) from MDT's and discussions especially where Oranga Tamariki is concerned:

"Part of my job at the ante-natal outpatient clinic was to facilitate the establishment of the MDT groups, and it was established just before I left. In MDT - there were discussions about patients not with their midwife. Women didn't know that they were being the topic of discussion and often their own midwife didn't know. So, it wasn't until the woman came into labour was the social workers at Oranga Tamariki and a group of senior management and the doctor, called into an MDT meeting, and they discussed whoever is due or whoever they're seeing in the clinic."

"So, there were conversations happening about patients – without their midwife knowing anything about it. Yeah, it's normalized that its standard practice here."

Better Resource planning needed

Several comments were made by the Wairoa team about resources and planning that could improve the services:

"When I look at some equity things, there is a scanning machine that sits in the Wairoa Hospital. And, I haven't been there for a little while, but when I was there, I used to think, "Why is this not being utilised for our māmā, so they don't have to go to Gisborne, they don't have to go to Napier, to have their scans?" And all they get is a measly 35 bucks to put in their car. For a lot of us, that ain't going to get you very far, $35, particularly if you have to go either way, which is two-hour, one hour, one hour and a half drive"

"We only used to get one obstetric clinic a month, which was only a half a day. You'd only do obstetrics for the half a day and then gynaecology for the rest of the day. So that only gave maybe five, six spaces for our māmā to have an obstetric appointment in Wairoa. And it's simple. Just increase the number of times that they came down, even if it was every second week. They come on a blinking plane anyway. How much does that cost them for them to fly down to Wairoa?

"And if they are short sonographers, why aren't they using that plane money to pay for you to up skill as a sonographer, and do the clinical measurement, and then their sonographers down in Heretaunga can do the interpretation?"

"We used to feel like we were like the poor cousin. We always used to get the hand me downs and the old shit that got discarded. Never got anything new. And that was the value that they put on our māmā, and our whānau and the future of our community. I know when I first got there [Wairoa hospital], we had to go and scrounge around for some old furniture that was down in the old surgical areas. That's all been busted down now, but I think we were just looking for a desk or something, and we had to go and scrounge around down there to go and find us the desk. It's like, far out. And they built this brand new three bay, beautiful bay, brand spanking new and we didn't get nothing"

"We painted room three, that's what we got out of it. That's just devaluing our māmā, and our pēpi and our whānau. I don't know whether this is right, but we've probably got one of the highest populations of Māori that we work with in Wairoa, and Kahungunu actually up here. So, where's the equity in that, with such a huge population of our whānau?"

Māori provider services are not routinely connected to whānau

Several community-based providers discussed the lack of connection to their services by the maternity services to ensure hapū māmā and whānau had good access to services during pregnancy and after the birth of the pēpi:

"This is where we need the wrap-around services for helping māmā and pēpi and their whānau – the first wrap-around (the pēpi). Then the next wrap-around is in health, education – from beginning to end. In ante natal care, we have incentives there as well. We provide free classes for them and work hard to get them coming back. They can spend up to 25-26 weeks with their midwife and so they do form a trusting relationship. We have good relationships with all the other services providing ante natal care too. It's that total integration of the services. It's the vibe we create – relaxed, warm, welcoming, non-judgemental."

"There's so many stories. We deal with all sorts and all ages in this mahi. The hospital world is a big difference to their own Māori world. Te Tai Whenua O Heretaunga – we have the tools and whānau can come here. There are the services – Whānau Ora, Tamariki Ora, Family Start. We requested that the hospital puts the Māori Provider question on their enrolment forms so they (whānau) know there is a choice, or they can say if they are registered already with one. That's vital information from the start. Then - no provider names - it's taken off, and so has the choice for our whānau been taken away, gone. The "ihi" seeing that change, just like that. People need to lose that 'power and control' hold. Secondments need to happen – if they want to be trained then have the placements with the NGO's, make it a requirement, so they can see what's happening with our people first-hand"

"The services need to have hostessing – have someone who welcomes people with some warmth at reception areas, that is a welcoming thing for whānau. No one greets them at the current services – it's so cold. You've got staff with history about our whānau, and they carry that and judge them with it, instead of parking it and just enjoy the moment with whānau. They know when they are being watched, being judged"

"*I guess everyone's acutely aware of what happened with CYFs a couple of years ago, because many of our communities, we have programmes for Tamariki Ora, therefore happy māmā and pēpi. Then, of course, bloody CYFs went and gave themselves a Māori name called Oranga Tamariki, and it confused our whānau. So, the nurses were knocking on the door saying they were all Tamariki Ora and getting told to bugger off because they thought they were coming in to take their kids. The whānau from a CYFs point of view. Over the years, we have noticed a lot of distrust. Young women aren't actually registering with midwives, only if they have to and at the last minute*."

A senior leader at the DHB also had a perspective about the relationship with community providers:

"*I'd like to think that we have a highly culturally safe and responsive service delivery in the hospital, but we will always be working with Kaupapa Māori providers. If we've got those partnerships with Kaupapa Māori providers, they will do part the job of making sure that we are held to account and making our servicing more responsive. So, it should be like this symbiotic relationship, and we probably need to find ways of recognizing that leadership that they provide to us, in the same way we pay a GP for the three hours of advice. We need to recognize it to clear up*".

Linked to this, LMCs were also asked about the ease of working with the HBDHB maternity service when they had a client to bring in. LMCs were asked if they felt they were able to take women they are caring for, to the HBDHB maternity service and access what is needed and receive appropriate support. The results show that while the majority agree they can achieve this, there were 3 of the 8 respondents who felt they could not access the service and feel supported:

Figure 6: LMC perspectives on accessing HBDHB maternity service

One LMC commented that they felt they had to provide additional care and support for their hapū wahine to make up for "*bad care*" provided by the maternity service. Another commented on the "them and us" mentality and culture of the unit and that they often felt judged and uncomfortable by maternity unit staff stating that "*you expect that something negative is going to happen to yourself or your client – makes you hypervigilant*". One participant stated that it depended on which staff (including care associates) were on shift, as to whether you were supported as an LMC.

In terms of their practice with women and their whānau within the maternity service setting, HBDHB staff participants were also asked if they were able to take women they are caring for to the service and access what they need while feeling supported. The results showed a stronger sense of being able to access services and feel supported internally, than for LMCs (as seen in the data above):

Figure 7: Accessing care and support for wahine

HBDHB staff were asked how they protect and respect women's privacy. Participants were asked: As a staff member of the HBDHB Maternity Service, I protect and respect women's privacy by…

- Accessing their record only with their consent
- Accessing their record when I am directly responsible for their care with their consent
- Access their record in an emergency with their consent if they can give it
- Access their record as part of unit daily routine without their consent
- All of the above

Figure 8: Protecting women's privacy

Quality improvement opportunities

Maternity Services and Quality Documentation

The review team looked at a range of maternity services documents including for instance:

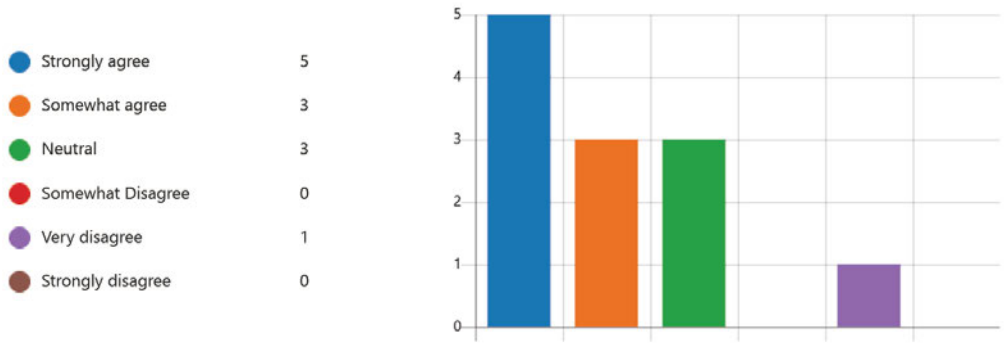
- clinical governance documents including a sample report from an MCG meeting (April 2021) which highlighted discussion areas
- Terms of Reference for the MCG Advisory Group (June 2020)
- A Patient Safety and Risk Committee Report
- HBDHB Maternity Service Meeting note examples
- Survey results undertaken during Covid

All of the matters that one would consider should be discussed appeared to be included in clinical governance and service meetings.

Stakeholder feedback on improving services for whānau

Interview participants were then asked the following question: Of recent times, important national leaders have reviewed and challenged the system's approach and stance on child health and wellbeing, such as the Children Commissioner Andrew Becroft's report Te Kuku o te Manawa (2020), and Ngahiwi Tomoana Chairman of Ngāti Kahungunu Iwi Incorporated's report, Kōrero Mai Whānau (2020). As a staff member of the HBDHB Maternity service and an advocate for women and their whānau, do you agree with such reports and feel the system needs an improved approach to service provision? Responses were as follows, and highlight that the vast majority agree with the report findings and a need for improvements:

Figure 9: Staff support for improvement and change



Improvement opportunities

HBDHB staff were then asked a series of questions about what things that the service provides that should start, remain, change, differ, stop, or reduce. The following responses were received. Of note is that the Tūranga Kaupapa one day course for all employees working at HBDHB was noted as a mandatory requirement – but feedback in the survey (and during interviews) that this is not occurring:

- *Providing the best care, we can in challenging circumstances*
- *Māori Midwifery Consultant Wahakura, muka ties, some displays and posters supporting Māori culture and Te Reo Breastfeeding support specific to Māori Whānau friendly (Somewhat) Tuai Kōpu*
- *Māori midwifery advisor*

- *Provide as much information as we can to keep woman and their babies safe. i.e., safe sleep, becoming smoke free. Increasing the use of Te Reo in our workplace.*
- *Quality focus Evidence based practice Culturally appropriate care*
- *Use Te Reo and pronounce names of baby, māmā and partner appropriately. Mandatory Turanga Kaupapa one day course for all employees working at HBDHB. Provide all Māmā with a support person who can stay 24 hours a day with them. Whānau rooms for family. Respect and cultural understanding when a baby is stillborn around the rites of what is important for the parents and whānau.*
- *Providing options and support around personal, cultural decisions in the maternity journey*
- *Well trained staff, educational days Quality care*

When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the · Things we should do **MORE** of

- *Empower women to be active in their own health decisions*
- *Encourage waiata, karakia and other spiritual practices Have a garden where we grow plants to aid healing - learn more about rongoā*
- *More interaction of those strong in Te Ao Māori within the unit More obvious use of and teaching of the Meihana model More use of Te Reo More available chances to learn Te reo Facilitation of Mihi whakatau for the arrival of new medical staff every 3 months to our unit*
- *Becoming more family/whānau orientated. We need to provide/support better whānau support and wrap around for our precious young mums and those families who are particularly vulnerable. I would like to see a better understanding of why some woman and families don't engage with us. What are their barriers, and can we help to mitigate these?*
- *Consistent approach to violent language/ behaviour better valuing of individual knowledge and skills better staffing levels More education for existing staff to support around family violence, substance abuse and supporting social complexity*
- *I would like to see more time to process an emergency Transfer to Theatre decision. A pause for timeout, to say a karakia.*
- *I think there should be more learning opportunities when women, whānau and midwives can learn together. E.g., karakia, flax weaving etc*
- *Time for One-to-one care with all women, not rushing from room to room…*

When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we should do **LESS** of:

- *Tick box forms. Tolerating bad behaviour from women and families toward staff*
- *Handwritten*
- *Antenatal clinic facilities are totally inadequate This has been flagged numerous times*
- *Be judgmental. Providing care by tick box*
- *Allowing poor behaviour because of social complexity Normalising poor staffing levels*
- *I don't understand the question*
- *There is a disjoint with the care women get when they transfer to Hastings. Sometimes I feel the women are treated differently coming from Wairoa*
- *I don't know*

When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to do **DIFFERENTLY**

- *Better care planning for complicated cases with clear care plans around partners who can and can't stay etc*
- *I would love to hear the answers to these pātai (13-15) from Māori staff*
- *Many*
- *We need to stop being so black and white in what we do and look at providing more individual care to the woman based on their needs rather than the unit as a whole...to do this we need more staff.*
- *More social work support better breast feeding support More beds to accommodate longer stays better coordination and communication between LMC and DHB staff to put woman in the centre of care*
- *Listen reflectively and be ready to offer the services of Kaitakawaenga if the Māmā feels shy about talking to me. Trust needs to be earned. Sitting quietly in the corner and waiting for her response may be all she needs before she has articulated what she wants from me.*
- *Increase the number of obstetric and scanning clinics in Wairoa so women do not have to travel out of district for secondary care*
- *Make them all feel knowledgeable, empowered, and ready to head home. Not asking people to go home when we need their bed space*

When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to **STOP** doing

- *Tolerating poor behaviour or violence towards women or staff*
- *Excluding medical staff*
- *Tying ourselves up with so much education to the woman we lose sight of who they are*
- *Discharging mums of babies in SCBU*
- *I think we could be better at introducing ourselves to all the whānau when we enter the room and be genuine about finding where they are from, especially our Wairoa whānau*
- *That culture of discrimination based on where women live i.e., from wairoa8anonymousI don't know*

When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to **START** doing:

- *Valuing our staff*
- *Have regular hui to korero about how we can make our service a safe place for tangata whenua where they feel at home*
- *Providing seamless collaborative care More communication with OBGYN*
- *Provide more Māori and Pacifica midwives. I used to believe I could provide all the care that was needed but I have come to understand that there is a difference at 'Soul" level and that I can never truly understand. I am not suggesting a segregated system but to have more Māori midwives would enhance our care.*
- *Better support and coordination of social complexity Accommodation for Wairoa family as required*
- *I would like to see a physiotherapist on the postnatal ward who is specialised in Birth injury and trauma. This is a huge area in inequity in Hawkes Bay. Only those who can pay $150 s session can get specialised treatment if they don't qualify for ACC as a treatment injury.*

- *I would like to see a lot more antenatal visits in home for women8anonymousUsing more te reo language or whichever language is appropriate, I try but am not confident to use sentences*

Lastly, staff were asked if there was a message or question for the HBDHB Chief Executive Officer, what would they like to say:

- *We need more midwives. There needs to be more honesty in the exec team. CEO and executives need to be brave and stand up for their front-line workers do not buckle to outside pressure*
- *Put more money into maternity*
- *Help*
- *Could we trial a separate, full immersion kaupapa Māori maternity service?*
- *What are the strategies HBDHB is implementing to employ and/or retain Māori midwives?*
- *The maternity workforce is doing its best in a really challenging environment for many reasons, but is nearing burnout*
- *What's the next step after this review?*
- *What was the process for setting up this review and why were medical staff excluded from the process?*
- *How about you come and work a Friday shift in Delivery Suite?*
- *Come and see our amazing service. We are doing great things but need more money to make it better*
- *Yes, With the current shortage of Midwives why can't we have nurses helping us to care for Māmā in labour in Delivery Suite and Waioha. With an LMC overseeing the delivery another pair of hands from a registered nurse would give us time for emotional and spiritual care during this very crucial moment of a mother, baby, and whānau life*
- *It would be great to have the option in Wairoa for a live in situation for our struggling or very young māmā to have some more intensive support options*
- *Look at the funding! This service is underfunded for the numbers and acuity using it.*

Effectiveness of problem-solving

LMCs were asked if it was easy to discuss any issues or problems with HBDHB maternity service staff. The results revealed a very mixed response:

Figure 10: LMC ability to discuss problems with Maternity unit staff

The majority of comments referred to the same issue as above – that it depended on who was on shift and how willing they were to discuss concerns and come to a joint resolution. Comments were as follows:

- *A delivery I had a while ago, I pushed the call bell, I asked for a catheter as the woman I was caring for had had a 3 day long induction a long labour, epidural and did not want to get up to PU, the midwife who's still there left the room and never came back, I pushed the bell again*

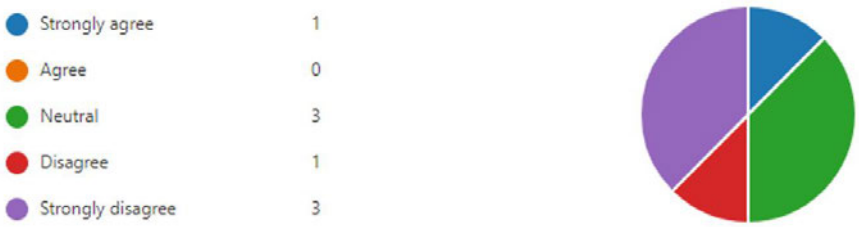
and asked for a catheter again but again she did not come back, I walked out of the room and asked her in front of the CM, I need a catheter and explained again why, she turned to the CM and said do you think she needs a catheter? An LMC was standing close by and heard and said yes. I did not wait for an answer and said I'm going back to my room. I walked in and less than 30 sec later we were having a PPH, she required oxygen and she was transferred to theatre.

- *So, if and when I hear another Māori midwife is under investigation. I ring her and ask are you're alright? Don't go on your own!*
- *Again, it depends who's on. The Team leader will listen but that doesn't mean that it will change the situation. For e.g... i want to use Waioha. Team leader no you can't tonight as we are busy so the midwife working in Waioha has to help in Ata Rangi. Therefore, you can't use Waioha. Primary women who have to use Ata Rangi are then admitted under 2ndy care which is not true.*
- *Mostly able to exchange views in professional manner*

The following question was asked of LMCs: Problems and errors in the relationship between the HBDHB and LMCs are communicated and a "no blame" process is undertaken. The responses were as follows:

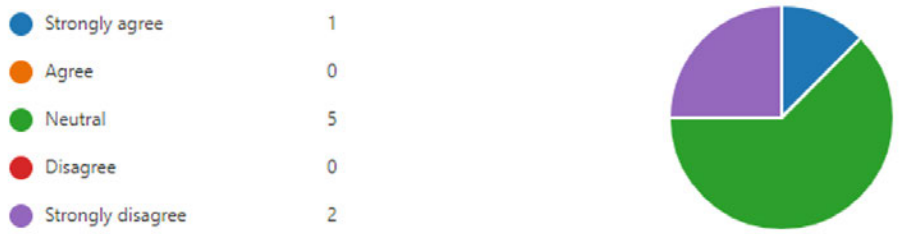
- *No, the hospital is an unsafe space for LMCs of the wrong colour, errors are used by staff as a bullying tool.*
- *The leadership at the DHB is flawed. Overseas midwives do not understand the needs or place of Māori as tangata whenua. The have this saviourism mentality like we all need saving. They need to save Māori from themselves.*
- *Obstetricians - depends on who. Can be condescending. For example. I've been told if you can't look after this woman you need to hand her over to 2nd care. They don't understand how our Māori women live. If the woman doesn't keep her appointment with me than she's certainly not going to with 2ndry care. In fact, the woman will let me into her whare but she's not going to let some white snobby pakeha into her whare*
- *It depends on the doctor and staff on the day. Unfortunately, it can be extremely variable.*
- *There appears to be some judging and blaming at times*

Figure 11: Problem solving between LMCs and Maternity service



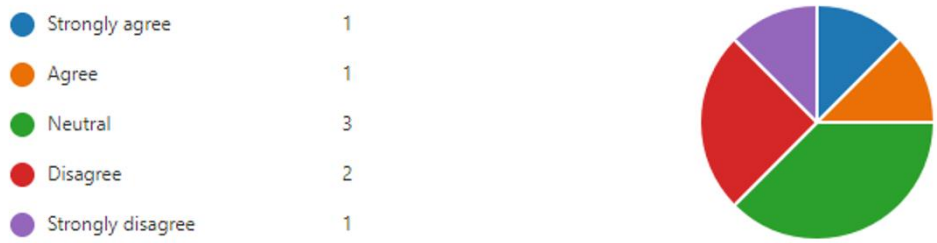
Again, there were mixed responses. One LMC said "*not the hospital is an unsafe place for LMCs of the wrong colour. Errors are used by staff as a bullying tool*" for instance by using it as a means for undermining the midwife's credibility. while another said "*the leadership at the DHB is flawed. Overseas midwives do not understand the needs or place of Māori as tangata whenua. They have this saviourism mentality like we all need saving*". When asked if regular meetings were being held between the LMCs and the HBDHB Maternity service to improve processes, the responses were as follows:

Figure 12: Quality improvement between LMCs and Maternity service



One participant said that the DHB maternity service did not want to listen and that strong personalities meant often any sessions were very challenging. One Māori midwife said that if meetings are happening, she had never been invited in her entire career while another said that meetings if they happened, focused on DHB needs and not LMC needs. Another said that she found any meetings patronising and unsafe so no longer attended. One said "*the DHB mentality does not allow a forum for Māori midwives to have a voice.*" A similar mixed response was received to a question on how LMCs and the maternity service work together to achieve organisational objectives of the DHB, and consumer needs:

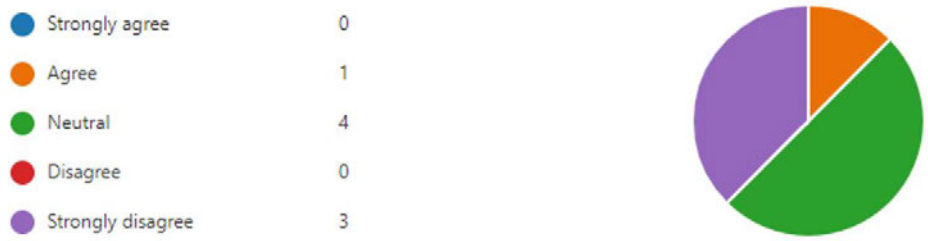
Figure 13: Meeting organisational and consumer needs



One stated that "*no, our whānau do not always want to stay because they feel unsafe so leave or self-discharge*" while another said, "*the opportunity for LMC Māori midwives to speak on behalf of Māori birthing whānau is limited or non-existent*."

LMCs were asked whether they felt improvements to services, processes and relationships was influenced by consultation with Iwi and hapū and the results were again mixed:

Figure 14: Influence of Iwi and hapū to service improvement



Finally, LMCs were asked if the maternity service recognises the inter-generational trauma experienced by Māori as well as the potential for wellbeing among whānau in its processes. One participant stated "*their model is MDT. The MDT is a colonial construct that ignores Māori midwives needs. There is also a fear factor that if you complain about something, you will be targeted*". The following comment summarises the themes from this question:

"There are people who sit in leadership positions within the maternity service who do not support this [recognition of inter-generational trauma of whānau]. They search through files and bring to light anything that would benefit keeping a woman and her tāne and whānau oppressed to the point it impacts the whānau even afterwards. Plunket and Tamariki Ora are unsafe for whānau. Our young wahine are told they have to give their babies to a day-care and complete training when they want to care for their babies. They are stigmatised as bad parents for being full-time carers of their babies they lose their benefit".

Photo credit: Whānau at Mamia with the Review Team

Supporting and developing the maternity workforce to provide culturally safe care

Workforce and Service Documentation

The review team considered the Maternity Service Plan 2020-21 and Maternity Community, Women and Children (CWC) Annual Service Plan 2018-19. This is a well written plan that identifies there are significant maternal and child health inequalities in Hawkes Bay compared to other regions of New Zealand. These differential health outcomes are unacceptable, and the DHB committed to making improvements. The plan describes HBDHB as providing a range of maternity services for approximately 2,000 women and their families every year. Statistics are provided in the Hastings site currently with 35 Lead Maternity Carers (LMCs) who access the facilities to provide primary care. Additionally, a team of over 70 clinicians and 10 care associates provide in-patient and out-patient care to the Hawke's Bay maternal population.

There is a strong focus on growing the workforce both local midwives and in partnership with Wintec and Ngā Māia to support Māori midwifery career pathways in partnership with RANZCOG in training future obstetric and gynaecological workforces with 3 trainee accredited positions. Quarterly reporting is to the Directorate Leadership Team. The plan could be improved through documenting and implementing a specific pathway for eliminating inequities – at present the goals are very high level and specifics are not noted.

The HBDHB Midwifery Draft Maternity Leaders Workforce Strategy 2021-25 was also reviewed and showed that several actions are planned to address gaps. A key area for action is increasing Māori midwifery leadership and much of this focus is via the Tuakana Teina model being promoted for Māori midwives. This is a kaupapa Māori based cultural mentorship/pastoral programme, designed to enhance, and develop Māori midwives through their training, new graduate, and ongoing career.

The review team also reviewed the Waioha Primary Birthing Unit Five Year Report 2016-2021 and the Five-Year Data Summary as well as the HB Maternity Annual Report 2019/2020. These are well developed and written reports that are very comprehensive including presenting information from a Kahungunu perspective. Possibly a shorter one-pager infographic might be useful for the summary of the annual report for those less literate or those who do not want to read a long report (For wahine / hapū Māmā and local Māori providers)

Job descriptions in maternity services

The team reviewed ten of the twelve job descriptions in the maternity service. Just three of the ten job descriptions provided specified key performance indicators – measures capable of being appraised on an annual basis that are specific to providing care to Māori Māmā and their pēpi, or to whānau and the Māori community, hapū and iwi. There were inconsistencies and variabilities in where the responsibilities and accountabilities for Māori cultural responsiveness lay in each of the role descriptions.

Workforce cultural responsiveness learning

The review team learned of the Ngākau Ora Staff Cultural Responsiveness Training launched 25 Feb21. This is a new programme targeted towards developing quality relationships with whānau, communities and staff. The purpose of the programme is to help the HBDHB to develop a positive environment based on the HBDHB's core values. It is a two-day programme for new and existing

employees and includes sessions on equity challenges; respectful relationships; unconscious bias; and relationship-centred practice

Capacity and capability of Maternity services workforce – staff feedback

HBDHB staff were asked in the survey whether, as a staff member of the HBDHB Maternity Service, they resonated with the cultural philosophies that support the wellbeing of whānau in this area? Responses were as follows and show an overall positive response:

Figure 15: Whether cultural philosophies that support whānau wellbeing resonate with HBDHB staff

Lead Maternity Carers (LMCS) were asked if, as a LMC caring for women in Ngāti Kahungunu, did they resonate with the cultural philosophies that support the wellbeing of whānau in this area? Overwhelmingly the response was positive and revealed a slightly stronger commitment than HBDHB staff.

Figure 16: Whether cultural philosophies that support whānau wellbeing resonate with LMCs

More focus needed on strengthening the Māori workforce

Comments were made about the need to develop, recruit, retain and support clinical Māori leadership with one participant stating *"There's a vacuum of Māori clinical leadership, so in Aotearoa they get a quick elevation to the top and they're not ready and then we leave them on their own, hang them out to dry, they struggle, they strain, and they quit. And you've got to have, that umbrella - has to be a Māori umbrella."* It was recommended that Māori clinical leadership needs access to support such as mentoring described as *"It's like Te Ara Mana Pou you need that tree to lean on until you grow yourself".* It was also considered that Māori who were appropriately qualified were not being considered for promotions or higher-level positions.

Overwhelmingly, respondents to the survey stated that the hierarchy that oversees the management of the maternity services was lacking in terms of Māori representation. Māori midwives cited examples of them applying for leadership positions over the years, either resulting in them being passed over for the role or "*being subjected to inquiries by pakeha's about how they demonstrate in their practice Te Tiriti o Waitangi. This line of inquiry being completely inappropriate for mana whenua of Ngāti Kahungunu. When these same staff requested feedback as to why they were not offered the*

position, they were informed that they lacked the skills required for the position, which had subsequently been given to pakeha staff."

Only one senior leadership position is held by a Māori midwife, and Māori staff who were interviewed expressed discontent with this. Furthermore, a concern expressed by numerous staff members is that the skills of Māori midwives are not fully recognised by the HBDHB Maternity Service. Rather it was felt that Māori midwifery positions were being used to "*create an appearance of diversity and equity to appeal to the Māori community*". For staff, this indicated that the organisation showed a lack of commitment to improve pathways to leadership for Māori employees.

Additionally, the Māori midwives expressed concerns about the wellbeing and safety of the sole midwife with the senior leadership role at the HBDHB due to the lack of collegial support that was available. Having the position however improved experiences for whānau because it alleviated fears among whānau and reprisal over real or imagined issues. The Māori LMCs unequivocally supported and collaborated with the sole midwife within the system.

Furthermore, the most senior leadership within nursing and midwifery acknowledged that the lack of Māori leadership within the maternity service is a serious problem that needs to be actively rectified.

The current data for the HBDHB maternity service indicates that 42% of women that give birth in Hastings are Māori, however the number of Māori midwives is vastly disproportionate. There are not enough Māori midwives able to cater to the Māori community. This problem extends beyond HBDHB and is recognised across the nation. Māori midwives bring to the table an understanding of culture, whānau structure, and manaakitanga for wāhine Māori and their pēpi. It was affirmed through the interviews that the value of a Māori midwife cannot be undervalued due to their dedication to wāhine Māori and cultural connection to the profession - all of which is artfully encapsulated in this quote from one of the Māori reviewees,

> *"I love working in midwifery for all that it has to offer and for all my learning experiences. I love the wairua… For me, it's about wairua. It's about being close to the whānau; it's about being close to the whakapapa. It's about being close to tipuna, and I value and cherish those moments… for me, I think it's a special place that we have as Māori, where we are able to live and be a part of who we are. It's that time for me to remember the stories, and to be able to be a part of history. To be a part of our whakapapa. And to be with our tipuna."*

The pattern of responses from the Māori midwives that have worked in the HBDHB maternity services has indicated that this institution has failed to aid and support them to conduct their work in a way that made them feel safe – both culturally and professionally. There is a demonstrable lack of insight into the values and practices of Māori culture that Māori midwives are trying to incorporate for the benefit of the māmā that they are caring for.

How well the current workforce is supported

HBDHB staff were asked what their hopes, dreams and aspirations were for the maternity service in the future. Responses were:

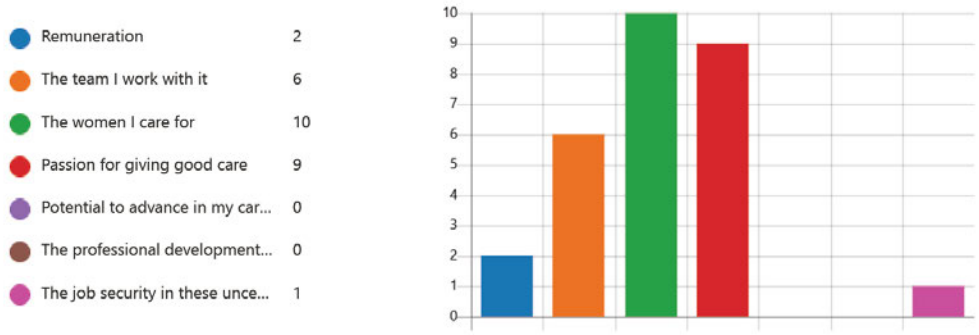
- *Increase the number of midwives working in the hospital to increase safety for māmā and Pepsi.*
- *I think the service just needs more money and more midwives*
- *To stop being institutionally racist*

- *That all women and whānau receiving care during any part of their pregnancy/hapū journey are treated with kindness, respect, and cultural consideration. That they leave the service feeling that they were heard and that their needs were met.*
- *More support from mental health team 24/7. Workshop on all ethnicity traditions.*
- *Continue giving good care*
- *That we learn from and respect the beautiful and spiritual ways of Māori culture. It's about people not about the organisation (DHB). We need to open our ngākau, whakarongo and be humble and stop thinking our ways are superior*
- *That wāhine hapū and whānau can walk into our unit and say "this space is great I can feel the respect and embracing of my culture"*
- *I would like to be part of a service where we are not stretched to breaking point by short staffing and high acuity. I would like to have the time to be with the women and to be able to truly provide holistic care to each woman in a way that is culturally appropriate, safe, and enhancing for us and our client base. I would also like to feel safe at work. Increasingly we are being abused and threatened and this impacts on the care we can provide especially to those families who are most vulnerable.*
- *Excellent care for women and whānau with medical, midwifery (DHB and LMC's) nursing and Allied health all working together with the woman as the centre of care*
- *To have safer workloads so that we can provide the care in partnership with and underpinned with equity for every māmā with respect manaakitanga and Aroha*
- *I would like further options to advance my knowledge and practice around cultural safety, especially specifically aimed at the location that I work in. At the moment there are opportunities that I feel unable to take due to being needed for clinical practice or protecting my work/life balance*
- *Excellent, supportive & inclusive care for all women & whānau where women feel empowered and confident going home with their pēpi*

One question in the survey explored the motivations for the HBDHB staff in their roles and the following responses identified that the women they care for is the main reason they do what they do, followed by passion for providing good care. Options were:

- Remuneration
- The team I work with it
- The women I care for
- Passion for giving good care
- Potential to advance in my career
- The professional development offered to me from working for government operated agencies
- The job security in these uncertain times of working for Health and Government

Figure 17: Motivation to work in the Maternity service



HBDHB staff were then asked about their access to protected time for clinical and cultural supervision revealing the following results. Both sets of responses show high levels of variability in this area. In relation to clinical supervision the options to respond were:

- Yes, I attend once a month a one hour guided reflective practice session
- No, the service does not offer me protected time to engage in a guided reflective practice session
- What is Clinical Supervision?

Figure 18: Access to protected time for clinical supervision

In relation to cultural supervision, the options were:

- Yes, there is organisational training we can opt in to/is mandatory for staff
- No, but I would like to
- I don't think it is necessary

Figure 19: Access to protected time for cultural supervision

OTHER REVIEW FINDINGS

Piki ake kake ake i te toi huarewa, Te ara o Tāwhaki i piki ai ki runga, I rokohina atu rā
Maikuku-makaka, Hāpai o Māui he waha i pā mai

Inevitably, when conducting a review such as this with a wide range of stakeholders, other issues arise which were out of scope of the maternity services review. The Review team however repeatedly received unsolicited perspectives and opinions on concerns and ongoing trauma from the 2019 attempted child uplift by Oranga Tamariki

Although outside the scope of the review, the Review team agreed to respect and honour the kōrero, - which often included significant emotion, passion, and tangi (tears) – and to include this chapter in the report. Many participants shared their deeply felt views on this matter and the Review team felt it would be disrespectful and disingenuous not to include their important whakaaro.

Affirming the need to change practice around child uplifts

A report on Oranga Tamariki[75] revealed that on 30th June 2019 the Chief Executive of Oranga Tamariki had custody of 6,450 children and young people in the Care and Protection of the State. 68% of these children identified as being of either Māori or Māori and Pacific ethnicity**.** (p7). The *East Coast Region including Hawkes Bay* made up (*12%* or 247) and was one of the top three regions with the highest numbers of children and young people entering into State care (Out-of-home placements of tamariki Māori (p7) had increased by 6%.but Return-to-home placements were low and had decreased slightly from 10% to 8.3%). Whānau experiences with Oranga Tamariki that emerged were those of trauma, discrimination, and prejudice. Whānau descriptions of Oranga Tamariki were that of violent and intimidating actions taken on their part, and feelings of powerlessness for whānau in dealing with organisational systems of inconsistencies making it impossible for whānau to get their children placed back at home with them.

Cultural impact of indigenous children removed from their families

As a central component of the assimilation agenda in the United States and of absorption plans in Australia, child removal became a systematic government policy toward indigenous peoples in both countries in the nineteenth and twentieth centuries (it was also a strategy used by settlers in Canada). Using the rhetoric of protecting and saving indigenous children, reformers and government officials touted child removal as a means to "uplift" and "civilize" indigenous children. Modern-day historians, until very recently, have characterized child removal in similar ways: as a well-intentioned, though ultimately misguided, alternative to warfare and violence against indigenous peoples. While outright violence against indigenous peoples in both the United States and Australia did virtually end in the late nineteenth century, efforts by colonizers to pacify and control indigenous populations and to confiscate their lands continued with the removal of indigenous children. Such a policy was hardly a departure from military methods of subjugation; rather, the systematic and forcible removal of their younger generations represented an ongoing assault upon indigenous communities.

[75] "Ko Te Wā Whakawhiti: Time for Change" | Summary Report of the Māori Inquiry into Oranga Tamariki. 2020.

- Australia's Aboriginal and Torres Strait Islander peoples: The Stolen Generations[76] have had devastating impacts for the people who were forcibly removed as children, their parents and families, and their descendants. All of these groups experience high rates of depression, anxiety, post-traumatic stress and suicide, and poor health and socioeconomic outcomes. It has led to many Aboriginal and Torres Strait Islander people suffering a loss of identity and culture, and families living with intergenerational trauma in a cycle of abuse and violence.
- America's Native Americans peoples: Native children were forcibly removed from their families and placed into Church-run Indian schools. For decades, the US took thousands of Native American children and enrolled them in off-reservation boarding schools. Students were systematically stripped of their languages, customs, and culture. And even though there were accounts of neglect, abuse, and death at these schools, they became a blueprint for how the US government could forcibly assimilate native people into white America. At the peak of this era, there were more than 350 government-funded, and often church-run, Native American boarding schools across the US. They were also a way to separate native children from their land and to "kill the Indian, save the man".
- Canada's First Nations children:[77] In Canada, the Indian residential school system[was a network of mandatory boarding schools for Indigenous peoples. The network was funded by the Canadian government's Department of Indian Affairs and administered by Christian churches. The school system was created to isolate Indigenous children from the influence of their own native culture and religion in order to assimilate them into the dominant Canadian culture. A government minister affirmed the policy as "killing the Indian in the child". Over the course of the system's more than hundred-year existence, around 150,000 children were placed in residential schools nationally. The last of these schools was closed in the 1980's.

Today the indigenous people of all three countries suffer significant impacts from inter-generational trauma, poor health, and many other worse social outcomes than their non-indigenous counterparts.

While New Zealand did not experience forcible removal of children, settler governments did apply strategies to remove the native language, culture, medicines, cultural practices, and lands of the Māori. The historical impacts of child removal and the intentional attacks on culture and identity – have impacted indigenous peoples in both New Zealand and these neighbouring Pacific countries.

Now, many believe the same governments have found a new way to assimilate their indigenous peoples and that is through funnelling indigenous children into the child welfare systems of the state(s)….and intentionally placing them often with non-indigenous foster and adoptive families.

The table below provides highlights on the disproportionate rates of involvement of indigenous children in child protection services and highlights the common patterns across these jurisdictions:

[76] https://www.commonground.org.au/learn/the-stolen-generations
[77] Killing the Indian in the Child": Death, Cruelty, and Subject-formation in the Canadian Indian Residential School System. https://www.jstor.org/stable/44030407

JURISDICTION	NEW ZEALAND (30 June 2020)	USA (Census 2016)	CANADA (Census 2016)	AUSTRALIA (2017/2018)
No. of indigenous children in State care / child protection	3,564 (59%)	Varies by State for example in Alaska 50.9%	14,970 (52.2%)	42 per 1,000 children in Child protection
TOTAL IN STATE CARE / CHILD PROTECTION	6,041	437,465	28,665	6.5 per 1,000 children

Reports on Oranga Tamariki in New Zealand

The role of Oranga Tamariki—the Ministry for Children (the Ministry) is to promote the wellbeing of tamariki, rangatahi and their whānau. Under the Oranga Tamariki Act 1989 (the Act) the Ministry has the power to take custody of, and remove, tamariki and rangatahi from their whānau when they are at risk of harm. This includes newborn pēpi. Under section 78 of the Act, the Ministry is able to apply for, and be granted, interim custody of tamariki in cases where other options to ensure their safety are not available. Further, in urgent cases it is able to do so without providing the parents and whānau of newborn pēpi the opportunity to be heard or respond before interim custody orders are granted. This should be in the context where other legal avenues, such as place of safety warrants and truncated notice periods, are not available.

Oranga Tamariki has undergone several reviews following the highly public uplift of the newborn baby at Hastings Hospital in 2019:

- 7 November 2019: An internal Oranga Tamariki review into the incident finds that although safety concerns for the baby meant Oranga Tamariki did the right thing to get involved, mistakes were made in how it worked with the family and other partners.
- 3 February 2020: Māori-led investigation into Oranga Tamariki chaired by Dame Naida Glavish calls for a complete overhaul of the ministry, saying there have been unprecedented breaches of human rights and inhumane treatment of Māori women. It says the Crown, through Oranga Tamariki, is failing to honour Te Tiriti o Waitangi.
- 8 June 2020: Children's Commissioner Andrew Becroft releases first part of Te Kuku o te Manawa report detailing the experiences of mothers whose children have been taken from them.
- 6 August 2020: A report by the Chief Ombudsman, He Take Kōhukihuki, A Matter of Urgency, finds that Oranga Tamariki was routinely taking new-borns without whānau consultation by using emergency court orders.
- 23 November 2020: Children's Commissioner Andrew Becroft releases second part of the report Te Kuku O Te Manawa, calling on Oranga Tamariki to end urgent removals of tamariki and pēpi Māori from hospitals, urging the government to commit to a transfer of power to Māori and detailing a slew of personal reports from midwives.

The Māori Inquiry into Oranga Tamariki (The New Zealand Ministry for Children, also formerly known as Child, Youth and Family or 'CYF') was launched as a result of the continued inaction by the New Zealand Government to respond to ongoing serious issues in relation to the treatment of tamariki Māori and whānau Māori within the government child and youth care and protection system. The

severe negative impacts on Māori whānau and tamariki are in direct contravention of Oranga Tamariki's stated aim of ensuring children are where they can be safe, connected and flourishing.

This resulted in the report entitled "Ko Te Wā Whakawhiti, It's Time for Change a Māori Inquiry into Oranga Tamariki - Summary Report[78]. One profound quote from their report which highlights the findings

- *"...I did not get told anything of why my kids were uplifted until 5 days later.....since then I have been lied about to judges, my kids have been traumatized, the lies and cover up on so many levels…"*

The Office of the Children's Commissioner has investigated and released a number of reports about the actions of Oranga Tamariki in conducting their mandated functions. In a 2020 report[79], the Commissioner called for:

> *"a total transformation of the statutory care and protection system."*
>
> *"Nothing short of a 'by Māori, for Māori' approach and a transfer of responsibility, resources and power from the state to appropriate Māori entities, as determined by Māori."*

In August 2020, the Chief Ombudsman released his report on Oranga Tamariki[80] after investigating the policies and practices of the organisation in relation to the removal of new-born babies (2017 – 2019). He examined whether there are any systemic issues connected to the Ministry's policies, procedures, and practices relating to the removal of newborn pēpi under without notice interim custody orders. He analysed the Ministry's case files for 74 newborn (and unborn) pēpi in respect of whom the Ministry applied for interim custody under section 78 during the review period. These 74 cases represented between 20 and 25 percent of all section 78 cases involving newborn pēpi during the relevant timeframe. In the 74 cases he examined, 56 pēpi (75 percent) were physically removed. In its own review in 2019 of half of these cases, Oranga Tamariki identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi.

The Ombudsman examined the Ministry's operating policies and procedures as they relate to the decision to apply without notice for interim custody of, and remove, newborn pēpi – and identified the following principles enshrined in law that should inform the Ministry's policies, procedures, and practices relating to the removal of newborn pēpi under section 78:

- Pēpi have the right, as far as is possible, to know and to be cared for by their parents, whānau, hapū, and iwi.
- Any intervention in family life should be the minimum necessary to ensure pēpi safety and protection.
- Where pēpi are at risk, the parents and whānau should be helped support them in discharging their responsibilities to their pēpi, and they have a right to fully participate in the decision-making processes.

[78] Ko Te Wā Whakawhiti. Authors: North Island: Hector Kaiwai; Dr Tanya Allport; Dr Ruth Herd; Dr Jo Mane; Dr Katrina Ford. South Island: Helen Leahy; Dr Golda Varona; Maire Kipa. © 2020 Whānau Ora Commissioning Agency. Whānau Ora Commissioning Agency February 2020

[79] Report Two of Two. "Te Kuku o Te Manawa") *of the Office of the Children's Commissioner, November 2020. ISBN 978-0-473-55383-8 www.occ.org.nz*

[80] "A Matter of Urgency. He Take Kōhukihuki Investigation Report into policies, practices, and procedures for the removal of newborn pēpi by Oranga Tamariki—Ministry for Children. Final opinion of the Chief Ombudsman. August 2020

- The use of without notice section 78 applications for interim custody should be reserved for urgent cases where all other options to ensure the safety of pēpi have been considered, and the delay caused by making an on-notice application would create a risk to the safety of pēpi.

The Ombudsman determined that in general, the content of the Ministry's overarching Practice Standards adequately reflected the objects and principles of the Act but identified a number of gaps in the Ministry's operating policies and guidance. Critically, he found the Ministry did not have any specific operating guidance on the use of without notice section 78 applications. The available guidance did not sufficiently articulate clear criteria for how staff are meant to identify and assess the viability of other options to secure the safety of tamariki. There was no reference to trauma-informed social work practice vis-à-vis assessing the parents' own childhood histories of abuse or neglect. It did not explicitly require specialist assessments for parents with alcohol or drug misuse, mental health needs or intellectual disabilities. It did not reflect the legal obligation on the Ministry to ensure that, where pēpi are at risk, the parents and whānau are helped to support them in discharging their responsibilities to their pēpi.

A number of findings and recommendations were made by the Ombudsman to improve the policies and practices of the organisation in relation to removing newborn pēpi from their whānau.

Four recommendations were of interest in the removal of pēpi generally, without specifically stating from hospital/s. An overview of these recommendations were:

- Specific guidance for Social Workers on cases (of removal) involving unborn and newborn pēpi, especially for parents with a history of being abused themselves or had tamariki previously removed.
- Improvement on specific policies and procedures for the process of removing newborn pēpi, especially in planning, communication and information sharing with parents, whānau, DHBs and midwives.
- Improving practices surrounding the removal of pēpi so this takes place in a manner that reflects ngākau maharatanga me te ngākau aroha, a period of quality time, empathy, sympathy, and love, minimising trauma and providing parents and whānau with support and clear information on next steps.
- Instruments on the Rights of the Child were cited: The United Nations Convention on the Rights of the Child; World Health Organization Guidelines and the Ministry of Health Guidelines on best practice to support breastfeeding; appropriate therapeutic and other support is to be available to all parents who have had pēpi removed from their care.

In April 2021, the Waitangi Tribunal released its report following the Oranga Tamariki Urgent Inquiry (Wai 2915) 2021[81]. The tribunal held an urgent inquiry after Oranga Tamariki came under scrutiny for its removal practices of tamariki and pēpi Māori from their families, following an attempt to take a newborn baby from a teenage mother at Hawke's Bay Hospital in 2019. The hearing started in July 2020 and aimed to find out why more tamariki Māori than non-Māori were being removed from their families, whether changes in law or practice had made any difference and what further changes might be required to secure outcomes that uphold Te Tiriti o Waitangi. The report, He Pāharakeke, He Rito Whakakīkinga Whāruarua, recommends establishing a Māori transition authority,

[81] Oranga Tamariki Urgent Inquiry (Wai 2915). 2021: He Pāharakeke, He Rito Whakakīkinga Whāruarua | Report

independent from the Crown, with the aim of identifying the changes necessary to eliminate the need for state care of tamariki Māori.

Some claimants called for a Māori authority to replace Oranga Tamariki but there was some concern from others that any Māori run alternative to Oranga Tamariki would turn a "white bureaucracy to a brown bureaucracy". The tribunal did not support calls for the abolition of Oranga Tamariki stating "For at least the foreseeable future we see a role for an Oranga Tamariki statutory social worker backed by the state's coercive powers in cases where a Māori organisation (be it whānau, hapū, or a Māori provider) meets resistance to an intervention considered necessary for the safety of a child or children," presiding officer Judge Michael Doogan said in the report.

The tribunal found that Oranga Tamariki had breached Te Tiriti o Waitangi by failing to "honour the guarantee to Māori" for them to have tino rangatiratanga over their kāinga as set out in Article 2". It said the disparity in the number of tamariki Māori in care was a direct consequence of the "Crown's intrusion" into this rangatiratanga. The Oranga Tamariki submission acknowledged there was a disparity, with tamariki Māori making up 69 percent of all children in state care in 2017. This had decreased to 59 percent, as at July 2020, as a result of the partnerships it had signed with iwi, hapū and Māori providers, and legislative changes that required a child's mana, culture, and whakapapa to be at the centre of all decisions. However, the tribunal found these changes were not sufficient "to realise the kind of transformation required" to meet the obligations of Te Tiriti o Waitangi. It said a transition authority would approve ways to transfer "some of the power, functions and responsibilities" of Oranga Tamariki and the Crown to ensure it had financial and administrative support to do this.

Impacts of children uplifted into State care

The literature identifies countries and describes the practice by settler government officials of removing indigenous children, including newborn infants from their parents and families as meaning to "uplift" and "civilize" indigenous children - or to "protect and save" them. Some of the western jurisdictions practicing this type of child removal are Australia, Canada, America, and New Zealand. In America and Canada, the express intent of removing children was to "kill the Indian in the child."

Studies have provided unfettered accounts and details about the cultural and health impacts on the indigenous people of all these countries that have resulted in significant inter-generational trauma, poor health, and many other worse social outcomes than their non-indigenous counterparts. Their rates of child removals by the State still remain very high in these jurisdictions in comparison to non-indigenous children. While New Zealand did not have child removal policies, the impacts of colonisation appear to have resulted in a similar outcome of high levels of child removals from their whānau by the State in comparison to non-indigenous families, and the Māori population.

In May 2019, the Hawkes Bay District Health Board became both a witness and 'victim' to this practice, first-hand. The District Health Board, is by association with the Crown, connected to the Ministry for Children, Oranga Tamariki, that undertakes the responsibility of removing children from whānau Māori, who are assessed as 'at risk'. A number of reviews have been undertaken following the May 2019 uplift process of a newborn baby from a Māori māmā.

Of particular importance to this cultural responsiveness review of the maternity service of the Hawkes Bay District Health Board, is the inter-connectedness of the findings from the published reports of inquiry into Oranga Tamariki's practice of removing children from their whānau. The Waitangi Tribunal review found that:

Oranga Tamariki had breached Te Tiriti o Waitangi by failing to "honour the guarantee to Māori" for them to have tino rangatiratanga over their kāinga as set out in Article 2".

There are known disparities in the number of tamariki Māori in care, and this was a direct consequence of the "Crown's intrusion" into this rangatiratanga.

The only means by which this statistic for that agency began to decrease, was as a result of having partnership agreements signed with iwi, hapū and Māori providers

The Tribunal recommended legislative changes that required a child's mana, culture, and whakapapa to be at the centre of all decisions.

Furthermore, the Tribunal also required a transition authority be approved as a mechanism to transfer "some of the power, functions and responsibilities" of Oranga Tamariki and the Crown to iwi, hapū and whānau and to ensure there was financial and administrative support to do this.

The New Zealand delegated authorities for the social wellbeing of Children (Ministry for Children, Oranga Tamariki); and for health (Ministry of Health and District Health Boards) have already recognised they must do better. Specifically, agencies must ensure that Rangatiratanga for whānau, hapū and iwi must shift closer to within their grasp, and the Crown partner must remain on notice to improve its responsiveness and cultural competence.

Although questions of this review were not directed at the practice of child uplifts, this was still a major area of concern for Iwi Māori across all stakeholder groups, that were interviewed in their various roles.

Members of the [former] Māori Relationship Board affirmed the need to review maternity services as often the HBDHB was more than "*just a silent party to the uplift practice. They were instrumental to the uplifts and the 2019 uplift was not the only one. It was however, the absolutely visible one because it was being recorded (by whānau and media) as it happened. Staff past and present, reported they witnessed many which have happened exactly the same way prior and currently*".

Other MRB members also raised concerns about the HBDHB practices, again making referrals to the practices of child uplifts:

"*Police become the enforcer and nurses stand silently as observer. Every single uplift, because in their hearts, the nurses and midwives believe that Māori whānau aren't probably equipped to look after them. So, the uplift is a natural par for the course. But the DHB buys into that, … as soon as this happened and we came back to the next meeting, they tried to dumb the meeting down by saying, "Oh, don't worry, we've got this in hand. And there's the Children's Commissioner doing an inquiry and there's the Royal Commission that's happening". I said, "yeah, but each of them is looking at different parts of a continuum of child abuse, pick-ups and state action. This has got to be specific*."

"*Where is the wahine Māori? Where is the wahine in this? The thing that we've got is men and even Māori men determining maternity systems and processes, and they've never raised a … kid in their life. They don't know what it's like to give birth. They don't know the emotional connection that we have. This isn't your expertise … and I said, no … I am a mother. I'm a grandmother. I am scared for my kids, you know. But the male's role is quite defined. And the minute you start to look at things from a male perspective, it becomes more automated as opposed to really getting to the heart. You know? So, I think we've got somebody else come on now. But this is nearly two years down the track. People have moved on from maternity so what are you trying to achieve?*"

"The way that the DHB responded by blocking [the midwife's] ID and that was actually a sign of the authority and who holds the power. The woman never held the power. The authority came from the powers that be. But that's how it is even within a normal day at work"

One MRB member advised that they had asked whether any further uplifts were occurring at the hospital (following the May 2019 incident), they were advised by one staff insider that they were – but instead of occurring in the maternity unit, they were now happening in the car park. They stated "*There's been no motivation in trying to remedy the relationship. It hasn't changed Oranga Tamariki's processes. It's just meant that things have gone to ground a bit more here*." On the other hand, an HBDHB Board member said they had passed a resolution that there would be no more uplifts within HBDHB's maternity unit. The concern of MRB members was that if this Board minute wasn't put into policy and intentionally communicated to staff, then "*none of those staff know that those orders were given*."

Comments from a representative of the local Iwi organisation added to concerns about whether uplifts were still occurring without an appropriate process:

"*So, what I would say is while they're (HBDHB) not equipped to respond they are equipped to refer and to engage with the right service. But if they're racist, they're unlikely to do that also. And my sense then, if their practices are racist, then the DHB have an obligation actually to deal with that. So, in the uplift that happened, as part of the independent review, yes, the social worker that was responsible for it, I don't know how she managed to coerce her supervisor and everything to agree to that, but she also had a person in cahoots with her within the maternity unit. We were given an undertaking by (the past CEO) that that policy would be revoked, it'd be reviewed and revoked. So, we've acted on that part, and we've gone to the other side. What I will say though, is, we've got an agreement from the local [OT] sites that no uplift will occur without notification from and involvement of Iwi and the providership."*

Another Iwi member stated "*That's what we are doing. So, there's nothing to stop us. At the time of the attempted uplift … if we go back two years now … we said not one more, baby. We fired up our work to try and change that section 18. The one that subsequent child has been revoked out of the legislation because of it. I believe that's because of the stance that our chairman made. I do believe that's a direct result for that section 18 was still in the play by that stage. Alongside of that, what was supposed to happen was the HBDHB were going to review the policy to ensure that no baby could be uplifted from the maternity unit. Now I'm not sure whether that ever occurred, but the Board agreed to it at the time of that uplift, that that wouldn't happen. Alongside of that - the Pou Tikanga in the DHB, ran a hui at the Mihiroa Whare to try and resolve the issues that had happened on that night*."

Other stories shared by some Māori midwives also revealed multiple experiences and trauma caused by maternity services who often over-rode the care planning of the midwife:

"I was her primary carer; I was the person to be contacted for all her care. For everything. I went there, organised this and that, she implemented things. This māmā, her māmā that had come to me. When I first met her, I was touched by the love of the mother for her daughter. I was touched by that. So, I was a strong in the belief of this family. Not even knowing their history or their whakapapa, but that didn't matter to me, that was the strength of that woman. What you don't see is that as the support people who were coming in, that were supporting... as they came in, they went out and sat

with Oranga Tamariki. So, all of those carers that were part of the plan. We work with them, we go into their homes, we go into the families"

"We work with the māmā. And I believe that's why we work with the wairua of the māmā, our tipuna. Our tipuna. I believe in that without a shadow of a doubt. I believe what we do on the Marae, when we karanga, it is exactly the same as the process. The women lead, and even if the husband hasn't got it, the woman's job, she will be able to protect that baby. She will. She's going to make the right decisions; we had that support around her"

"When she went into the post-natal ward, they read through her notes, found her history, spread like wildfire. So went back to management. I said, "What's going on?" The stuff that they've put in past history, it's got nothing to do with the present. I said, "There's nothing wrong with her. She has her support place, she's got her support in place, she's been referred to Family Start, she has a plan, there's nothing wrong." But it was instigated that they tried to uplift the baby at the time"

One story from an independent Māori midwife demonstrates another example of care plans being developed with hapū māmā, and then being ignored by staff within HBDHB maternity services. In this particular example, an Oranga Tamariki uplift eventuated that had not been part of the care plan developed by the midwife with the hapū māmā:

> *"With me, I believed in the hospital, I believed that they had set up a multi-disciplinary team. This multi-disciplinary team had all people who could wrap around that māmā. They had community, they had DHB, they had everybody in that multi-disciplinary team. So, believing that they were there for my māmā. With my māmā, when I do a care plan, I always ask what do you want? She creates it [care plan], she comes with all her whakapapa, she comes with all that history. I tell her this team …they can help you. This is what I'm telling this māmā, "They've got everybody there that's going to help you, because this is what you want." And she was willing to do everything that they said - that they will do to help her to be able to have her baby with her. Everybody. Because I was engaged in it, I knew the whakapapa, the history, I knew all of that because I was involved and they're communicating. When she went into their hospital, when she went in … there was missed information in there. I looked and I thought, "Where's the plan for this māmā? Where's the care plan that we had agreed to, that was going to happen with this māmā?" When I went into delivery, where's the plan? Where's the plan where's this māmā is going to go with their baby to the safe home? Nothing was in there. I was like, "Something isn't right." And so I went through each process, I went to the leader of the team there, "Where's the plan?" She goes, "Ah, they had a meeting" This their system, they have their own meetings to decide what's going to happen. It's the clinical meetings. I was not privy to any of them, so I don't know what they're doing over there. No plan was in there. No discharge plan was in there. All it said was she's to stay in there for X amount of time, no plan for discharge. So, I thought somethings not right here. So, I went to the team leaders in the maternity unit, one team leader says to me, "The handover that we got was that the baby's going to be uplifted by order of Oranga Tamariki. And I was like, "What? It doesn't say that in here." And then the other team leader says she doesn't know, she'll go and find out. So, I went to the cultural team leader at the time, she goes, she looked … there's no plan in there. She's my māmā. Under midwifery, she's under me. Yet they were doing everything to cut me out."*

Conclusions

Taku wahine purotu! Taku tane purotu! Kōrua ko te tau e…

The maternity service environment

In comparing the literature with other major health studies of services in other countries experiencing similar challenges with their indigenous Maternal and Child Health services, it was found that:

There is shared concern for focusing attention on reducing health inequities for pregnant women and their babies and increasing access to affordable quality maternity care is a pressing global concern. Disadvantaged women face health inequities that are avoidable, unjust, and mostly, beyond their individual control.

Lead Maternity Carers (LMCs) who are either Midwives or General Practitioners, provide care to women both in the community in primary health care and within maternity facilities that are hospital-based, with a generic access agreement under Section 88 Notice.

While Māori women are engaging early with health services for maternity care, they can immediately meet barriers from their first health contact that can invariably lead to avoidable delays to them accessing a seamless maternity care pathway. There is a lack of sufficient and appropriate information and support particularly for the younger population of Māori māmā.

Other barriers exist to equitable maternal health care in Aotearoa New Zealand and six integrated factors are noted:

1. Physical Access
2. Political Context
3. Maternity Care System
4. Acceptability
5. Colonialism
6. Cultural factors.

The structure of the maternal health system in New Zealand is expected to help to ameliorate inequity in maternal health and yet does not appear to. A complex set of underlying structural and systemic factors, such as institutionalised racism, serve to act as barriers. These inequities in access to maternity care could be reduced through an integrated model of care that sees maternity care beginning at the first interaction with health care services.

A positive consideration is evident for fusing clinical and cultural practice in current maternal infant frameworks through the lens of the three articles of Te Tiriti o Waitangi – Kāwanatanga, Rangatiratanga and Ōritetanga. Additionally, the values of mātauranga Māori and Kaupapa Māori incorporated in the maternal clinical environment, offers this fusion of clinical and cultural practices providing harmony and balance to an appropriate maternal care and support system for Māmā and their pēpi, particularly in the immediate post-partum period.

Inequities for Māori women are also likely to be present amongst Māori midwives who are severely under-represented in the midwifery workforce across clinical, education and professional settings.

A great deal more research is required for better focus on the Māori midwifery workforce but current patterns of their training, recruitment, employment, and retention are highlighting differences to those same movements in the non-Māori midwifery workforce. What is known, is a general under-reporting of Māori midwifery workforce data and that New Zealand has a significant deficit in the number of Māori midwives who can care for Māori women. This workforce makes up between 6.72% (220) and 10.26% (336) of the national workforce. In the Hawkes Bay District Health Board (Kahungunu) region in 2019, there were just 19 Māori midwives.

The midwifery profession and individual midwives have a critical role in contributing to the elimination of, and not compounding to, the inequities faced by Māori. To safeguard Māori women, babies and whānau, change is necessary to enable stronger resilience of Māori midwives to work and walk alongside their Tiriti partner. The profession is urged to open the door to true Tiriti-led partnerships with their colleagues and doing so, will open the door for revolutionary change.

Cultural responsiveness

Cultural responsiveness is described in the literature as having cultural safety at its core. Cultural responsiveness is a commitment to becoming aware of one's own behaviour (individual or organisational) and self-knowledge. Knowing why and how to incorporate that self-knowledge and engage in genuine dialogue with the community served, is to transform care into achieving, maintaining, and governing cultural safety.

Cultural responsiveness can also be presented as a set of behaviours, attitudes, and policies that collectively, can enhance systems or enable professionals to work across culturally diverse situations with the ability to function effectively and respectfully when working with and treating people of different cultural backgrounds to their own.

This ability requires commitment and accountability from the frontline to the most senior positions in health. Evidence suggests five domains for consideration in the development of cultural responsiveness:

- Leadership – Māori are recruited to senior decision-making positions in the organisation
- Accountability – Organisation's report to whānau, hapū and iwi on how they are performing against a mutually agreed key set of indicators. From their frontline to their executive
- Practice – All staff regardless of role engage in local cultural capability training and report
- Relationships – Members of whānau, hapū and iwi are involved in decision making
- Workforce – Māori staff are targeted proportionate to the percentage of Māori people

Cultural competency can be measured. An internationally recognised Cultural Competence Continuum was developed with measures of competence from recognition of destructive behaviour, attitudes, and practices towards those of another culture, to the ultimate proficiency of being culturally safe in behaviour, attitudes and practices when dealing with those of a different culture to one's own.

Significantly, evidence from within Māori culture itself has highlighted that even as a first time māmā, young Māori mothers can be taught within their own cultural space of te ao Māori, how to survive and thrive through their own innate strength, whānau support systems and connection to practices

that are from a Māori worldview of kaupapa and mātauranga. While these successes are not gained in mainstream systems and society, they are a requirement of the workforce in mainstream to be able to serve this cohort in the future and deliver their expected outcomes through greater cultural competence, inclusive of te reo Māori across all disciplines.

This advancement will need to be cognisant of the importance of culture in patient-centred care where there already is growing recognition of the need for improving the health outcomes of Māori.

At the same time, there is also heightened awareness amongst Māori academics, professionals, and practitioners that there is often disregard for Māori research and frameworks to be adopted into mainstream as a way of working in Aotearoa. Hence, there is a paucity of collective Māori Midwifery leadership strategies, Māori health strategies by/for midwifery, and proactive Māori midwifery workforce strategies. As a key workforce in maternity care, there are obligations and accountabilities to support this group of workers, and one way this can be realised is through mainstream proactively addressing institutional racism in the system.

It is essential that institutional racism and bias in the health system is eliminated and treated as unacceptable as a systemic, multi-level and multi-faceted detriment that has various pathways to health. Health impacts for Māori mean that health inequities are the result of both active discrimination and passive inaction and racism will not be removed from society without dedicated and directive effort, hence ignoring racism is not an option if we wish to achieve health equity,

Vulnerable populations

Marginalised groups and underserved populations make up the people who are exposed to conditions and processes in society that prevent them from fully participating in social, economic, and political life. They are more vulnerable to being 'underserved' and are further disadvantaged because of this, achieving poorer clinical outcomes, suffering a greater burden of disease, receiving lower quality care, suffering a greater proportion of medical errors and adverse effects, and/or having more limited access to appropriate services.

Māori form a larger part of the underserved population in this country and Māori health inequities persistently demonstrate their experiences and health outcomes that continue to be lower compared to non-Māori in Aotearoa New Zealand.

Internationally, other countries share the same descriptions of their marginalized populations, including their vulnerable and underserved groups of women, which in turn encompasses women in their child-bearing years. Increasing access to affordable quality reproductive services is a pressing concern in many countries for socially disadvantaged pregnant women and their infants such as:

- Poverty and related issues
- Lack of culturally appropriate care and time constraints
- Health care providers and their routine practices sometimes posing additional barriers
- Insufficient communication skills or judgmental care delivered
- Not being given options/choices, information

All these factors influence whether or not, women will access and/ or utilise the full course of maternity care – in New Zealand this is termed – the maternity continuum and includes pre-conception, pregnancy (antenatal period), labour and birth (intrapartum period), and six weeks following birth (postnatal period).

Timeliness of access to maternity care and timely engagement in antenatal care improves maternal and child health outcomes and is an important element of healthcare performance measurement. This is also supported by good feedback from mothers about their satisfaction with maternal care as client satisfaction was seen as an essential component of quality (maternity) care internationally, including: having a clean facility to give birth in, and being satisfied with their interaction with healthcare providers, However, lower satisfaction has been reported amongst mothers in other countries for instance, with the assistance (not given) to feed their baby. Birthing in primary level facilities tended to be more satisfactory for mothers than those who gave birth in hospitals, and having a companion increased, on average, the overall satisfaction with services the women received.

Māori women experience inequalities in access to maternity care services and have reported lower levels of satisfaction with maternity services than most other women from other ethnic groups (in Aotearoa NZ).

Maternal ethnicity, age, parity and education, and household deprivation with timely engagement have been described in one study and as a result it was found that:

- (98%) stated they had an LMC
- Of these, (90%) reported the time taken to engage an LMC
- And of those women who engaged an LMC 86% to 92% did so in a timely manner (that is, their time of contact to engage with an LMC for their pregnancy care, was measured by the estimated time of their gestation that was already used)
- Delayed engagement was independently associated with their ethnicity: Māori, Pacific or Asian; their first pregnancy; their age if under 20yrsold; their socio-economic deprivation; and LMC type chosen, being a hospital midwife or a combination of independent care providers (LMC's).

Ultimately, timeliness of LMC engagement in NZ is poorer for non-European women, younger women, women in their first pregnancy, and women living in more socioeconomically deprived areas. Improving the timeliness of LMC engagement for these groups of women has the potential to reduce inequalities in maternal and child health outcomes.

The influence of this type of care and support from midwifery providers cannot be under-estimated. It has been shown to have knock-on effects for satisfactory birth outcomes and post-natal care and is able to mitigate the effect of such things as household income (economics) on postpartum depression, possibly through the social support that midwives are able to provide through midwife-led continuity models and programmes. Utilizing interventions such as community-based maternity programmes for women facing intersecting forms of disadvantage are another opportunity for minimizing inequities in maternity care. Providing access to mental health nurses. Providing home visits that minimize costs associated with transportation, childcare, can be a critical tool to improving outcomes as well.

Experiences of Māori parents and their whānau who birth at HBDHB facilities

The overall findings are that hapū wāhine and their whānau have highly variable experiences and outcomes from accessing the maternity services of the HBDHB. In some areas the service was noted as very good, with whānau feeling the midwives / staff were responsive, accessible, caring, and supportive. This was especially so for the Wairoa-based maternity service and the team there received multiple accolades from wāhine for their work.

The experience of hapū wāhine accessing the Hastings service however was markedly different. Rarely were there compliments for the service among Māori māmā, and many shared stories of being subjected to a myriad of discriminatory practices that specifically target Māori women, from violations of privacy to targeted judgment, stereotyping, acts of institutional racism and sometimes harassment. Some noted being threatened with Oranga Tamariki if they did not do tasks with their babies at the time they were instructed to do by staff – even if it was in the middle of the night. These unjust practices appear to have plagued Māori māmā, their partners and whānau over many years, as indicated by whānau with multiple children. These experiences have negatively impacted on their view of the HBDHB maternity service. Hapū wāhine from Wairoa were in some cases very fearful of having to be transferred to Hastings to birth and basically wanted the experience to be as short as possible so they could quickly return home. In some cases, some wāhine have become actively fearful of falling pregnant again due to their desire of not wanting to relive their experiences. There were many stories shared that indicated ongoing trauma for some wāhine and their whānau.

Hapū wāhine need support for themselves and their circle of whānau – whether it be their partner, siblings, parents, or grandparents. They want a service that looks after them as well as their support team and stories were shared of grandmothers sleeping on the floor; not being offered any manaaki; and arguments between staff and support people. Several māmā talked about not being informed appropriately about their rights; not being given information as decisions were being made about their care or their pēpi care; and not being given information in a form they could understand. Several discussed receiving opposing instructions from medical and maternity staff. Several staff commented on care planning not being carried out consistently with the māmā and comprehensive assessments being done of the māmā full social and whānau circumstances (such as not acknowledging a women's support network and assuming she might be incapable of caring for her child). This lack of comprehensive cultural, social, and clinical assessments meant the supports or referrals needed for a māmā and her whānau were not being put in place.

Cultural needs were not consistently met – not just for Māori but for other ethnic groups as well such as Asian, Pacific, and Indian women. While some work has been done to indigenise the physical spaces, and to train staff, this was seen as ad hoc and not taken seriously by staff. There is not a strong thread of cultural recognition, support, awhi, manaakitanga and whanaungatanga through the Hastings service, but this is strong in the Wairoa site. Wāhine noted availability of cultural supports but often were not helped to access it. There were also perspectives on the disconnects between the maternity service and other support services that could be made available to new māmā such as local Māori provider services; supports for whānau who are there for the hapū māmā during her birthing process; and cultural supports from Māori health staff available at the site.

Overall, there are significant variations between the HBDHB's Hastings and Wairoa services for wahine and their whānau – resulting in variations of experience and outcome for whānau. Put simply some get a good service and some do not. It would appear that for Māori – most do not have a positive experience within the HBDHB Hastings maternity service, leading to fear of returning to the service or in some a fear of becoming pregnant again.

Finally, among many of the Māori midwives, there was support for an independent Māori birthing unit that could serve the wahine living within the Kahungunu rohe. Many want to operate their own unit to guarantee the kinds of kaupapa Māori experience that they want for all wahine. Several of the midwives' doubt that there will be changes or improvements to the current HBDHB that will be

impactful enough to improve the experience for whānau, and to maintain a level of consistency and fairness for ALL whānau.

Understanding practices and behaviours of HBDHB in responding to the cultural needs of whānau Māori

Document review findings

The documentation review sought to understand what the HBDHB has documented in terms of expected "understanding, practice and behaviour" that results in cultural responsiveness of the maternity services and to identify perceived gaps in the documents. The engagement process will then test whether what is in the documents, is actually implemented as expected. The Annual Reports particularly were a highlight.

Fifty-one documents were reviewed. In examining these documents, the reviewers' understandings of the history, philosophy, and operations of the maternity services were greatly enhanced and helped to balance the overarching organisational context within which maternity services operate. There were no major flaws in the documents reviewed, but rather areas for review and improvement:

a) overdue dates for internal review on some of the documentation
b) updated language needed and reference to MOH Te Tiriti o Waitangi Framework (updated after WAI2575 findings) for the Treaty of Waitangi policy (and subsequent integration of this into Ngākau Ora training
c) overdue review date for the Multi-disciplinary Team Policy on Child Protection
d) some outdated plans

Governance and Leadership

Documentation in governance and leadership was mainly a positive representation of the HBDHB commitments to Māori health, the Treaty of Waitangi and cultural responsiveness. There are gaps however in the policy guidelines that are implemented proactively to assess and review the status of child protection across the maternity services. In these areas such as the Multi-disciplinary Team membership there is a serious lack of senior Māori expertise in clinical and cultural matters of importance that are discussed in this forum.

There are gaps in the structural diagrams of the services in that there was an obvious absence of Māori leadership positions (even though an incumbent senior Māori health leadership position – and person – exists). Nowhere in all three documents on structural diagrams of the organisation services, did any Hauora Māori services feature, even though these services have existed for many years in the HBDHB.

Maternity Service and Workforce Plans & Reports

There is well written documentation of maternity reports and plans submitted for review. These are updated and inclusive of Ngāti Kahungunu kōrero – on values, vision, aspirations, tribal hauora concepts, tikanga and cultural responsiveness. This is inclusive of both Māori authored and HBDHB service authorships. This indicates high involvement and engagement of Iwi, Hapū and whānau in the directions for the DHB services at strategic, planning and hauora Māori levels.

Job / or position descriptions were reviewed and revealed that these may have been modified on the initiation of this review in August 2021. It is noted that job descriptions however minor the alterations or modifications, need to be alerted to any incumbent holding these roles and consultation must be

entered into with the staff concerned before changes are made in their position documents. Some roles were noted to have appropriate key performance indicators or measures, other roles did not. There were varying levels of inconsistency throughout the job descriptions which lacked cohesion and standardization of common statements most job descriptions in DHB organisations tend to have. For example, Northland and Auckland DHB's, and the Ministry of Health document a Te Tiriti o Waitangi / or Treaty of Waitangi statement on their role descriptions when advertising jobs especially of a senior, or prominent service position. These statements are usually in the front of the JD's and not buried amongst the task schedules or person specifications and provides a good indication of the kaupapa and stance the DHB wishes to portray to potential employees.

Maternity Quality and Clinical Governance

No currently active Risk Register documentation was reviewed from the maternity services, but templates were requested and supplied. This was to check if there were standard items of regular discussion, review and/or audit internally across the service. Templates and samples of the service documents appeared to be unremarkable in terms of cultural responsiveness.

Positive feedback documents were provided from the staff training recently held in 2021 for the Ngākau Ora Staff Cultural Responsiveness Training; the COVID-19 lockdown impacts on Māmā and their whānau; and reports that included consumer comments and feedback in the services directly.

The voice of internal and external stakeholders

Interviews were held with HBDHB governance, management, maternity staff, as well as LMCs & Māori midwives, local Iwi, Māori, and community providers. A survey was also carried out for LMCs and for HBDHB staff.

Themes from the review of understanding, practices, and behaviours of HBDHB staff within the maternity service, again revealed significant variation. Despite commitments by governance, management, and Iwi partners – the ability to embed these commitments throughout the organisation and within the maternity service, is severely lacking. This started at the top where the relationship and influence of the DHB's Tiriti partner in setting standards and expectations of service quality were non-existent. Former Māori Relationship Board (MRB) members and some Iwi representatives felt frustrated that they could not influence the standard of care that would reflect Ngāti Kahungunu tikanga. Some said the partnership was quite ineffective because the MRB could not exert sufficient authority to change the standard of care for whānau that they knew was compromised. Some are starting to see some light in recent times however, and the potential offered by the health reforms. Several managers reinforced their commitment to doing better and improving maternity services as a result of this review.

There were challenges both for Māori health staff within the DHB and for Māori providers and midwives working with the DHB maternity service – to embedding more kaupapa Māori approaches within the service. It was felt to be tokenistic in some areas and not taken seriously. The Kaitakawaenga service was seen as effective, however the birthing suite processes and personnel were given variable feedback. A culture of institutional racism was evident throughout the Hastings service, evidenced by many stories of whānau feeling judged, targeted, stereotyped, blamed, discriminated against, frequently ignored, under-estimated, under-served and unwelcome. Partners with tattoos felt judged and treated differently to other partners in the unit. Furthermore, it was considered that much of this racist attitude was displayed by managers recruited into the service from

other countries. Several providers commented on the fact that there were more non-New Zealanders than Māori sitting in leadership roles in the maternity service, with little or no understanding of Te Tiriti, the status of tangata whenua, kaupapa Māori approaches and their accountability under Te Tiriti to their mana whenua partners. Despite the above findings, the surveys did show that LMCs and HBDHB staff resonate with the cultural philosophies of Ngāti Kahungunu and the wellbeing of whānau in the area – and learning more.

Staff expressed their desire to incorporate more waiata and karakia into current practices, becoming more whānau orientated in their care to better support both māmā and her whānau, and branching out to different models of care. The results emphasise the need for deeper incorporation of Māori practices within the maternity services. While survey responses indicate that the lack of Māori culture within the maternity services unit needs to be improved upon, evidence from interview transcripts show that this problem runs deeper than a lack of representation of Māori within the working environment – rather this problem has advanced to instances of cultural appropriation, cultural racism, and discrimination against Māori wahine.

The model of care at the Wairoa site was overwhelmingly supported by the midwives and team that work there, and the high morale, commitment to the wahine of the area and job satisfaction demonstrate this. This cohesive team provides a service that is enjoyed and respected by wahine and their whānau from Wairoa. Several elements of the model of care operating at Hastings, however, give rise for concern. Variations in provision of appropriate care that meets the cultural needs of wahine, as well as variations in clinical decision-making, mean wahine receive a compromised service in Hastings that frequently subjects them to harm. The MDT was identified as ineffective for wahine Māori outcomes. The lack of strong connection between the service and local Māori midwives and Māori providers also compromises the care plan for wahine and their whānau. The differences in perceptions of the quality of the service are evident between LMCs and HBDHB maternity staff. There is also a lack of consistent clinical and cultural supervision for staff with some saying they have never had either. The workforce needs support in this regard – and urgently.

Respondents to the survey stated that the leadership that oversees the management of the maternity services was lacking in terms of Māori representation. Māori midwives cited examples of them applying for leadership positions over the years, either resulting in them being passed over for the role or being subjected to interviews requiring them to explain care for Māori and Tiriti o Waitangi based practice. It was considered insulting to have midwives from other countries (South Africa, UK, Australia etc) questioning Māori midwives on Te Tiriti, especially since they would likely have little competency to assess the value of the answer.

Other Key Findings

One key issue was frequently raised by many stakeholders. Although unsolicited, the issue was discussed often enough to warrant inclusion in this report. The issue relates to the interface with Oranga Tamariki and the practice of child uplifts from the maternity service and the damage that this practice has done to whānau, midwives and local relationships. New Zealand shares a history with other international western jurisdictions with the practice of uplifting children, including new-borns from their families. It is a confronting and brutal practice that has been shown to have devastating cultural impacts for indigenous children and families who have experienced this.

The practice in Aotearoa New Zealand is not yet relegated to our past as it still continues in this country, to this day. This shared history comes from settler approaches that were explained as “protecting and saving” the child. The removal of children means to "uplift" and "civilize" them. Jurisdictions practicing the removal of children from their families are (among others,): Australia Canada America and New Zealand. Alongside these jurisdictions, the New Zealand settler governments also engaged strategies to remove the native language, culture, medicines, cultural practices, and lands of the Māori.

The cultural impacts on the indigenous people of all these countries are significant inter-generational trauma, poor health, and many other worse social outcomes than their non-indigenous counterparts.

Related findings of those reports of inquiry have appropriate relevance to Hawkes Bay District Health Board and to the maternity services specifically. In that the Waitangi Tribunal found Oranga Tamariki had breached Te Tiriti o Waitangi by failing to "honour the guarantee to Māori" for them to have tino rangatiratanga over their kāinga as set out in Article 2”. It said the disparity in the number of tamariki Māori in care was a direct consequence of the "Crown's intrusion" into this rangatiratanga. The only means by which this statistic for that agency began to decrease, was as a result of having partnerships signed with iwi, hapū and Māori providers, and legislative changes that required a child's mana, culture, and whakapapa to be at the centre of all decisions.

Not satisfied with this, the Tribunal also required a transition authority be approved as a mechanism to transfer "some of the power, functions and responsibilities" of Oranga Tamariki and the Crown to Iwi hapū and whānau and to ensure there was financial and administrative support to do this.

The New Zealand delegated authorities for the social wellbeing of Children (Ministry for Children, Oranga Tamariki); and for health (Ministry of Health and District Health Boards) have already recognised they must do better in that Rangatiratanga for whānau, hapū and iwi must shift closer to within their grasp, and the Crown partner must remain on notice to improve its responsiveness and (cultural) competence.

The review has revealed that many have not overcome the trauma and impact of that 2019 uplift incident. Moreover, there is a concern that many maternity staff have not learned from that experience or changed their behaviours and attitudes toward wāhine Māori and her whānau. There are still indications of adverse events, concerning feedback from wāhine Māori about how they and their whānau are treated, and judgment calls made by some senior staff in the maternity service that manifest in what service users and some Māori midwives describe as institutional racism and discrimination. These matters must be attended to as a matter of urgency.

APPENDICES

Appendix 1a: Engagement Flyer for staff

HAU TE KURA

nurturing our treasures

HAU TE KURA is a kaupapa associated with improving the cultural responsiveness and safety of maternity services in Hawke's Bay. A review is being undertaken that looks at ways to improve the experience of whānau so that every child is born in a safe and caring environment, and where Māori whānau particularly feel respected, listened to, cared for and supported with their new pēpi.

Hawke's Bay District Health Board (HBDHB) supported by an Expert Advisory Group, have commissioned this cultural responsiveness review of the HBDHB Maternity Service, in order to ensure it meets the expectations of whānau Māori, and the organisation. This work has been prioritised following whānau feedback, and implementing the recommendations of the review will be a priority for the DHB.

The review team will be interviewing and engaging with a wide array of stakeholders – from the leadership and staff within the HBDHB Maternity Service, as well as independent midwifery services, whānau, hapū and Iwi, and community-based providers. The team is also reviewing a number of HBDHB guiding documents to identify any gaps in policy or practice.

Details of the review team are on the back of this flyer.

[redacted]

HAVE YOUR SAY

We are asking midwives, LMCs, nurses and any others involved with maternity care to share your kōrero!

First Code for Lead Maternity Carers

Second Code All Staff

HAWKE'S BAY District Health Board Whakawāteatia

KāhuiTautoko Consulting

THE REVIEW TEAM

- **Mara Andrews**: *Ngāti Kahungunu, Whakatōhea, Ngāti Raukawa:* Director/Senior Consultant, Kāhui Tautoko Consulting Ltd since 2000. KTCL works with health and social Government and community providers, across the country in the Māori Health area, particularly in strategy development; policy matters; service reviews and evaluations.

- **Moe Milne:** *Ngāti Hine:* Consultant NZPN, ONZM. Moe was awarded Officer of the New Zealand Order of Merit (ONZOM) for services to Māori and Health. She has addressed mental health issues in the Māori community in her roles as a psychopaedic nurse and as a general and psychiatric nurse. Moe contributed to Te Hau Mārire, the national Māori Addiction Strategy, and developed several education programmes. Moe's knowledge of Māori health, education and research is extensive. A fluent native speaker in Te Reo she is committed to ensuring her whānau grasp hold of the values and culture of their ancestors.

- **Linda Thompson:** *Ngāti Kahungunu, Te Atihaunui a Paparangi Whanganui, Tuwharetoa:* Consultant NZRN ADipN QCM was awarded the Queen's Commemoration Medal 1990 for services to the public and Women's Health. She is a founding member and life member of Te Kaunihera o Ngā Neehi Māori o Aotearoa (1983). Linda held the first management role for Māori health, as Director in the Manawatu Whanganui Area Health Board and went on to join the first Māori Health team in the Ministry of Health that set up Te Kete Hauora Māori Health Directorate under the Deputy Director General of Māori Health management

Judy Ann Cooze: *Ngāti Kahu, Ngāti Aukiwa* Clinical Midwife / Nurse Consultant demonstrates understanding of a Māori world view through her delivery of midwifery services and drawing on her whānau and hapū practices in this area to ensure safe, clinical and cultural practice in her field of expertise. Judith is an experienced Māori Midwife with a history of working in both hospital and the community in New Zealand and Australia – amongst indigenous women in both countries.

Henare Kani: *Ngāti Kahungunu, Rangitāne, Tuwharetoa:* Consultant spent time with Ngā Māia as well 2000 - 2019 in various roles. He has background experience in tutoring cultural competency for midwifery schools and midwives nationally 2006 – 2015. He developed Tūranga Kaupapa which is a reference and source of support for midwives, wāhine and whānau and was developed for Ngā Māia in 2006 to enhance Ngā Māia kaupapa and to provide cultural guidelines. Tūranga Kaupapa are guidelines for cultural competence that have been formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives.

Appendix 1b: Engagement flyer for wahine and whānau

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[redacted]

KāhuiTautoko Consulting

HAWKE'S BAY District Health Board Whakawāteatia

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- **Moe Milne:** *Ngāti Hine:* Consultant NZPN, ONZM. Moe was awarded Officer of the New Zealand Order of Merit (ONZOM) for services to Māori and Health. She has addressed mental health issues in the Māori community in her roles as a psychopaedic nurse and as a general and psychiatric nurse. Moe contributed to Te Hau Mārire, the national Māori Addiction Strategy, and developed several education programmes. Moe's knowledge of Māori health, education and research is extensive. A fluent native speaker in Te Reo she is committed to ensuring her whānau grasp hold of the values and culture of their ancestors.

- **Linda Thompson:** *Ngāti Kahungunu, Te Atihaunui a Paparangi Whanganui, Tuwharetoa:* Consultant NZRN ADipN QCM was awarded the Queen's Commemoration Medal 1990 for services to the public and Women's Health. She is a founding member and life member of Te Kaunihera o Ngā Neehi Māori o Aotearoa (1983). Linda held the first management role for Māori health, as Director in the Manawatu Whanganui Area Health Board and went on to join the first Māori Health team in the Ministry of Health that set up Te Kete Hauora Māori Health Directorate under the Deputy Director General of Māori Health management

Judy Ann Cooze: *Ngāti Kahu, Ngāti Aukiwa* Clinical Midwife / Nurse Consultant demonstrates understanding of a Māori world view through her delivery of midwifery services and drawing on her whānau and hapū practices in this area to ensure safe, clinical and cultural practice in her field of expertise. Judith is an experienced Māori Midwife with a history of working in both hospital and the community in New Zealand and Australia – amongst indigenous women in both countries.

Henare Kani: *Ngāti Kahungunu, Rangitāne, Tuwharetoa:* Consultant spent time with Ngā Māia as well 2000 - 2019 in various roles. He has background experience in tutoring cultural competency for midwifery schools and midwives nationally 2006 – 2015. He developed Tūranga Kaupapa which is a reference and source of support for midwives, wāhine and whānau and was developed for Ngā Māia in 2006 to enhance Ngā Māia kaupapa and to provide cultural guidelines. Tūranga Kaupapa are guidelines for cultural competence that have been formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives.

Appendix 2: All staff and LMC survey

Hawke's Baby District Health Board (HBDHB) Maternity Services - All Staff and LMCs Cultural Responsiveness Review Survey

Pinepine te kura, hau te kura, Whanake te kura i raro i Awarua

1. The Ngāti Kahungunu tribal oriori (lullaby) speaks to the precious taonga that are our tamariki and mokopuna inferring that we are created and brought to the world from two sacred lineages through our mother and our father. From a Māori worldview, our Māori origins rest in celestial and ancient realms making our existence both divine and human. As a staff member of the HBDHB Maternity Service, do you resonate with the cultural philosophies that support the wellbeing of whānau in this area?
2. Of recent times, important national leaders have reviewed and challenged the system's approach and stance on child health and wellbeing, such as the Children Commissioner Andrew Becroft's report Te Kuku o te Manawa (2020), and Ngahiwi Tomoana Chairman of Ngāti Kahungunu Iwi Incorporated's report, Kōrero Mai Whānau (2020). As a staff member of the HBDHB Maternity service and an advocate for women and their whānau, do you agree with such reports and feel the system needs an improved approach to service provision?
3. My ethnicity is
4. As a staff member of the HBDHB Maternity Service, providing services for whānau, do you feel there are clear and safe processes for escalation when you feel uncomfortable about the way a woman is treated?
5. As a staff member of the HBDHB Maternity Service, I get up out of bed every day because I am motivated by my…
6. As a staff member of the HBDHB Maternity Service are you offered protected time for Clinical Supervision?
7. Are you offered cultural supervision or support by your organisation?
8. As a staff member of the HBDHB Maternity Service, - what are your hopes, dreams, and aspirations for this service in the future?
9. As an LMC/staff member of the HBDHB Maternity Service, I am able to take women I am caring for to the service and access what is needed and feel supported
10. As a staff member of the HBDHB Maternity Service, I protect and respect women's privacy by…
11. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we (HBDHB Maternity Service) are already doing and should KEEP doing
12. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the · Things we should do MORE of
13. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we should do LESS of
14. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to do DIFFERENTLY
15. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to STOP doing
16. When you reflect on the service the HBDHB Maternity Service provides for women and their whānau, what are the Things we need to START doing
17. If there was a message or question for the HBDHB Chief Executive Officer, what would you like to say?

Appendix 3: Lead Maternity Carer Survey

Hawke's Baby District Health Board (HBDHB) Lead Maternity Carers Cultural Responsiveness Review Survey

Pinepine te kura, hau te kura, Whanake te kura i raro i Awarua

1. The Ngāti Kahungunu tribal oriori (lullaby) speaks to the precious taonga that are our tamariki and mokopuna inferring that we are created and brought to the world from two sacred lineages through our mother and our father. From a Māori worldview, our Māori origins rest in celestial and ancient realms making our existence both divine and human. As a LMC caring for women in Ngāti Kahungunu, do you resonate with the cultural philosophies that support the wellbeing of whānau in this area?
2. I am a Lead Maternity Care in
3. My ethnicity is
4. As a Lead Maternity Carer (LMC) I am able to take women I am caring for to the HBDHB Maternity Service and access what is needed and feel supported
5. It is easy to discuss issues and problems I am experiencing as a LMC with the HBDHB Maternity Service
6. Members of the HBDHB Maternity Service Team value and respect us as LMCs and our contributions
7. It is difficult to ask members of the HBDHB Maternity Service Team for help
8. Problems and errors in the relationship between the HBDHB and LMCs are communicated, and a "no blame" process is undertaken
9. When someone makes a mistake as a LMC this is often held against them
10. When interacting with the HBDHB Maternity Service it is easy to discuss issues and problems
11. When interacting with the HBDHB Maternity Service different ways of working are embraced
12. Regular meetings are held with the HBDHB Maternity Service to work out ways to improve processes
13. When working with the HBDHB Maternity Service mistakes are talked about and ways to prevent and learn from them are discussed
14. Differences of opinion and conflict are handled with discretion or isolation rather than addressing them directly as a group
15. Differences of opinion and conflict are handled with discretion or isolation rather than addressing them directly as a group
16. LMCs and HBDHB Maternity Staff frequently coordinate with each other to meet organisational objectives of HBDHB
17. LMCs and HBDHB Maternity Staff cooperate effectively with each other, over all shifts to meet organisational objectives and consumer satisfaction needs
18. The HBDHB Maternity Staff are very good at keeping everyone informed on team planning and achievements
19. People from outside the LMC group and the HBDHB Maternity Service Staff are invited to share their views on our collective services. People such as iwi and hapū representatives
20. The outcomes of consultations with iwi and hapū result in new processes or procedures and productive relationships
21. The HBDHB Maternity Service recognises the intergenerational trauma experienced by Māori as well as the potential for wellbeing among whānau, and consider that consistently when developing new processes and procedures

22. The HBDHB Maternity Service values the work of the LMCs and strives to improve collaboration with them
23. The HBDHB Maternity Service Core Staff supports LMCs when the women we are caring for need to be handed over for care
24. The HBDHB Maternity Service's core staff assist LMCs by providing adequate support and/including breaks when we are in their facility
25. The HBDHB Core staff support a safety culture by relieving us as LMCs when we have exhausted our hours for safe practice
26. The HBDHB Maternity Service Core staff assist LMCs by caring for women in early labour, so we have adequate hours available for the birth
27. The HBDHB Maternity Service Core staff communicate adequately when women we are caring for are discharged from the facility
28. The HBDHB Maternity Service Core Staff provide adequate information to women about things to call their midwives about upon discharge from the facility
29. Is there anything else you would like to add?

Appendix 4: Interview participant Information Sheet

INFORMATION SHEET

PROJECT OVERVIEW: CULTURAL RESPONSIVENESS REVIEW OF HAWKES BAY MATERNITY SERVICES

Background

In 2021, the Hawkes Bay District Health Board (HBDHB) agreed to establish an Expert Advisory Group to lead a cultural review of the HBDHB maternity services across the area Wairoa, Napier, Hastings and Central Hawkes Bay. HBDHB maternity services provide care to expectant parents throughout the pregnancy journey (prenatal, labour, birth and postnatal), and the care that they provide can have a lasting effect on whānau. The ability to respond to the cultural needs of a whanau, as well as their clinical needs, is imperative to ensure a positive experience and the best possible outcomes for māmā, pēpi and whānau.

HBDHB commissioned this cultural responsiveness review of maternity services in order to ensure the cultural responsiveness of maternity services is meeting the expectations of whānau Māori and the organisation. This work has been prioritised as a response to whānau feedback, and the recent attempted uplift of an infant by Oranga Tamariki, that aligns with DHB policy. The key objective of this review is to improve the maternal and child outcomes for Māori parents and their pēpi who birth at HBDHB facilities, by implementing the recommendations of the review.

Review Process

HBDHB called for proposals from reviewers who most possessed experience and understanding of both the clinical (maternity) and cultural worlds, and who could demonstrate ability to successfully balance these views. Kāhui Tautoko Consulting Ltd has put together such a team. The review team is made up of:

- Mara Andrews
- Linda Thompson
- Moe Milne
- Judy Ann Cooze
- Henare Kani

The work requires engagement with a wide array of stakeholders – from the HBDHB leadership and staff within HBDHB maternity services as well as independent midwifery services, whānau, hapu and Iwi, and community-based providers. The review team will be reaching out to stakeholders over the August, September and October period if necessary, to seek input to the review. The team is also reviewing a number of HBDHB clinical and cultural documents to identify any gaps in policy or practice.

The report is due 20 December 2021 which includes findings and recommendations for improvement.

Next Steps

The HBDHB will randomly identify whānau who have birthed at HBDHB facilities during the past two years, to develop a sample for interview. These whānau will be asked if they consent to participate, and if they choose not to, other potential candidates will be approached to achieve a sample of around 25 whānau from all 4 areas of Hawkes Bay. Other stakeholders such as staff within the HBDHB and those in the community, will be approached directly by a member of the team to arrange a process, time and date for interview. Everyone who is approached may choose not to participate.

[redacted]

Appendix 5: Interview Participant Consent Form

CONSENT FORM

CULTURAL RESPONSIVENESS REVIEW OF HAWKES BAY MATERNITY SERVICES

- ☐ Ethnicity – Identify as Māori
- ☐ Ethnicity – identify as non-Māori

- ☐ I am an HBDHB governor, manager or staff member
- ☐ I am a whānau member and we have birthed at a HBDHB facility
- ☐ I am from a hapu, Iwi or Māori NGO organisation
- ☐ I am from a Māori community provider
- ☐ I am from a non-Māori community service provider
- ☐ Other: Please identify: _____

I confirm that I understand:

- ☐ the purpose of the review
- ☐ the reason for wanting to interview me
- ☐ That my identity will remain anonymous and that I will not be identified in the report

Signature: _____ / /

If done by zoom or phone, interviewer to seek consent and then note "Consent obtained verbally at [time] and [date]

If a whānau member, please print first name and surname in full

_____

(Your name will not appear in the report. This is just so we have a record of who was paid a koha for participating in the review)

Appendix 6: Interview questions for governance and leadership

GOVERNANCE / IWI PARTNERSHIP AND RELATIONSHIP BOARD AND EXECUTIVE LEADERSHIP QUESTIONS

The review intentions are to examine how the Hawkes Bay District Health Board measures its cultural responsiveness utilising the three articles of Te Tiriti o Waitangi with an emphasis on

- Article One: Kāwanatanga – development, consultation and appropriate implementation and delivery of maternity services to Māori in the Hawkes Bay District Health Board setting.
- Article Two: Rangatiratanga – will be explored and questions asked about what means of engagement of whānau, hapū and Iwi in the consultation and implementation processes exist? What level of control and governance do whānau, hapū and Iwi have in the Maternity services space?
- Article Three: Ōritetanga – how does the Hawkes Bay District Health Board measure its equity for Māori and when there is recognition of inequity what action plans are put in place to address these inequities from a Safety and Quality perspective? What is the timeline of review and target dates for completion of agreed action plans? How is accountability communicated up, and to whom?

TE TIRITI O WAITANGI is the basis of cultural responsiveness for all health services, including the maternity services of Hawkes Bay District Health Board

1. In your opinion, are the policies of Hawkes Bay District Health Board the right fit?
2. In what ways do the practices in the services reflect these standards of Te Tiriti o Waitangi?
3. What has been the response to the Kahungunu Iwi goals – what and how do the Hawkes Bay District Health Board goals align with these?
4. What has been the Hawkes Bay District Health Board response to "Korero Mai Whānau"?
5. What type of governance relationship exists between the Hawkes Bay District Health Board and other Crown agents locally? Which agencies? Formal? Informal?

Standard One: Te Tino Rangatiratanga (Article Two)

What means of engagement of whānau, hapū and Iwi in the consultation and implementation processes exist?

1.0 Is it working in Governance?

- With Iwi / Hapū?
- With MRB?
- With Māori Consumers?

1.1 Is it working in Management?

What level of control and governance do whānau, hapū and Iwi have in the overall DHB space/s?

1.2 Is it working in Operations?

and in the Maternity services space?

Standard Two: Kāwanatanga (Article One)

Key here is development, implementation, and delivery:

Is it working?

2.0 How well developed are these areas of service delivery: Consultation with the (Māori) clients of the service/s?

2.1 Appropriate implementation and delivery of maternity services to Māori in the HBDHB setting to meeting Māori inequities/ disparities?

2.2 In other / alternative settings?

2.3 Is the workforce appropriate to the client base and their needs – culturally?
2.4 Which is the loudest voice in your ear? And what is it saying?

Standard Three: Ōritetanga (Article Three)

What are the measures in equity for Māori? How many equity action plans are developed for implementation and delivery to date? Any sign of when we are going to "get there"?

Is it working?

3.0 How does the HBDHB measure its equity for Māori?
3.1 When there is recognition of inequity what action plans are put in place to address these inequities from a Cultural Safety and Cultural Quality perspective?
3.2 What is the timeline of review and target dates for completion of agreed action plans?
3.3 How is accountability for Māori and cultural responsiveness currently communicated up, and to whom?
3.4 These areas have been mooted from Government levels and as a result some health reforms are now in train for improving:

a. Te Tiriti responses
b. Māori health inequity / disparity responses
c. Agreements with Iwi, hapū, Whānau – showing transfers of – what?
d. Transitioning power, resources, financial and administrative support – in what ways?

e) **In the new order of the health sector:**

- DHB's will go
- hospital services will remain, and
- a Māori Health Authority will be established

In your opinion, do you have any confidence that there will be any enduring legacy for continuing vigilance for Māori cultural responsiveness in the DHB/hospital services?

Iwi alignment

Hawke's Bay DHB's overarching commitment to a system that is Te Tiriti based and one that actively and purposefully invests in equitable health outcomes for its Māori population. *(Ref: HBDHB Statement on Institutional Racism)*

What are your thoughts about how the HBDHB can fulfil this above statement, based on these alignments below with Kahungunu Iwi goals?

Kahungunu Goals

1.0 Promotion and assistance in the education of Ngāti Kahungunu Iwi.

2.0 Promotion of the custody and preservation of the beliefs, customs, and language of Ngāti Kahungunu Iwi.

3.0 Promotion of the social and economic welfare and advancement and vocational training of Ngāti Kahungunu Iwi

4.0 Promotion of personal and community physical, spiritual, mental health and raise the living standard of Ngāti Kahungunu Iwi.

5.0 Promotion of high-quality communications for the benefit of Ngāti Kahungunu Iwi.

Appendix 7: Interview questions for executive leaders

HBDHB ORGANISATION LEADERS: EXECUTIVE MANAGEMENT
DIRECTORS / MANAGERS / OFFICERS / ADVISORS / CONSULTANTS
Māori Health
Maternity Services
Midwifery
Quality and Safety

1. Can you describe Māori health within the structure of the HBDHB – what does that look like to you?
2. Where are you and what is your role in supporting that (Māori health) space in the DHB?
3. Explain your level (upwards) and breadth (outwards) of influence on the area you mostly work in?
4. What areas of this role give you the most satisfaction? And the most concern?
5. What is your response when things trouble you about Māori health, Māori clients, Māori Māmā and whānau? What do you do about it? Who do you talk to about it?
6. **On a scale of 0 to 5 (0=low; 5=high) what would you score yourself on these:**
    a. Knowledge and understanding of Te Tiriti o Waitangi?
    b. Knowledge, understanding and practice in Māori health equity action?
    c. Knowledge, understanding, actions and influence in maternity service delivery to Māori?
7. What is your understanding of institutional racism? If you could change anything in the service you lead or work in, what would those changes be?
8. Who would benefit the most from these changes?
9. Did you fill in the survey questionnaire for all the staff of the Maternity services?

PARTNERSHIP AND PARTICIPATION

To share in equal and true partnership, our aspirations, operations, resources, and decision-making between Māori and HBDHB that includes cultural competency in service provision and ensures Māori participation in service delivery to their people. This standard is upheld in the maternity services by:

A Partnership and Participation

A1 How is Māori input evidenced in processes and systems related to clinical practice?

A2 Is the service aware of any barriers for Māori whānau/patients that limit them from accessing this service?

B Proactive Patient/ Whānau consultation Education

B1 In the past 12 months, 2019-2020, what consultation and education has been formally and informally provided to patients/whānau in this service about – the maternity services, and maternity conditions they have, and any other support they can expect from the health services in HBDHB?

B2 What service follow-up processes are in place to ensure patients/whānau have understood how to use the maternity services of HBDHB effectively for their wellbeing?

C Timely Discharge Planning Procedures

C1 How would you describe the maternity service's quality of discharge information, and coordinated care that is provided to Māori whānau/patients?

C2 Explain the roles in discharge planning of the:

- Maternity service

- the patient and
- the relationship between the service and related providers, or other technical support for Māori whānau/patients?

C3 What are the areas of improvement the service needs to have in place for Māori whānau/patients' handover from hospital to primary care?

EQUALITY AND EQUITY

The New Zealand Public Health and Disability Act 2000, requires DHB's to address Māori health outcomes and reduce health disparities. Services are greatly enhanced by sound systems for Quality Improvement and Workforce professional development. This standard is upheld in the maternity services by:

A EQUALITY AND EQUITY

A1 Is the maternity service aware of what inequalities exist in relation to Māori whānau/patients' maternity health issues?

A2 Has the service examined how the inequalities occur? Or how they are maintained or increased?

A3 Has the service considered how /where it will intervene to tackle this issue?

A4 How will the service improve the outcomes and reduce health inequalities experienced by Māori patients?

A5 Who will benefit most?

A6 Would there be any unintended consequences?

A7 What needs to happen in the maternity service to ensure the intervention does reduce inequalities?

A8 How will the maternity service know if inequalities have been reduced?

B Relevant Staff Orientation

B1 How many staff in your service identify as Māori?

B2 Is growing the Māori workforce seen as a responsibility / or obligation of the service/organisation to promote?

B3 Are there Māori designated positions within your service?

B4 Are areas of Māori health needs in your Service identified and well understood?

B5 How is culturally safe practice a part of staff assessment processes?

C Timely Staff Training Opportunities

C1 What provisions have been made to enable staff to up-skill and develop to meet the cultural needs of Māori clients?

C2 How proactive is the service in encouraging training opportunities for:

- Te Tiriti o Waitangi training?
- Cultural Safety and practice in service delivery?
- On-line cultural training programmes?

C3 Does the service have any evidence about the most effective methods for training clinicians in cultural quality and improvement practices?

C4 After the training – what happens to measure staff performance in cultural responsiveness?

D Regular Staff Professional Development

D1 Is advanced professional development for staff a priority in the service?

D2 Are staff asked how they see the future of maternity health care?

D3 How do staff stay informed with current trends in Māori health advancements?

D4 Is the service proactive in training staff in professional practices and improvement techniques in the service?

Appendix 8: Interview questions for HBDHB staff and health workers

HBDHB STAFF AND HEALTH WORKERS:
Māori Health: Kaumātua / Kuia, Kaitakawaenga
Maternity Services: Kaitakawaenga, Kaiāwhina

1. Can you describe Māori health within the structure of the HBDHB – what does that look like to you?
2. Where are you and what is your role in supporting that (Māori health) space in the DHB?
3. Explain your level (upwards) and breadth (outwards) of influence on the area you mostly work in?
4. What areas of this role give you the most satisfaction? And the most concern?
5. What is your response when things trouble you about Māori health, Māori clients, Māori Māmā and whānau? What do you do about it? Who do you talk to about it?
6. The HBDHB has acknowledged they "could do better" for Māori health and for whānau, how well placed do you think the maternity services are to achieving better things for whānau, hapū and Iwi?
7. **On a scale of 0 to 5 (0=low; 5=high) what would you score yourself on these:**
    a. Knowledge and understanding of Te Tiriti o Waitangi?
    b. Knowledge, understanding and practice in Māori health equity action?
    c. Knowledge, understanding, actions and influence in maternity service delivery to Māori?
8. What is your understanding of institutional racism?
9. If you could change anything in the service you lead or work in, or represent, what would those changes be?
10. Who would benefit the most from these changes?
11. Did you fill in the staff survey questionnaire for this review?

PARTNERSHIP AND PARTICIPATION

To share in equal and true partnership, our aspirations, operations, resources, and decision-making between Māori and HBDHB that includes cultural competency in service provision and ensures Māori participation in service delivery to their people. This standard is upheld in the maternity services by:

A Partnership and Participation

A1 Do you know how Māori input is sought and/or evidenced in the service processes and systems related to clinical practice?

A2 Is the service aware of any barriers for Māori whānau/patients that limit them from accessing this service?

B Proactive Patient/ Whānau consultation Education

B1 In the past 12 months, 2019-2020, what consultation and education has been formally and informally provided to patients/whānau in this service about – the maternity services, and maternity conditions they have, and any other support they can expect from the health services in HBDHB?

B2 Do you know how the service follows-up to ensure patients/whānau have understood how to use the maternity services of HBDHB effectively for their wellbeing?

C Timely Discharge Planning Procedures

C1 How would you describe the maternity service's quality of discharge information, and coordinated care that is provided to Māori whānau/patients?

C2 Explain the roles in discharge planning of the:

- Maternity service
- the patient and
- the relationship between the service and related providers, or other technical support for Māori whānau/patients?

C3 What are the areas of improvement the service needs to have in place for Māori whānau/patients' handover from hospital to primary care?

EQUALITY AND EQUITY

The New Zealand Public Health and Disability Act 2000, requires DHB's to address Māori health outcomes and reduce health disparities. Services are greatly enhanced by sound systems for Quality Improvement and Workforce professional development. This standard is upheld in the maternity services by:

A EQUALITY AND EQUITY

A1 Is the maternity service aware of what inequalities exist in relation to Māori whānau/patients' maternity health issues?

A2 Has the service examined how the inequalities occur? Or how they are maintained or increased?

A3 Has the service considered how /where it will intervene to tackle this issue?

A4 How will the service improve the outcomes and reduce health inequalities experienced by Māori patients?

A5 Who will benefit most?

A6 Would there be any unintended consequences?

A7 What needs to happen in the maternity service to ensure the intervention does reduce inequalities?

A8 How will the maternity service know if inequalities have been reduced?

B Relevant Staff Orientation

B1 How many staff in your service identify as Māori?

B2 Is growing the Māori workforce seen as a responsibility / or obligation of the service/organisation to promote?

B3 Are there Māori designated positions within your service?

B4 Are areas of Māori health needs in your Service identified and well understood?

B5 How is culturally safe practice a part of staff assessment processes?

C Timely Staff Training Opportunities

C1 What provisions have been made to enable staff to up-skill and develop to meet the cultural needs of Māori clients?

C2 How proactive is the service in encouraging training opportunities for:

- Te Tiriti o Waitangi training?
- Cultural Safety and practice in service delivery?
- On-line cultural training programmes?

C3 Does the service have any evidence about the most effective methods for training clinicians in cultural quality and improvement practices?

C4 After the training – what happens to measure staff performance in cultural responsiveness?

D Regular Staff Professional Development

D1 Is advanced professional development for staff a priority in the service?

D2 Are staff asked how they see the future of maternity health care?

D3 How do staff stay informed with current trends in Māori health advancements?

D4 Is the service proactive in training staff in professional practices and improvement techniques in the service?

Appendix 9: Interview questions for HBDHB consumer representatives

HBDHB CONSUMER REPRESENTATIVES
In
Maternity Services and Midwifery Care and Support

1. As a Consumer representative on the HBDHB Board/Committee can you describe Māori health within the structure of the HBDHB – what does that look like to you?
2. Where do you think your strengths are in being able to advocate for Māori whānau in this committee / Board?
3. Are you able to be heard? Do you think anyone listens and considers what you have to say? How do they do that?
4. If or when you have anything important to contribute, do you feel it is safe to do so in that forum?
5. Can you describe the type of "listening" / respectful / understanding behaviour you see in the committee?
6. Explain your level (upwards) and breadth (outwards) of influence on this committee / Board?
7. What areas of this role give you the most satisfaction? And the most concern?
8. What is your response when things trouble you about Māori health, Māori clients, Māori Māmā and whānau? What do you do about it? Who do you talk to about it?
9. **On a scale of 0 to 5 (0=low; 5=high) what would you as a Consumer score your committee / Board members' overall, on these:**
    a. Knowledge and understanding of Te Tiriti o Waitangi?
    b. Knowledge, understanding and practice in Māori health equity action?
    c. Knowledge, understanding, actions and influence in maternity service delivery to Māori?
10. What is your own understanding of institutional racism?
11. Can you say if your own health literacy has increased or improved, or not, through being on this committee / Board?
12. If you could change anything in the committee / Board you are on, what would those changes be?
13. Who would benefit the most from these changes?

Appendix 10: Interview questions for external stakeholders

EXTERNAL STAKEHOLDERS
SERVICE PROVIDERS – Health / Social / Education / Iwi

Hawkes Bay District Health Board is seeking responses from its maternity services to ensure their ability to respond to the cultural needs of whānau, as well as to their clinical needs, achieves a safe, positive experience and the best possible outcomes for māmā, pēpi and whānau using their services.

The objective of this review is to ensure the cultural responsiveness of maternity services is meeting the expectations of whānau Māori and the organisation (HBDHB). These provider exploratory questions were based around discussions held with Ngāti Kahungunu Iwi Incorporated management.

A) NGĀTI KAHUNGUNU IWI INCORPORATED

Questions were focused on:

1 Iwi – Crown Governance Relationships
2 Iwi – Whānau Relationships
3 Iwi – Crown Agency Management Relationships
4 Iwi – Whānau & Provider Relationships

B) SERVICE PROVIDER EXPLORATORY QUESTIONS

1. What actually is working between your service and the DHB?
2. What alignments exist between your service goals and those of the District Health Board?
3. What does it all look like? Any collaborations – Partnerships – Innovations? – Together?
4. How do you see a direct relationship between the DHB reporting from your service back to them - is there any agreement on this area? MOU's? or Service Contracts?

Child Health Services

- What is preventing you – say as a child health service provider for instance, from saying this child that's born today from this hospital is expected to be born with the whole integrity of its Tupuna? When we talk about investment – what is the service's best investment with the DHB in terms of your client base?

Cultural service model

- If all of our focus was on the services being culturally constructed for delivering good outcomes for Māori, what do you think that service modelling would/should look like?
- Whose powerbase should that model work best from?

Service access

- If the intention is to have a greater influence ... when anybody, any māmā any whānau needs a service, what would be the things stopping the whānau from coming to the services? What would be the things enhancing easy access for whānau to have the services they need?
- A big part of our focus is...How does a māmā come into the service - and transition through it - and come out the other end with a healthy pēpi / uri o Kahungunu? And a happy māmā and whānau?
- What do you think it takes to get it right? – from the start?

Service capability

- What level of service interventions do you think the DHB is / and is not equipped to provide?
- Take the vision for your service – do you think it would change the status of Māori in Kahungunu one whānau at a time? Or marae? Or hapū?
- For whānau ora / oranga whānau – how much time is spent with the whānau working with them ... on making decisions
- We all want to be caretakers of our own children, so how well equipped do you think services need to be to enhance whānau wellbeing - their hinengaro or their wairua
- Is there any relationship with maternity services in that aspiration?
- What do you think would be the scope of your caregivers, your staff roles?
- Does the service have any capability for training staff to deliver on whānau aspirations?

Experiences of Māmā and whānau in maternity DHB service

- The DHB generated this review because of negative feedback they received about the maternity service – has your service heard or experienced this feedback also about the DHB maternity services?

Your thoughts on these comments:

- The māmā who come and give birth in this hospital... they should be accorded the same rights and privileges that are accorded to anybody who comes into their care.
- When any māmā irrespective of status or station comes into this DHB, there should be some confidence that the birthing process for them will be one that's safe, will be one that has a live birth at the end of it. And that there's no harm to the māmā or the father in the process.
- It's really about how do we actually get a really clear signal that we have the least amount of influence, impact or engagement in their care that is negative?

WORKFORCE

- There's a lot of great intention, but how and when – in driving the capability of the staff within the maternity services and advocating for Māori staff members – how is this done effectively?
- In the maternity service no pathway to senior leadership or no Māori fitting in there when there are plenty of capable Māori staff there – and in the community. But somehow within that structure they never ascend to senior leadership within the maternity space and that's concerning because that's not a culturally capable service if you don't have Māori all the way to the top.
- From the minute you walk into an organization, you should understand what your pathway is, be you Māori, non-Māori, all the way through, and every moment at every checkpoint, as you progress in the service, you need to be reminded again of your obligation.

EQUITY

- Is your service able to recognise when there are inequities – internal (inside) & external (outside) of your services, from a cultural safety, cultural quality perspective?

KAUPAPA MĀORI

- Some immediate aspirations are – e.g., Māori Midwives, to have their own Māori Birthing Unit? Has that vision been shared with your services? With Whānau / Hapū / Iwi?

Appendix 11: Interview questions for whānau who have birthed at HBDHB facilities

EXTERNAL STAKEHOLDERS
WHĀNAU: Māmā and their whānau and Service Providers

NGĀ PĀTAI – WHĀNAU ENGAGEMENT

1. **Where did you birth?**
    a. At Home
    b. Primary – Wairoa, Waioha (Hastings Hospital)
    c. Secondary – Ata Rangi (Hastings Hospital)

2. **Talk about your own journey birthing in the HBDHB Maternity Services system?**
    a. **At what stage of your pregnancy did you seek care?**
        i. Why was it at this time?
        ii. Did you understand what was happening?
        iii. Were you given good/clear information/explanations?

    b. **Were your choices respected?**
        i. Birth Plan
        ii. Who was involved in your care?
        iii. Did you feel respected?
        iv. Did you feel cared for?

    c. **Were there any barriers to your care?**
        i. Access to scans?
        ii. Appointments with specialists e.g., Diabetic Clinics/Obstetric Clinics?
        iii. Travel?
        iv. Communication?

    d. **If you had to travel to Hastings what support was offered?**
        i. Travel?
        ii. Accommodation?
        iii. Other referrals
            1. Social support, Whānau ora, Māori providers?
            2. Dental, Physio?
            3. Rongoā?

    e. **How was your care while you and your baby and whānau were in hospital?**
        i. Were your cultural needs respected?
        ii. General comments?
        iii. Did you feel any pressure?
            1. Leave early?
            2. Be discharged early?
            3. Feel welcome?

f. If you were transferred to the Special Care Baby Unit (SCBU), Hastings

i. Were your cultural needs respected?
ii. General comments?
iii. Did you feel any pressure?
1. Leave early?
2. Be discharged early?
3. Feel welcome?

3. Did you have kaitautoko with you?

a. Who did you have?
b. Did you feel you and your kaitautoko were listened to?
c. General comments?
d. Did you feel any pressure?

i. Leave early?
ii. Be discharged early?
iii. Feel welcome?

4. Who cared for you?

a. Doctor, Midwife, Specialist?

i. Before birth?
ii. During birth?
iii. Following birth?

b. Did you feel you were listened to?
c. Were your cultural needs respected
d. General comments?

5. Cultural Needs?

a. Did you require any specific cultural or health needs?

- Te Reo Māori – e.g., Name pronunciation?
- Whenua?
- Whāngai Ū?
- Muka?
- Karakia?
- Tikanga?
- Manaakitanga?
- Kaumatua?
- Auahi Kore?
- Whānau Ora?
- Tamariki Ora / Plunket?
- Wahakura?
- Whanake Te Kura / Birthing Wānanga?
- Te Whare Pora?
- Mamia?
- Māori midwife?
- Maternal Mental Health/AoD?

b. Were any of these options part of your care or Birth Plan?
c. Are any or all of these important or relevant for you?

Appendix 12: Data examples from Waioha 5 Year Report

Below are only those outcomes useful for comparison, with data measured as a rate of all women (AW) or Standard Primiparae women (SP) – woman aged 20-34 years birthing their first baby with no history of pregnancy complications.

Population Indicators – 5 year average	Waioha	Ata Rangi
Women with deprivation level 8-10 (AW)	62.2%	63.5%
BMI greater than 35 (AW)	4.0%	7.4%
Not smokefree at discharge (AW)	17.9%	21.0%
Exclusive breastfeeding at discharge (AW)	90.1%	76.7%

Total births by ethnicity July 2016 – May 2021	Waioha Total	%	Ata Rangi Total	%
Māori	1013	42.4%	3107	42.3%
Pacific	157	6.6%	477	6.5%
Asian	132	5.5%	608	8.3%
NZE + other	1086	45.5%	3151	42.9%

INTACT GENITAL TRACT AMONG STANDARD PRIMIPARAE GIVING BIRTH VAGINALLY

	Clinical Indicator Numerator	Clinical Indicator Denominator	Clinical Indicator Result
MĀORI	105	192	54%
PACIFIC	17	38	41%
ASIAN	14	45	30%
OTHERS	113	299	39%
TOTALS	**249**	**565**	**44%**

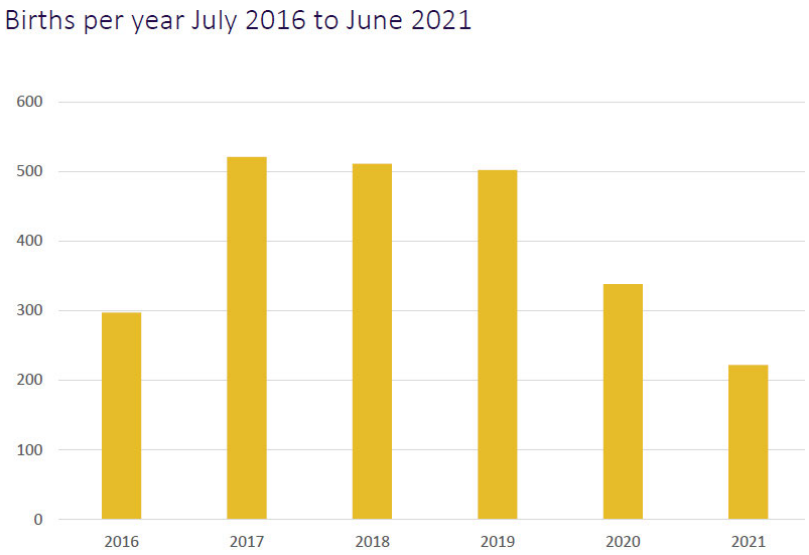
EPISIOTOMY AND NO 3RD OR 4TH DEGREE PERINEAL TEAR AMONG STANDARD PRIMIPS GIVING BIRTH VAGINALLY

	Clinical Indicator Numerator	Clinical Indicator Denominator	Clinical Indicator Result
MĀORI	4	192	21%
PACIFIC	1	38	26%
ASIAN	1	46	43%
OTHERS	9	289	31%

TOTALS	**16**	**565**	**28%**

3RD OR 4TH DEGREE PERINEAL TEAR AND NO EPISIOTOMY AMONG STANDARD PRIMIPS GIVING BIRTH VAGINALLY

	Clinical Indicator Numerator	Clinical Indicator Denominator	Clinical Indicator Result
MĀORI	3	192	1.6%
PACIFIC	1	38	2.6%
ASIAN	4	46	8.7%
OTHERS	14	299	4.8%
TOTALS	**22**	**565**	**3.9%**



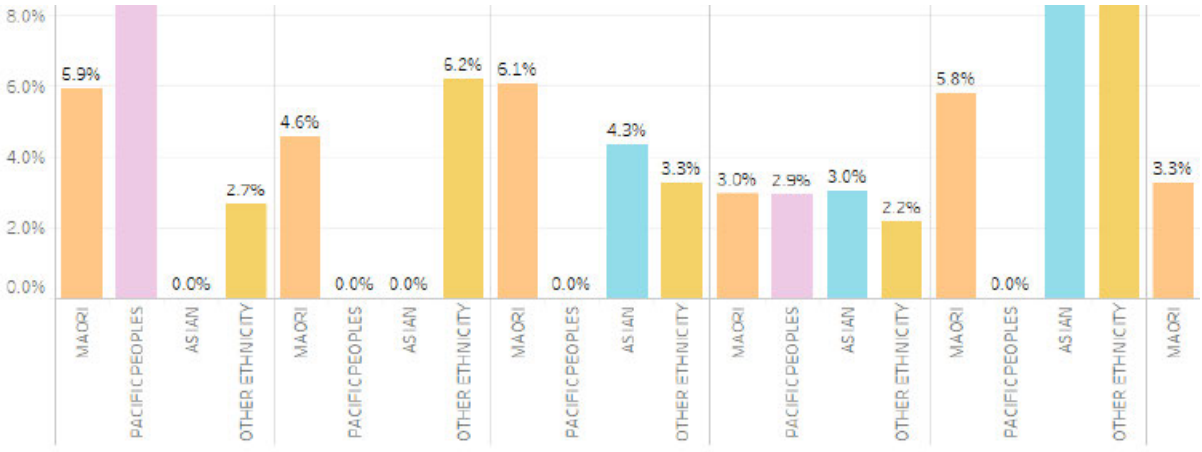
TERM BABIES REQUIRING RESPIRATORY SUPPORT

	Clinical Indicator Numerator	Clinical Indicator Denominator	Clinical Indicator Result
MĀORI	15	887	1%
PACIFIC	1	144	0%
ASIAN	2	124	1.6%
OTHERS	10	1143	0.9%
TOTALS	**28**	**2298**	**1.2%**

SCBU ADMISSIONS AMONG ALL BABIES

MĀORI (data is lifted from the graph below)

2016	2017	2018	2019	2020	2021
5.9%	**4.5%**	**6.2%**	**3.0%**	**5.8%**	**3.2%**



Appendix 13: List of Documents reviewed

The following table outlines the documents that were provided by the HBDHB for review.

1	**HBDHB POLICIES & POSITION STATEMENT (F.1)**
1.1	PO HBDHB Policy Position Statement on Institutional Racism
1.2	PO HBDHB Policy Guide on Maternity Wellbeing
1.3	PO HBDHB Policy on Child Abuse and Neglect
1.4	PO HBDHB Policy on Child Protection and Alert Management
1.5	PO HBDHB Policy on Deceased – Care of
1.6	PO HBDHB Policy on Treaty of Waitangi Responsiveness – Assessment
1.7	PO HBDHB Policy on Treaty of Waitangi Responsiveness – Procedure
2	**HBDHB STRUCTURAL DIAGRAMS (F.3)**
2.1	SS CWC Service Structure
2.2	SS Health Service Functional Structure Chart
2.3	SS Health Service Mapping to New Groups Oct.2020
3	**HBDHB STRATEGIES PLANS REPORTS (F.2)**
3.1	BD HBDHB BOARD MINUTES 2019 – sourced from website (F.4)
3.2	PL CWC Directorate Priorities
3.3	PL HBDHB Health Equity Framework
3.4	PL HBDHB Workforce Strategy 2019
3.5	PL HBDHB Māori Health Strategy 2014-19
3.6	PL HBDHB Māori Health Profile 2015
3.7	PL HBDHB Māori Health Annual Plan 2016
3.8	PL HBDHB Health Strategy Whānau Ora Hapori 2020
4	**MATERNITY SERVICE AND WORKFORCE PLANS**
4.1	PL Maternity Service Plan 2020-21
4.2	PL MMC Planned Objectives 2021 Updated
4.3	PL HBDHB Maternity Leaders Workforce Strategy 2021
4.4	PL Midwifery Career Pathway 2020-2021
4.5	PL HBDHB Nursing and Midwifery Strategy 2020
4.6	PL HBDHB Nursing and Midwifery Strategy 2020-2025
4.7	RE TOR Maternity Morbidity
4.8	RE Tuakana Teina Report Doc.002
4.9	RE Waioha 5Yr Report – Mod. Aug.2021
4.10	RE Hawkes Bay Maternity Annual Report ACR 2019
4.11	RE Maternity Severity Assessment Code SAC Examples2018-19 HQ&SC
4.12	LE HBDHB MQSP Acknowledgement Letter MOH

5	HBDHB JOB DESCRIPTIONS (F.5)
5.1	JD 00 Associate Clinical Manager Midwifery 2016
5.2	JD Breast Feeding Advisor
5.3	JD Lactation Consultant
5.4	JD Health Care Assistant (HCA) Maternity Services
5.5	JD Clinical Midwife Coordinator CMC
5.6	JD Registered Nurse – Maternity service
5.7	JD Director of Midwifery DOM)
5.8	JD Clinical Midwifery Manager CMM
5.9	JD Midwife Advisor – Hauora Māori
5.10	JD Midwife Educator – Whānau & Communities Group
5.11	JD Caseload Midwife
5.12	JD Midwife Educator – Diabetes
6	**WORKFORCE PERFORMANCE (F.7)**
6.1	WF Ngākau Ora Staff Cultural Responsiveness Training 25 Feb21
6.2	WF Performance Appraisal GS Template – Nurse
6.3	WF Performance Planning
7	**HBDHB MATERNITY CLINICAL GOVERNANCE (F.6)**
7.1	MCG Actions MCG Apr.2021 – sample
7.2	MCG Agenda – sample
7.3	MCG TOR July 2020 – sample
7.4	MCG Patient Safety and Risk Committee Report Jan.2021
8	**HBDHB MATERNITY SERVICE MEETINGS**
8.1	Leadership Meeting Template
8.2	Leadership Meetings Actions
8.3	Positive Culture Meeting Minutes 2020
9	**COVID-19 LOCKDOWN MATERNITY SERVICE SURVEYS (DOCS)**
9.1	FB HBDHB Maternity COVID Consumer Survey Summary of Outcome
9.2	FB HBDHB Maternity COVID Lockdown Survey Results
9.3	FB HBDHB Maternity COVID Summary Themes

Documents that guide practice, understanding and behaviour

Governance and Leadership documents

HBDHB POLICIES & POSITION STATEMENTS

The following section reviews the following documents: HBDHB Policies and Position Statements; Organisational Structural Diagrams; and Strategic Plans, Strategies and Reports. In summary, the documents identified the following:

The HBDHB Position Statement on Institutional Racism (23 February 2021 HBDHB Board CEO)

This is a sentinel document for the organisation which outlines current health sector trends at governance level to address Māori health inequities that research has clearly demonstrated the health system has created.

> *"We hope we are ..... moving to a stage where racism will not be tolerated, equity will be demanded and that critique of the role the health system plays in creating or maintaining inequities will become the norm. To achieve this, anti-racism and pro-equity activities can no longer be the work of the fringe but must become a priority and core work for the entire healthcare service".* (Tamatea et al 2019)

Strengths are in the offer of the policy position to develop a system for making complaints about racism in the organisation safely. This strength can also be viewed and experienced by potential claimants and perpetrators as weak if this system is not carefully crafted, implemented, and monitored with the appropriate reporting, advocacy, and cultural safety supports being in place.

Strengths	Weaknesses	Assessment
Strong Policy position Offers to develop a system for making complaints about racism safely	Need to clearly identify the system has key areas for cultural support, safety, and advocacy available. Important that privacy and confidentiality are protected where necessary, and appropriate mediation processes are offered. Needs timeframe for staff consultation and their policy education and training.	The policy offers appropriate tools for eliminating racism and most importantly enabling and empowering support to do so. Māori health service structure and policy position must be strengthened to support and provide an important policy development, quality and complaints system development, and policy training and education role.

<u>HBDHB Policy on Treaty of Waitangi Responsiveness – Assessment and Procedure</u>

This is a positive affirmative policy and a strength that the HBDHB benefits from having in place. However, there is a need to update and revamp this policy. Review dates were 2015 and 2018. These are now outdated by recent events advancing the health sector trends and presenting clearer, current language for use in this type of policy environment, particularly to be cognisant of the WAI2575 Claim findings and updating of the outdated 'principles' of the Treaty of Waitangi often used in Crown documents.

Strengths	Weaknesses	Assessment
The presence of a policy on the Treaty of Waitangi is a strength. Ngākau Ora, launched on the 21st and 22nd February 2021, supported by HBDHB CEO), Chair Ngāti Kahungunu Iwi Incorporated, HBDHB Director of Allied Health, Programme Manager Māori Health, Director Mental Health & Addictions, and others. Ngākau Ora is a two-day programme for all HBDHB employees with the goal of supporting and developing staff to work in partnership with whānau, communities, health professionals and colleagues. Developing and maintaining true partnership is essential for transformational change, eliminating institutional racism, addressing inequity, supporting cultural change, honouring true partnership with Iwi, and engaging effectively with whānau and community. This programme is for all existing HBDHB staff and new staff during orientation. Ngākau Ora utilises evidence-based research along with indigenous knowledge and tikanga.	The policy is overdue for review, revamp, and updated language. A strengthened policy on Te Tiriti o Waitangi needs evidence of tangata whenua perspective (Kahungunu whānau/hapū/iwi input). Principles replaced with the Articles (ref: WAI2575) and stronger alignment with Institutional Racism and Māori Health Equity policy statements.	The two policy statements need combining into one document with clear steps set out for the HBDHB's policy and commitment to Te Tiriti o Waitangi Showing relevance to application in health service environment, relevant measures, and timely monitoring would be an advantage. It is relevant to have as part of the policy, the clarity and process described for cultural awareness, cultural safety, cultural competence, and cultural responsiveness. Review HBDHB application of Te Tiriti in its policies (Māori version) as this would align with the Ministry of Health's Te Tiriti o Waitangi Framework (Whakamaua)

The Hawkes Bay District Health Board Health Equity Framework

The equity framework aims to transform the DHB systems to deliver health equity – Mana Tangata Taurite. This is a strong planning and performance strategy for the DHB. It is also aligned with the Hawke's Bay Health Sector - Transform & Sustain five-year strategy that commenced in July 2013. This focuses on improving responsiveness to population need, consistently delivering high-quality care, and maximising system productivity. It requires a one-system approach that challenges the way planning and delivering services happens. A series of key intentions form the basis of the programme and there are eleven transformation strategies that are aligned with the DHB equity framework. Four key stages are identified, and five key principles are provided in the framework – all focused-on improvements for Māori health equity and cultural responsiveness across the DHB.

Strengths	Weaknesses	Assessment
HBDHB are able to quantify and qualify its equity position and has progressive measures to enable continuous quality improvement	One equity goal is achieved to date (2021) for Immunisations.	Areas and measures for improvement are identified and a framework is in place to implement progress

HBDHB Policies on Maternity Wellbeing, Child Abuse, and Child Protection and the Child Protection Multi-Disciplinary Team (CPMDT) Guideline.

This is a strong policy guideline with intent to have the best outcome for vulnerable pregnant women and their whānau. Whilst this is also relevant and responsive in that there is a structure, in the form of a Multidisciplinary Team and Committee in place to implement an appropriate pathway for this outcome to be realized, this is weakened by the lack of specifically identified Māori representation in: senior Māori Midwifery presence; and senior Māori cultural expertise present. The aims, objectives, vision, and intent of the Terms of Reference of this structure are severely limiting and compromised without the physical presence of senior Māori clinical midwifery and senior Māori cultural expertise clearly evident.

Strengths	Weaknesses	Assessment
Strong intentions to enable the best possible outcome for vulnerable pregnant women and their families.	The guideline was authored in 2002, reviewed in 2016. The document is now 5 years old this month and has not been subject to review. This should happen immediately given recent adverse events in this service. Māori representation needed in membership – this is weak A clear membership needed for a senior Māori Midwife	Cultural perspective and intention for children and vulnerable women is relevant and responsive but weakened by lack of equivalent Māori maternity/midwifery clinical and cultural representation. Documentation of this nature in the health sector commonly have a limited review period capped at 3 years to keep pace with changing legislation and

Strengths	Weaknesses	Assessment
	position, equivalent to the CMM and the MWCP. A clear membership needed for Cultural support and advice (Kaumatua cultural expertise) is missing, but a clear role must be stated for this expertise.	emerging evidence, indicating updates necessary.

HBDHB Manual: Clinical Practice Guidelines and Child Abuse and Neglect Policy

This policy has strong focus for Māori and Pacific intents, values, and recognition. However, it is insufficient, and compromises the integrity of a robust policy position to be satisfied with documented support for "cultural support being available". Cultural expertise and presence with strong focus on Māori and tikanga practices must be physically evident and participating in the child abuse and neglect decision making process.

Strengths	Weaknesses	Assessment
Strong policy for child protection, reporting abuse, Māori and Pacific perspectives, Treaty of Waitangi and cultural support and recognition.	Requires clear points for identifying timeliness of cultural support, alerting for cultural advice and appropriate times to include cultural advice throughout the assessment, and reporting processes For example: p.34 DHB *recommends that the staff member seeks the support and advice of the unit manager, DHB's child protection coordinator and/or DHB's legal adviser* This should also include &/or cultural support/Advisor. Māori clinical and cultural policy training and education / consultation is missing.	Cultural support is documented as "being available" but this needs to be clarified at what specific times and informing, requesting, alerting this support needs clarification. Māori health service systems will need strengthening to support this policy.

HBDHB Manual: Clinical Practice Guidelines Child Protection Alert Management Policy

This policy will need direct alignment with the Child Protection Multi-Disciplinary Team Guideline (see Document CPMDT)

Strengths	Weaknesses	Assessment
As for policy (CPMDT) Document	As for policy (CPMDT) Document Māori representation needed and advice sought appropriately	As for policy (CPMDT) Document Māori representation needed and training in these policies.

HBDHB Policy on Care of Deceased

This is a strong and appropriate policy.

Strengths	Weaknesses	Assessment
Strong policy and culturally appropriate		Cultural relevance evident throughout.

HBDHB STRUCTURAL DIAGRAMS

The following documents were provided for the review: SS CWC Service Structure, SS Health Service Functional Structure Chart, SS Health Service Mapping to New Groups Oct 2020.

None of these structures depicted or placed the Māori Health Leadership anywhere within the diagrams. Nor was the Hauora Māori Health Service identified, and there was no evidence showing any alignment of the positions or the services with all other health services, Directorates and Executive positions on the diagrams.

It is accepted that the diagrams provided may have only been those for the maternity service being reviewed, but it was noted in the "SS Health Service Mapping to New Groups" dated Oct.2020 this diagram had governance, executive and service groups identified – but no Māori health service structure is included.

SS CWC Service Structure	
Communities Women & Children Directorate Mental Health & Addictions Directorate	
SS Health Service Functional Structure Chart	
Operations Directorate Older Persons, Allied Health & NASC Directorate	
SS Health Service Mapping to New Groups Oct.2020	
Chief Executive Officer Keriana Brooking Chief Operating Officer Chris Ash Professional Advisory Roles Medical Directorate Surgical Directorate	Hospital Group Whānau & Communities Group Mental Health & Addictions Group Support Services Other Functions

Strengths	Weaknesses	Assessment
Three organisational structural diagrams viewed and identify maternity service place in the organisation and chain of command	Nowhere in the organisational structural diagrams was there any obvious Māori position, structure, or incumbent? Link to the Māori Health Team was not identified consistently across documents	Māori positions or incumbents not identified in any leadership or service roles Lack of linkage to Māori health team

HBDHB STRATEGIES PLANS AND REPORTS

The following documents were reviewed to inform this section: HBDHB meeting minutes, health directorates, health and wellbeing directorates, and strategy documents.

<u>The Hawkes Bay District Health Board Minutes, and Māori Relationship Board Minutes</u>

Minutes were sourced via the Ministry of Health and the District Health Boards' website for perusal. All District Health Boards have websites for the minutes of their Board meetings, Committee Meetings, Finances, Audits and Expenditure. DHB performance on national health targets are also evident in the Board Minutes. Meeting Minutes where the public are excluded are not digitally available.

Strengths	Weaknesses	Assessment
Minutes are maintained according to Government requirements and public minutes made available online Māori Relationship Board minutes and agenda are available online on HBDHB website	Often Māori and Pacific are grouped together because they share inequities. This does not recognise the unique place of Māori as tangata whenua and Treaty partner, which take precedence over any equity analysis. In fact, equity analysis should be embedded as one indicator of the Treaty relationship's effectiveness. Agenda for MRB appears to be led by DHB agenda items and little evidence of a proactive allowance on the agenda for MRB to bring Māori issues forward and for these to be recorded (by service or by geographic area or population/age group)	Embed a Treaty of Waitangi lens in the focus of equity for Māori and separately report and set accountabilities for upholding the equity focus within the context of Te Tiriti. Make intentional space on agenda for MRB to bring issues forward and for these to generate action items by service or geographic area

The Children and Women's Health and Wellbeing Directorate

Priorities identify two areas that relate directly to the cultural responsiveness of maternity services. These areas are:

A: Embed Person & Whānau Centred Care.

- Wairoa – Hoki ki te kāinga in rural; integrated
- Māori midwifery team/rural; Kaiāwhina
- Mat/Paeds/CommNur/CDS

B: Equity for Māori / Pacific Unmet Need. With Actions:

- Ultrasounds free for all pregnant māmā
- Create an integrated Māori Midwifery team/Rural
- Kaiāwhina Maty/Paeds/Com Nursing/CDS
- Enhance values-based recruitment

Strengths	Weaknesses	Assessment
Values are recognised – for Kaupapa Māori Two system goals appropriate to align with cultural competence and responsiveness	Often Māori and Pacific are grouped together because they share inequities. This does not recognise the unique place of Māori as tangata whenua and Treaty partner, which take precedence over any equity analysis. In fact, equity analysis should be embedded as one indicator of the Treaty relationship's effectiveness	Embed a Treaty of Waitangi lens in the focus of equity for Māori and separately report and set accountabilities for upholding the equity focus within the context of Te Tiriti.

HBDHB Workforce Strategy 2019

The specific area relevant to the maternity service review related to the goals:

- Sustainable, Engaged Midwifery Workforce
- To deliver safe, equitable, culturally responsive quality care to support positive experiences and improved outcomes for wāhine, pēpi and whānau
- Recruitment NZ New graduates - Wrap around support for Māori and Pacific undergraduates
- Increase in Māori and Pacific graduates.

Strengths	Weaknesses	Assessment
Strengths are in the intent of this strategy to integrate Treaty of Waitangi principles to deliver responsive health care.	Aligned in this strategy is the goal for New Zealand to have a sustainable, world-class, patient-centred health care and disability support system,	The intent is to utilise and apply Māori models of health that are responsive to Māori. And are proactive in developing education and

Strengths	Weaknesses	Assessment
And to ensure the nursing and midwifery workforce have capacity and capability to be responsive to Māori. Objectives and Measures are identified for each goal	which will attract and retain its workforce through its commitment to continually improve health quality and deliver equitable and sustainable care.	research to support a kaupapa Māori worldview for whānau, hapū and iwi. The community will receive health care which enables all to reach full potential for a healthy life.

HBDHB MAI Māori Health Strategy 2014-19

OBJECTIVES for Whānau Ora, the Long-Term and Enduring Objective. For accelerating Māori Health and Well-Being, the Medium-Term Objective. For Better Access to Health and Well-Being Knowledge and Services, The Short-Term Objective. This strong organisational plan was developed in collaboration with Ngāti Kahungunu Iwi Incorporated and Māori communities, this plan guides the district health sector in the pursuit of improved Māori health. Aiming to have more effective partnerships with Māori communities with improvements that aim at working more within community structures, and better engaging Māori whānau and consumers.

HBDHB Māori Health Annual Plan 2016 / 17

Te Tiriti o Waitangi guarantees equitable health and social outcomes for everyone, and all Government agencies have a role in making sure that happens. Co-ordinate the delivery of publicly funded health care and wellness support services. DHB responsibilities are based on eleven health targets for improvement in Māori health. Three priorities are:

1. Engaging Better with Whānau	2. Delivering consistent high-quality care	3. More efficient use of resources
• Community support & development • Community leadership development • Establish and maintain communication channels	• Māori consumers are engaged in service design, development & review • Better analysis & feedback of how well the system is working for Māori	• Awareness of all health & wellbeing work • Workforce development • Provider capacity & capability

Māori Workforce & Cultural Competence

There is a general intention in Hawke's Bay to increase the Māori workforce across all government agencies. Under the organisational development component of Transform and Sustain, it is a district priority for Health Services to increase Māori staff representation in the health system. In June 2013, the proportion of Māori employed by HBDHB was 9.9% of total staff numbers. This has increased slowly and at the end of June 2015 was 12.3% against a target for the year of 12.97%. This target has increased by 10% to 14.3% by 30 June 2016 and as a stretch target is providing significant challenges to the DHB. In addition, the expectation of cultural competence across the workforce has been raised to ensure that services become more responsive to the Māori population in the quest for driving out inequity through continued rollout of our Engaging Effectively with Māori training which 50% of staff completed on 31 January 2016.

HBDHB Health Strategy Whānau Ora Hapori 2019 – 2029

Tuāwhakarangi – Vision for Whānau ora, Hapori Ora. Healthy families, healthy communities

He Rautākiri – Mission – Working together to achieve equitable holistic health and wellbeing for the people of Hawke's Bay. Message from the CEO, Board, Clinical & Consumer councils – Whānau Ora, Hapori Ora sets the scene for the delivery of health services to individuals and communities across Te Matau-a-Māui, the Hawke's Bay region, for the next ten years. This strategy provides the foundation for the planning, delivery and monitoring of services, which will result in better health outcomes, thereby enabling all people within our region to experience similar health outcomes.

This is a strong strategy developed with the Kahungunu Iwi goals in mind and in collaboration to provide the Ngā Mātāpono – Principles

Whānau participation in their own care	**H**olistic and wellbeing approach
Healthy lifestyles are encouraged	**A**uthentic and trusting relationships
Access to healthcare is easy	**P**erson and whānau-centred care
Nurturing environments of trust are established	**O**ur healthcare system is easy to navigate
Affordable primary care is targeted to need	**R**esearch and evidence-based healthcare
Understand our populations and their perspectives	**I**ntegrated health care teams
Outstanding quality of care is everywhere	**O**utcomes-focused
Relationship-centred practice is where care begins	**R**espectful relationships matter
Adopting safe practice at all times	**A**chieving equity for Māori is a priority

Quality improvement opportunities

Maternity Services and Quality Documentation

HBDHB MATERNITY CLINICAL GOVERNANCE

A sample report was supplied was an MCG meeting (April 2021) which highlighted discussions on the following, persons responsible and due dates:

- Anti D prophylaxis
- Vaginal Breech birth group
- Scanning / Pricing
- Maternal Morbidity review toolkit
- Audits
- Policies
- Waioha transfers
- Partograms
- LMC early engagement
- FSEP
- HDC maternity trends
- Well Child App

A sample standing agenda was also supplied which included:

- Embedded documents for pre-reading
- Confirmation of Minutes from – last meeting
- Matters/Actions from previous meeting
- New Business
- MQSP workplan update
- Consumer update – verbal reports from representatives
- CCDM Update
- Guidelines and Policies Update
- Risks and Events
- Member issues / Round table
- Next meeting: date

The Terms of Reference for the MCG Advisory Group was provided (June 2020) which outlines key purposes of the group:

- To provide a consultative and directive forum, inform strategic direction and contribute to maternity annual plan for managing quality and safety across maternity services
- To ensure equity is a central tenet to maternity quality and safety activities intentionally progressing towards eliminating disparity in health outcomes for Māori, Pacifica and those who are most in need
- To monitor identified clinical risks, ensuring a robust risk framework, as per HQSC Maternal morbidity framework is utilised in conjunction with HBDHB event reporting system. To recognise themes and learning outcomes and support implementation of quality and safety initiatives to minimise risks
- A transparent and effective shared communication and decision-making process will ensure an intentional and responsive approach to advancing maternity practice, to better meet the needs of the community we serve.

<u>Level of Authority</u>

The Maternity Clinical Governance Group level of authority is:

- To approve all maternity service clinical guidelines and policies
- To monitor and endorse clinical practice recommendations
- To oversee the sharing of learning from adverse events
- To ensure the national maternity standards and maternity clinical indicators are adhered to and monitored
- Delegated authority will make recommendations on behalf of the maternity service
- Commission pilots to trial innovation and new ways of working to feed into the quality agenda

The sample supplied highlights the following:

MEMBERSHIP: CORE MEMBERS

- Midwifery Director / Educator leadership /Chairmanship
- Medical Directorship
- Obstetrics and Gynaecology Expert Practitioners
- Māori Midwifery Representation & New Zealand College of Midwives representation

• LMC, Core midwife, Rural midwife representatives • Māori and Maternity Consumer Representatives Co-opted Membership: Various individuals that are appropriate to the key items for discussion per agenda Tenure: Length of elected tenure is 3-yearly. The re-nomination and re-election process occurs 2 months before the end of tenure
RESPONSIBILITIES OF INDIVIDUALS OF THE MATERNITY CLINICAL GOVERNANCE GROUP ARE TO: • Prepare for meetings by reading papers/material sent in advance of meeting • Actively engage in discussion and decision-making processes • Contribute to the development of and provide feedback on documents received. • Role model the values of HBDHB • Abide by the decisions of the Maternity Clinical Governance Group • Ensure confidentiality of information provided to the Maternity Clinical Governance Group and disseminate relevant information and liaise with the work group the member is representing. • Fulfil the requirement to engage with subcommittees and relevant stakeholders, as and when necessary, with an expectation to provide feedback to the group • Ensure all learning and opportunities for service wide improvement are shared through relevant meetings, forums, and emails • Ensure that assigned actions are followed through and reported on in the time frame agreed to • Members to attend at least 80% of meetings on an annual basis Attendance record is maintained and presented to the group annually
REPORTING • The Chair will send a report to the Patient Safety & Risk Management Committee quarterly • A formal Annual Clinical Report will be submitted to the MOH as per requirements and subsequently to the next Patient Safety & Risk Management Committee • A full Annual Clinical Report will be available on the DHB website and other venues as per MOH MQSP requirements • Response to external governance bodies e.g., HQSC, MOH, PMMRC will be within the requested timeframe with a copy to the MCGG and Patient Safety & Risk Management Committee • Feedback to and from other relevant committees will occur as required

<u>HBDHB Maternity Clinical Governance: Patient Safety and Risk Committee Report</u>

Summarised sample of minutes:

MCG PATIENT SAFETY AND RISK COMMITTEE REPORT JAN.2021: CLINICAL COUNCIL GOVERNANCE SUB COMMITTEE REPORT	
Committee Name	Maternity Clinical Governance Group
Committee Purpose	The purpose of the Maternity Clinical Governance Group is to provide a consultative and directive forum, inform strategic direction and contribute to maternity annual plan for managing quality and safety across maternity services, and to ensure coherence across the quality activities

OVERVIEW OF ACTIVITIES

- Maternal Early Warning Score (MEWS) implemented hospital wide and in Wairoa. Monthly audits ongoing, audit to start in Wairoa.
- Newborn Early Warning Score (NEWS) implemented in January, to be implemented in Wairoa June 2021
- Maternal Morbidity and Mortality Review Toolkit for Hawkes Bay complete for review at MCGG
- Safety First Campaign continues with new emphasis on using Partograms and Placenta/Whenua forms.
- New Early Engagement with a Midwife campaign to commence, use of social media to engage women.
- Vaginal Breech Workshop ongoing.
- Annual Clinical Report 2019/20 published in March.
- Full time permanent ACMM position established and filled.
- Working with 1st 1000 days group to establish a Māori Midwife for breast feeding support for Māori māmā in the community.
- Visiting Te Whare Pora to explore opportunities to improve connection with Māmā where they feel safe and supporting Te Ao Māori practices
- Event review – themes initiatives:
- CCDM progress to FTE calculations for maternity services

Risks: Key risks that require escalation to clinical council. Wherever possible include mitigations. Key risks with mitigations: -

1. There is lack of capacity for DHB obstetric USS. Surcharges from community providers have increased. This is ***increasing inequity in access with associated escalating clinical risk.*** This has been escalated to DLT CWC with re prioritisation of DHB scanning capacity to support the required demand for USS for pregnant women.

2. ***Rates for early engagement with a midwife below target.*** New campaign via social media to commence next month. Working with maternity consumer representatives to listen to whānau voice regarding maternity care for women. Māori consultant leadership working with Māori midwifery roopu

3. ***Māori midwives underrepresented in our workforce***. Māori Consultant Midwife working with Schools of Midwifery (WINTEC< VUW), Ngā Māia ki Heretaunga, Turuki Workforce and Waiora midwives to increase the number of Māori Student Midwives entering the workforce. Te Ara ō Hine – Tapu Ora funding available for all Māori student midwives.

Equity assessment: *Ensure ethnicity is included in data collection, analysis, and interventions.* Highlight areas for improvement to address inequity based on findings.

- Registering with an LMC in the first trimester of pregnancy rate is significantly reduced for Māori women. Rates of pre-term birth and tobacco use in pregnancy and the postnatal period are significantly higher for Māori women. Work is ongoing (see risk section) regarding early engagement with a midwife. Smoke free team continue with project and initiatives to help wahine and whānau become smoke free.

- ***Plan to engage a Māori Midwife to work in the community to promote and support Māori māmā to breastfeed.***

- Diabetes prevalence appears to be increasing and higher in our Asian and Pacifica women – to collate data evidencing experience and outcomes and to inform model of care

Alliance with Patient and Whānau Centred Care Principles

*"Working **with** consumers and families/whānau, rather than **doing to** or **for** them." Putting people, families, and communities at the heart of health care and wellbeing.*

Two Maternity Consumer Representatives now in place.

- Working (1st 1000 days) in collaboration with Māori Health and Tuai Kōpu to encourage early engagement with midwives and maternal wellbeing.
- Continuing connections with Te Haa Matea programme, Te Whare Pora, Mamia maternal programme and He Korowai Aroha (Wairoa), Māori Health
- Working with 1st 1000 days group to establish a Māori Midwife for breastfeeding support for Māori māmā in the community.

Working in partnership to plan, design and deliver services, systems, care, and support that are designed around the needs of consumers and their whānau.

Transformational change is supported by a system, process, and structure to ensure it becomes business as usual (sustainability).

HBDHB Maternity Service Meetings

Examples were provided of Maternity Service leadership meetings that included culture workshops.

Maternity Services and Quality

COVID-19 Lockdown Maternity Service Surveys

Maternity services in Hawke's Bay during lockdown gathered and reported whānau feedback. These were reported as the Maternity COVID-19 L4 Lockdown Consumer Survey results (26 March – 28 April 2020). This survey was developed locally but reflects national questions considered by DHB midwifery leaders to identify national consumer themes and learnings on what this time was like for pregnant māmā and their whānau. This report provided a summary of the themes articulated from wahine feedback and evident from some partners as well with learnings and opportunities to do things differently.

1 Question: If you had a virtual/telephone consultations with Te Kākano/Antenatal Clinic or Community midwives, what was that like for you?

- Learnings/Improvement opportunities
- Important to ensure when the national health advice from MOH requires virtual consultations that our triage processes are clear and understood by our consumers. Where possible safe face to face consultations are offered

2 Question: Were you affected by your support person not being able to visit during your stay? Can you tell us how this affected you?

- Learnings/Improvement opportunities
- These comments were mostly made by first time mums and those experiencing a caesarean birth and those with babies in SCBU. Significant impact for most women in this feedback of not having their support person with them. Evidence of ongoing impact for these women in their mental health wellbeing.
- For review by maternity: If there is re-escalation to L4 Lockdown – support person should be able to stay throughout postnatal stay. What maternal mental health supports are in the community for these women and how could we connect them?

3 Question: Did COVID lockdown change how long you stayed in hospital after baby/pēpi was born? If yes, was this your choice or at the request of hospital staff?

- Learnings/Improvement opportunities
- Partner support is key to mums feeling supported and willingness to stay for those that were affected by this. Loneliness is an overwhelmingly evident theme.

4 Question: How well supported did you feel during your stay in hospital after baby/pēpi was born?

- Learnings/Improvement opportunities
- Care was provided in a meaningful way in extraordinary times – aroha to the maternity team.
- Peace and quiet is important to enable rest and recovery. The importance of the presence of the woman's named support person

5 Question: What was the best thing about the care you received during your post-birth hospital stay? Could we have improved on anything?

- Learnings/Improvement opportunities
- The importance of the support person for rest, learning to be a parent and to work as a team is invaluable

6 Question: How well did supported did you feel by your midwife after you returned home with your new baby/pēpi?

- Learnings/Improvement opportunities
- The change in face-to-face expectations in the PN schedule has had a significant negative impact for our mums during this time. Different experiences evident which could be practitioner dependent rather than service dependent. The importance of clearly discussing the expected postnatal visiting schedule plus being responsive to new mother's needs. Face to face home visits for postnatal care, reassurance and support is a requirement to support being a mum and dad and feeling safe.

7 Question: After you returned home, how were you and your whānau affected by having to stay in your bubble and not being able to have visitors?

- Learnings/Improvement opportunities
- For some of our women the bubble was a time of peace and bonding with baby
- For some of our women it was incredibly lonely, stressful and has affected their mental health and wellness. Whilst our community midwifery workforce were the only health professionals in this space during this time this proved very challenging to ensure connections with our primary care partners in a meaningful way for māmā and whānau. We have a responsibility as a service and a maternity workforce to work through what this looks like for our māmā and babies if the country re-escalates to L3 or L4

HBDHB Maternity COVID Summary Learnings

HBDHB Maternity COVID Lockdown Survey Results

Place of birth

- Majority = 79% Hastings Hospital
- Average = 18% Home birth
- Minority = 3% Wairoa Hospital

Age and Ethnicity

AGES:

- Majority = 30yr – 39yrs = 47%
- Average = 20yr – 29yrs = 44%
- Minority = (15-19yrs & 40+yrs) = 4.4%

ETHNICITIES:

- Majority = European 65%
- Average = Māori 37%
- Minority = all others 8%

Q4 Virtual/telephone conversations with Te Kākano / antenatal clinic or community midwives /91 answered /91

- Majority = 44 satisfactory
- Average = 18 not applicable
- Minority = 16 no contact, not satisfied

Q5 Effects of not having your support people visit during your stay after baby/pēpi was born due to lockdown? How did that that affect you? /91 answered /91

- Majority = 60 not satisfied

Q6 Did COVID/lockdown change how long you stayed in hospital after baby/pēpi was born? If yes, was this your choice or the request of hospital staff? /89 answered /91

- Majority = 51, yes it did

Q7 Well supported with - breastfeeding, rest, readiness for home, etc)? /91 answered /91

- Majority = 65 were satisfied
- Average =
- Minority = 10 were not well supported

Q8 The best thing about the care received during and after your birthing hospital stay? Could we have improved on anything? /91 answered /91

- Majority = 74 were satisfied

Q9 How well supported did you feel by your midwife after you returned home with your new baby/pēpi? /91 answered /91

- Majority = 85 were satisfied

Q10 Returning home with your new baby/pēpi, how were you and your family/whānau affected by having to stay in your bubble and not being able to have visitors? /91 answered /91

- Majority = 77 were satisfied not affected.

Strengths	Weaknesses	Assessment
Feedback obtained is mainly positive for all questions This is particularly focused on the COVID-19 lockdown effects / impacts and a proactive step to take	Follow through important to also document on the less than satisfied consumers e.g., queries that ask – "How can we do better?"	Appropriate inquiry system for feedback.

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