New Zealand Institute of RURAL HEALTH

Midland Region
Rural Maternity Services Consumer Engagement Study

Midland District Health Boards

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Please reference as follows: Lancaster G, Gosman K, Lawrenson R, & Gibbons V. (New Zealand Institute of Rural Health). Midland Region Rural Maternity Services Consumer Engagement Study. New Zealand Institute of Rural Health. Cambridge, New Zealand. June 2014.

Acknowledgements:

The authors would like to place on record their thanks to the women and people of the Midland region who gave freely of their time and shared their experiences who have made this study possible. We would also like to thank Plunket, and Iwi Tamariki Ora providers from the 11 tribal areas across the Midland region, Ngāti Maniapoto, Te Tai O Hauraki, Ngāti Raukawa, Ngāti Ruanui, Ngāti Tūwharetoa, Whakatōhea, Whānau –a- Apanui, Ngai Tūhoe, Ngai Tai, Ngāti Awa, Ngāti Porou including participants from other tribal areas. Ngā Hau e Whā – (the four winds), South Waikato Pacifica Services, and Ngāti Porou Hauora Charitable Trust who helped us to recruit the mothers and who went the extra mile to ensure the mothers voices could be heard. We also would like to acknowledge and thank, Iwi Māori Council, Waikato DHB, Te Nohanga Kotahitanga, and Lakes DHB. We would also like to take the opportunity to thank Professor Ross Lawrenson and Doctor Veronique Gibbons for their supervision and support with the designing, implementation and analysis of this study.

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Executive summary

HealthShare Ltd invited the New Zealand Institute of Rural Health in 2013 to undertake a consumer engagement study to understand rural women's views of maternity services and any barriers they might experience in accessing services. This study was to inform the regional rural health and maternity action groups' investigation of rural health needs. These groups are committed to good clinical governance, the integration between primary and secondary care, the reduction of barriers and inequalities for Māori, addressing workforce needs, and ensuring quality information services. As part of the information gathering they were particularly interested in:

- ensuring Māori views were captured in the study
- assessing whether there might be workforce issues that needed addressing, and
- understanding the relationship between primary care/general practice and the maternity services.

The study was run in a partnership model with the lead investigators being Māori and NZ European. The views of rural women were explored through the means of focus groups and individual interviews, supported by a demographic questionnaire. Women who had given birth three to 12 months previously and lived within the designated areas were approached with the assistance of their Well Child providers and asked to take part and offered the choice of either a focus group or individual interview.

The selected areas were chosen in order to ensure a good representation of the Midland population including Māori and Pacific peoples. Focus groups and interviews were held in, Hawera, Te Kuiti and surrounding areas, Tokoroa, Coromandel, Matamata, Turangi, Opotiki, Gisborne (only women who lived half an hour minimum driving time from hospital), and Tolaga Bay.

Three focus groups and two individual interviews were held within Māori organisations premises, one within a Pacifica organisation, four focus groups were held within Plunket rooms and other focus groups and individual interviews were held in homes or at an agreed location. The focus groups held with Māori participants followed the Tikanga (practices of the tribal area) to establish the relationships. This included introductions that provided the opportunity for participants and the interview team to acknowledge where they were from

(geographical location) and their Hapū or family group, name and place of residence. The process established an environment of safety and inspired confidence.

Individual interviews held in homes and other locations followed the planned introduction and interview process. Eleven tribal areas were identified across the Midland region and included participants from other tribal areas. A total of 62 women were recruited across the region of which 26 (41 %) were of Māori descent. 74% of the women enrolled with a Lead Maternity Carer (LMC) before 13 weeks gestation.

The findings were grouped into five key themes which were:

- Access to services
- Quality of clinical care
- Information
- Role of partners, family and friends
- Culture

Access to services

More than half the women's first point of contact was their General Practitioner (GP) who provided them with information on maternity services and LMC contacts. One woman was very disappointed she couldn't have her GP for her maternity care. Some women had difficulty accessing a LMC as there was limited or no choice, of these three enrolled at 21 to 24 weeks and a further three at over 25 weeks gestation. For some it was the time of year which limited their access to a LMC e.g. Christmas. Māori women were more likely to enrol with a LMC at a later gestation than others. According to the questionnaire the majority of women travelled less than 10km to access maternity services but the transcripts indicated they travelled further distances past local primary birthing units to get to the birthing unit of their choice. Women saw their LMC locally but wanted to give birth where emergency medical help was available in order to feel safe and secure.

Quality of Clinical Care

While most of the women had good access and clinical care and were satisfied with the maternity service, some did not. The majority of women who were unhappy about the care they received did not appear to know how or who to complain to.

Information

Only three out of 26 Māori women attended antenatal classes and of those who did not attend only one had attended with their first child. Six of the women either did not know about the classes or were not advised to go and a further five either did not want or need to attend or felt they had plenty of family support. These findings were similar to the Ministry of Health Maternity Consumer Surveys 2011 (2012). A number of young women used the internet or mobile phone apps. to gain information that would usually be obtained from antenatal classes.

Role of partners, family and friends

The role of partners, family and friends during women's pregnancy and birth provides them with an essential support network. They are advocates, coaches, and fonts of knowledge and have a major influence in the decisions women make on all aspects of their pregnancy and birth, whether it is to attend antenatal classes or breastfeed. The women all talked about their partners, friends and families role in supporting them and the majority of them felt their LMC encouraged and supported their involvement. In a couple of instances women of Māori descent's whanau perceived to have been actively discouraged from being present at the birth despite their wishes which were expressed in their birth plan. The involvement of a partner, friends and family throughout the woman's pregnancy and birth is an area which is generally well supported by the LMCs, apart from some aspects around Māori culture. It is suggested that when considering any aspects of the provision of rural maternity services the role of partners, family and friends be taken into account particularly within a cultural context.

Culture

In some areas Māori cultural practices were supported and respected, in others women felt less supported. Māori women want to be able to enjoy their pregnancy and birth in a respectful and culturally appropriate way and to be able to have the support of their whānau throughout.

Introduction and approach

Background

In New Zealand the Midland region stretches from Cape Egmont in the west to the East Cape and is in the centre of the North Island. There are five District Health Boards (DHBs) within the region: Tairawhiti, Taranaki, Lakes, Bay of Plenty and Waikato. The region covers an area of 56,728km^2, or 21% of New Zealand's land mass (Midland District Health Boards, 2012).

The Midland region has a more rural population than the average for New Zealand as a whole which creates challenges in the provision and access to services. At 17% the percentage of Māori living within the Midland area exceeds the national average, with areas such as Tairawhiti having 48% of its population as Māori (Midland District Health Boards, 2012)*. There are disparities in health status nationally which are clearly identified in the Ministry of Health report, however, this report does not address maternity services (Ministry of Health (a) (2012). There is one tertiary, five secondary and 18 primary birthing units within the region and there were 11,218 births in the 2010/2011 period.

In 2011 the Ministry of Health conducted a maternity consumer survey which provided an opportunity for women to comment on the maternity services they received during pregnancy, birth and in the postnatal period. The survey helped the government and the Ministry of Health to understand women's priorities during this time, what was working well and where improvements could be made (Ministry of Health (b), 2012). The survey identified antenatal classes received the lowest satisfaction rating, especially for those mothers having home births. Whilst this did not have much of an effect on the overall satisfaction for maternity services, for those surveyed the impact was greatest on young mothers and Māori mothers.

According to the primary maternity facility and services evaluation completed by Lakes District Health Board in 2010/2011, of the 1,608 women who gave birth in the Lakes DHB hospitals in the 2009/2010 fiscal year 47.6% were Māori of which 14.8% were teenagers

* the percentage of Māori is unevenly distributed across the Tairawhiti district

when they gave birth (Lakes DHB, 2011). If this trend could be extrapolated to the Midland region DHBs it is important that these issues are addressed in order to provide an equitable service for young Māori mothers in the region.

Within New Zealand there is a concentrated effort to provide a better, sooner, more convenient health service by providing care closer to where it is needed (Ministry of Health, 2011). DHBs have come together regionally in order to develop a consistent standard of care and to support vulnerable services, improve equity of access and better health outcomes throughout the region (Midland District Health Boards; 2012). HealthShare Ltd is the shared services agency which has been formed to facilitate this.

The Midland Regional Services Plan 2012/13 has identified a number of vulnerable services, two of which are of concern - maternity services and rural services. Included are the viability of some rural maternity units, the availability of rural midwives, the lack of general practice support for intra-partum care, and acknowledgement that the needs of Māori women may not be being met.

HealthShare Ltd invited the New Zealand Institute of Rural Health (NZIRH) to consult with women in the rural areas of the Midland region about their experiences of maternity services as part of an evaluation. This will ensure stakeholder involvement, enable meaningful Māori participation, and provide useful feedback on consumer experiences of maternity services. This in turn will facilitate the DHBs in the Midland region in providing a first class maternity service.

Aim

To establish whether rural maternity services in the Midland region fulfil the perceived or actual needs of rural women.

Methodology

To ensure women from each of the five Midland DHBs contribute to the study, and that there is representative input from Māori, a mixed methods approach including qualitative exploration of the issues and a quantitative approach to understanding the characteristics of participating women was used. Focus groups and individual interviews explored women's

experiences of rural maternity services with the support of a topic guide. Responses were digitally recorded and then transcribed.

A demographic questionnaire provided specific information about participants relating to age group, initial contact with LMC, attendance at antenatal clinics and travelling distance to maternity services. A thematic approach was used to analysise the transcripts.

The questionnaires were anonymous and not linked to interview responses but were used to identify variation between focus groups/areas and the collective responses from the individual interviews.

The focus groups held with Māori participants followed the Tikanga (practices of the tribal area). This included introductions that provided the opportunity for participants and the interview team to acknowledge where they were from (geographical location) and their Hapū or family group, name, and place of residence.

This process established an environment of safety and inspired confidence. Individual interviews held in homes and other locations followed a planned introduction and interview process.

Recruitment

Information sheets/leaflets and consent forms were distributed via the following identified champions, through the use of advertising through posters and flyers.

- Plunket
- Well Child/Tamariki Ora providers
- South Waikato Pacific Services
- Māori providers
- General Practices.

Inclusion criteria

The study needed to explore the women's experience of the whole journey through pregnancy, birth, up to the handing over of their baby's care to the Well Child provider. It was also thought that women would be very busy with the care of their new born up to three months post-partum but after this they would have settled into a routine and have

more time to take part in the study, and that the recent pregnancy experience would still be fresh in their minds. With this in mind the following criteria applied:

- Women who had given birth at least three months prior to the consultation whose primary residence is within the designated areas.

Focus groups and interviews

There are health inequities for Māori people and in order to ensure Māori women were equitably represented the following areas were chosen:

- Waikato: Te Kuiti, Tokoroa, Coromandel and Matamata
- Bay of Plenty: Opotiki
- Lakes: Turangi
- Taranaki: Hawera
- Tairawhiti: Tolaga Bay, Gisborne (mothers residing at least half an hour's drive from Gisborne).

Separate focus groups for Māori were offered and individual interviews conducted if requested by interested mothers. This included in some instances interviews via the telephone.

Analysis of Transcripts

A thematic approach was used by each investigator individually to identify key themes which were then compared and discussed. From this five themes were identified which were, access to services, quality of clinical care, information, role of partners, family and friends, and culture. Participants were asked to relate their experiences of their pregnancy and the birth of their child up to and including the transfer to Well Child services. Some key questions were used if necessary to aid discussion to ensure all aspects of the maternity pathway were included. Each theme was subsequently subdivided into areas of the maternity pathway such as LMC, antenatal care/classes, delivery, and postnatal care.

Results

Demographic information

Univariate analysis

Age group	Count	%
17-20	5	8.07%
21-24	4	6.45%
25-29	19	30.65%
30-34	17	27.42%
35-39	11	17.74%
>40	6	9.67%
Grand Total	**62**	**100.0%**

Ethnic group	Count	%
NZ European	30	48.39%
Māori	24	38.70%
Pacific Islander	2	3.23%
Asian	2	3.23%
NZ European/Māori (if using priority ethnicity this would be coded under Māori)	2	3.23%
African	1	1.61%
South African	1	1.61%
Grand Total	**62**	**100.0%**

Area	Count	%
Coromandel	5	8.1%
Gisborne/Tolaga	9	14.5%
Hawera	6	9.7%
Matamata	4	6.5%
Ōpotiki	10	16.1%
Te Kuiti	8	12.9%
Tokoroa	12	19.3%
Tūrangi	8	13..0%
Grand Total	**62**	**100.0%**

Which health professional did you contact <u>first</u> when you discovered you were pregnant?

First referral	Count	%
Fertility Clinic	1	1.61%
GP	34	54.84%
Midwife	27	43.55%
Grand Total	**62**	**100.0%**

How many weeks pregnant were you when you enrolled with your lead maternity care provider (GP/Midwife/Specialist Obstetrician)?

Weeks gestation at LMC enrolment	Count	%
<13	46	74.3%
13-16	6	9.7%
17-20	3	4.8%
21-24	3	4.8%
25-29	1	1.6%
30-34	1	1.6%
31-40	1	1.6%
not answered	1	1.6%
Grant Total	**62**	**100.0%**

How far did you need to travel to maternity facilities?

Distance travelled to maternity facilities	Count	%
>60km	5	8.1%
1-10km	38	61.3%
11-20km	5	8.1%
21-30km	2	3.3%
31-49km	6	9.7%
50-60km	5	8.1%
Not answered	1	1.6%
Grand Total	**62**	**100.0%**

Did you use your own transport?

Transport	Count	%
No transport	6	9.7%
Own transport	56	90.3%
Grand total	**62**	**100.0%**

If no, how did you get there?

No transport	**6**
Midwife came to me	2
Midwife did home visits	2
Walked	2

Did you attend antenatal classes?	Count	yes	%	no	%
NZ European		15	24.2	15	24.2
Māori (including NZ European/Māori)		3	4.8	23	37.1
Pacific Islander		-	-	2	3.3
Asian		1	1.6	1	1.6
African		-	-	1	1.6
South African		-	-	1	1.6
Sub Total			30.6		69.4
Total					**100**%

Questionnaire analysis

A total of 62 women were recruited across the region of which 26 were of Māori descent. 54% of women saw a GP as the first health professional and 43% saw a midwife. 74% of the women enrolled with a LMC before 13 weeks gestation. Three women enrolled at 21 to 24 weeks and a further three at over 25 weeks gestation. Māori women were more likely to enrol with a LMC at a later gestation than NZ European women. According to the questionnaire the majority of women travelled less than 10km to access maternity services but the transcripts indicated they travelled further distances past local primary birthing units to get to the birthing unit of their choice.

Only three out of 26 Māori women attended antenatal classes and of those who did not attend, only one had attended with their first child. Six of the women either did not know about the classes or were not advised to go, and a further five either did not want or need to attend or felt they had plenty of family support. 15 out of 30 NZ European women attended antenatal classes and of those who did not attend eight had attended with a previous pregnancy. Neither of the Pacifica women attended antenatal classes.

Key themes

Access to services

Initial registration

Access to maternity services was one of the main themes identified from the focus groups and interview transcripts. Although most of the women were able to access maternity services easily, there were some areas where this was not the case. Of the 62 participants in the study, 34 (54.84%) initially accessed maternity services by seeing a GP and 27 (43.55%) saw a LMC first, with women who were pregnant for the first time more likely to see their GP first. None of the women were able to select a GP as a LMC, although one woman (1.61%) wanted to. Our finding around the reasons women accessed their particular LMC were similar to the findings in the Maternity Consumer Surveys 2011 (Ministry of Health, 2012). Some of the participants had been uncertain about how to find out about a LMC and one had not registered with a LMC but had relied on the local hospital midwives to deliver their baby.

A number of the rural women in our study had difficulty finding a LMC due to a shortage in their areas, resulting in some cases with the woman seeking out of area care. “It took me about five months before I actually found a midwife to take care of me” (7) and, “we are restricted here, well rurally anywhere because you don’t really have a lot of choice” (27). Others chose to go out of town because of a negative perception of the local midwives, “I just wasn’t comfortable with them so I went to one [midwife] in [out of area] which was hard” (4). In some areas women were concerned for local midwives who had a good reputation as the women perceived them at risk of burning out and were concerned they would be left with either no midwife or one whose practice was perceived to be inadequate.

The reasons women decided to change their LMC during their pregnancy were similar to those in the Maternity Consumer Surveys 2011 (Ministry of Health, 2012) but the participants in this study who changed their LMC talked more about their dissatisfaction in the service received. Those women who were unhappy, expressed their reasons as not always keeping appointments, referring for scans, communicating test results and perceived lack of good communication.

Back-up or locum LMC services

Access to a backup/locum LMC was one of the areas which either went well because the LMCs in question had a good system working well together, or it was an area where this was

not the case. LMCs frequently worked together, either in a collective or to back up and support each other in order to provide women with 24 hour access to maternity services. In some cases this was organised extremely well and women found access easy, ”my midwife had gone away so she got a backup midwife” (14), “She just made sure that her locum backup was all sorted, that was really cool, I felt comfortable with that” (29), while other women felt unsupported and let down, “wow, I didn’t even know she had a backup midwife, she didn’t tell me” (1), and “If I went into labour on her non-working days I would get whoever was on call – I didn’t know that would happen…it made me worried in case I got someone else, …” (4).

According to the Maternity Consumer Surveys 2011 (Ministry of Health, 2012), this was an area of care which was identified as needing improvement. Women expect to have built up a trusting relationship with their LMC and were disappointed if the LMC was not going to be available. If the backup LMC had been introduced to the women or been involved in a shared care situation the women were more confident about their care. It is interesting to note that seemingly contrary to this reliance on the LMC to be present for birth, when some women had to be transferred to hospital because of complications during their pregnancy or delivery, they were happy and confident with the care they received from the DHB midwives whether or not they had met them before. This could be related to the trust the women have in their LMC’s expertise and knowledge which led to the decision to refer them for expert assistance in relation to the safety of themselves and their baby.

Access to scans

For rural women accessing services such as scans meant having to travel some distance, and while for many the distance was not too great or not seen as an issue, for others it was demanding, particularly when extra monitoring was needed. In some areas facilities are only available one day a week and in others a backlog in scans meant the women had to travel an extra hour on top of the half hour to the local facility, incurring extra cost. When a more local service opened in one area it was much appreciated as it reduced travel time by half. Overall, rural women seem to accept they are going to have to travel for services because they are not supplied locally.

Access to place of birth/specialist services

Some of the women who had to access specialist services in the antenatal period found the LMC made access easy. One woman had gestational diabetes, “She referred me immediately, I had to go up to [base hospital] for some classes and I had to monitor my glucose six times a day” (18), and for another woman in the same focus group, “straight away she referred me to mental health” (4). In general, most women who needed access to specialist services during their pregnancy, birth and postnatal period gained it easily with only a couple of exceptions. Where access was difficult it was related to distance to service, unavailability of local services, and crossing DHB boundaries.

From analysis of the transcripts it appears many of the women chose to access birthing facilities where there was easy access to secondary services for safety reasons, whether this was on the advice of their LMC or other reasons. This resulted in many rural women bypassing primary units where there is no emergency back-up and travelling to primary units near secondary services. This extra travelling distance was not reflected in the questionnaire because of the way the women interpreted the question about distance travelled to maternity services, but according to the Maternity Consumer Surveys 2011 (Ministry of Health, 2012) 86% of women gave birth in a maternity unit of a general hospital, which would appear to support these results.

Further investigation into the reasons LMCs are advising women to bypass rural primary birthing units and how this affects rural maternity service provision should be considered. The viability of some rural primary birthing units is currently being investigated within the Midland region (Waikato DHB, 2013).

Access to postnatal care and Well Child services

Many of the women had good access to postnatal care, with varying lengths of stay in a birthing unit. The frequency of postnatal visits from their LMC varied, with some women receiving more visits than contractually required and others did not. “The midwife was good, she came weekly up to six weeks” (6), and “she came in and saw us every second day while we were in hospital…and came up every second day for the first week to make sure we were ok, then every three to four days, then once a week for a couple of weeks” (29). Some had few visits, “It was more like every two weeks” (1).

Women had varied experiences with the establishment of breastfeeding and the support provided. “We were in the hospital for eight days; my midwife just wanted to make sure I was confident with breastfeeding, just being so far away from town” (26), “Both my babies were pretty good at breastfeeding, I had good support” (10). Some women did not get the support they needed. “She struggled to get the baby on the breast and the attitude of the nurse was not helpful” (7).

In general the LMCs transferred babies care to the Well Child provider around six weeks after the birth. Sometimes women were able to choose which provider they were referred to, “they gave me a list…and then I was passed over to Well Child at four to six weeks” (11), while others were not consulted. “I was discharged at four weeks and sent to Plunket” (16), “they said do you want Plunket or Tamariki Ora, I did say I wanted the Māori one and they didn’t even send me to that one” (1). In some instances the referral was delayed, or the Well Child provider did not receive the referral.

Quality of clinical care

The quality of clinical care and the need to feel safe and secure was important for rural women and the majority received care which met their expectations and they were very satisfied, which was a similar result as the Maternity Consumer Surveys 2011 (Ministry of Health, 2012).

The quality of care provided by LMCs varied and there were many mothers who had a good experience during their pregnancy where everything went as expected. These mothers were quick to praise their midwives and the maternity services, “the midwives were very proactive and I had a lot of support” (4), “The care I got was fantastic, especially from the midwives at …” (4), “I think that happiness comes from the confidence with your midwife” (16), and “My midwife was fabulous, she was so in control and nothing was an issue” (29).

The care some women received did not meet their expectations and some changed LMCs because of this, “I had problems with her and I had to change my midwife at 33 weeks” (19). “I saw her about three times but we just didn’t click”, and “I didn’t feel that comfortable with …, also partly because she doesn’t attend caesarean births …there was just a couple of things that she said – I thought I would go with someone else” (21).

Some women who participated in the focus groups had concerns about the care they received and wanted information about what they could do, “When we have a problem with a midwife and we feel that it needs to be taken further than just her boss or something, what do we do?” (6). This woman had not heard of the ‘Code of Rights’ but others in her focus group had, “My midwife talked to me about it on the very first visit, which was all good because otherwise I think I would have just put it (the leaflet) in the bin! She sat and talked to me about it and she explained everything - it was good” (6).

Health professionals have a duty to ensure their clients are aware of their rights and how to make a complaint. The apparent lack of awareness of some of the participants about their rights would imply that the way in which they are being informed was either not effective, or that they were not being informed.

Women tended to talk about their whole experience and how good it was rather than in specific clinical practice, “I ended up with the most amazing midwife, she checked everything, like every month she was monitoring you, checking baby’s heart beat…she bent over backwards to make sure that everything went well” (2) , or “I had great labour, great pregnancy and fantastic care, follow up care she was fabulous right through “(29), and “I had a pretty cruisey birth” so it was just the gas and Pethidine and then I pushed her out, easy 45 minutes ….we were very pleased with her care” (29). Some LMCs went the extra mile for their clients, “I had to have a caesarean……but she still turned up……my midwife would still come in every day just to check on us” (6).

While there were many women who had excellent care there were some who felt their experiences were less than perfect. In some cases it was the attitude of the LMC, “she was nonchalant, she told me not to go to the hospital until baby was coming……she didn’t turn up until four or five minutes before baby popped out…” (2). Another woman said, “There was quite a lot of blood and quite a lot of meconium and they just kept observing that and they didn’t tell me what that was about….that happened the night before about 9 or 10 o’clock and continued through the next day…by 2pm the obstetrician had come in and said ‘enough is enough’… My midwife wanted me to give birth naturally, and the obstetricians wanted to intervene” (13).

A minority of the participants thought perhaps it was the payment system for midwifery services which had influenced their LMC's decisions about their care. This concern should be explored further with both midwives and consumers to investigate if the present payment system impacts on women's care during their pregnancy and birth.

LMC advocates which birthing facility

Safety for themselves and their unborn child was a major underpinning factor in women's expectations. For some women their LMC advocated they give birth near to or in a secondary care birthing unit for safety sake, "She said she wouldn't give me a home birth as well because I was too far away, she also says because it's so easy for things to go wrong," (2), and "My midwife said if you are going to birth here you might as well have a home birth because you are still going to need an ambulance if anything happens" (29).

Women accepted their LMCs knew best as they were the experts, "she was the professional so I took her word for it" (2). For others this was not the case and one woman found she felt pressured to use a particular facility she did not want, "midwife kind of put out to me every time we talked about it that I will be able to birth in …, that my body can do this, and so I kind of felt pressured and I never handed the birth plan in….she wasn't quite listening to us not talking, she wasn't listening to what the silence said" (8). Women needed to know they were safe and supported in a vulnerable situation and while some women did, others were left scared.

Information

Women wanted to be able to make informed decisions at all stages of their pregnancy and many felt they were well informed, while others described a difficulty to get the information they needed. A few women found it challenging to access information on how to get an LMC or what to expect during their pregnancy and found the way LMCs and maternity services were advertised fragmented and difficult to explore.

People learn information in different ways and while most of the women who attended classes did get information from them, some did not, "the information was there but I don't learn like that, I need someone to tell me stuff, if I have to read it all I don't bother too much" (6), and "she was really hands on but I kind of found that a lot better than saying here is a piece of paper, read it through" (26). First time mothers were more likely to attend

antenatal classes. The reasons women did or did not attend them were similar to the Maternity Consumer Surveys 2011 (Ministry of Health, 2012). Some of the women who did not attend, had found innovative alternatives. One young woman declared that "Google" was her antenatal class. It could be argued that the current reproductive generation are more likely to be looking to the internet and other similar technologies to source information and that this is the way we should now deliver this education.

The Maternity Consumer Surveys 2011 (Ministry of Health, 2012) identified younger mothers being less likely to attend antenatal classes and those that did being dissatisfied. Therefore using modern technology would be particularly suited to the younger mothers and rural women. Possibly a virtual classroom with interactive components with discussion groups and experts available through a website, would solve some of the issues around access for rural women. This could also potentially solve the issue around the timing of classes, making it easier for busy women to be able to fit in.

In addition to the LMC and antenatal classes, family and friends were frequently used as sources of information and advice, "I asked my mum and I asked new mums as well and they told me what I wanted to know" (29), and "I went home and told mum and she said that doesn't sound right" (16). For some the advice was preferable to that of the health professional, "a couple of people (friends) were more helpful, she felt, than sometimes her midwife was" (7). Women wanted information on what to expect during their pregnancy and what care they should receive from their LMC so they could make informed decisions on their choice of LMC and their care. Some women felt they did not get all the information they needed to make a decision about who to choose as their LMC.

All women wanted to be kept informed about their progress and any issues or concerns in order to feel safe. If there were complications and decisions needed to be made the women wanted to know what was happening, what the options were and the inherent risks involved in order for them to make an informed decision. For some women and their partners this happened, "My partner he was scared and he didn't realise either but she talked him through it" (29). For another woman it was a different situation, "... wasn't telling us anything that was happening…It wasn't until the ambulance came and we were like, what's going on?" (9).

Role of partners, family, and friends

Partners, families and friends are an integral part in most women's maternity experiences. While many of the participants were able to have support from whom they wanted, when and how they wanted, there were some exceptions for some women. Some of the birthing units or LMCs did not encourage families to stay.

Many women received all the support they needed from their partner and family but others only wanted their partner there, "we had a strong whānau presence, I'm saying that, the support was there" (7), "he was the only support person" (29), and "I was at the hospital pushing and she (mum) was helping me out" (14). Sometimes family were actively discouraged from being at the delivery to support the woman, "For her to turn around and tell me that my whānau aren't allowed in there, I don't think so, at the end of the day that's my support" (7).

One woman whose pregnancy ended up needing extra monitoring and care at the tertiary hospital needed to know she had her support network near her. As she lived 2 ½ hours drive away from the tertiary hospital's birthing unit this proved impossible and she ended up transferring to another DHB which was nearer to her support networks, "I had to get really staunch because there was hardly any real support for me in…, it was horrible having to say constantly that I wanted to go to …" (15). Since partners, family and friends are crucial to be involved at all stages of the pregnancy, midwives need to explore alternative models of midwifery care if the woman wants to go out of area to be closer to supports.

Culture

Significance of the study

From the analysis of the emerging theme 'cultural issues', in particular the experiences of Māori women and their whānau it was noted that there was a difference in the responses and information shared.

It is intended to focus on the interview groups and the way information was imparted. It is important if the experiences of Māori women are to be understood in the context of the environment in which they live today and the services that they receive.

Te Ao Māori concepts and Hapū Ora

The Māori focus groups followed the introductory, Tikanga (practices) of the tribal area. Whakapapa (genealogy) is important. It is the inter-relationship between generations, emphasises the relational and collective nature of Māori societal structures (Henare 1988, Ministry of Justice 2001, Pere 1988). Whakapapa establishes sets of roles, obligations and accountabilities within whanau, hapū, and Iwi. (Pere 1988) and connects Māori culturally, socially and spiritually to the wider environment. Whakapapa is also cyclical, bringing to the fore the relationships between past and present generations, and highlighting the fact that birth, life and death are interconnected (Ministry of Justice 2001, Moewaka Barnes, H. , Moewaka Barnes, A., Baxter, J., Crengle, S., Pihama, L., Ratima, M., and Robson, B., 2013). The process for the Māori groups established an environment of safety and inspired confidence.

This is not to say that the women who attended other interviews were less safe. One woman at the end of an individual interview saw their cultural affiliation as separate because, "I wanted to get the best service possible…there are other midwives up the coast…" (contemporaneous notes 26). Women interviewed individually and in mixed groups were more reserved in sharing culturally specific information and only at the end of a formal session when engaged in conversation.

It served to demonstrate that the women who attended mixed focus groups were less likely to discuss Māori preferences or practices. The exception was one woman who expressed her mamae (sadness) and her 'knowing' that baby was gone because the "morepork was sitting there and calling" (2). In some tribal areas the significance of the morepork is important. The morepork is the messenger of a passing or pending death. It was clear that the woman wanted to share her experience and for it also to be known that she had indicated to the LMC that the "baby was not growing…she (the LMC) did not listen..."(2). The baby was stillborn. She was the first speaker in that group.

Māori knowledge, values and beliefs were also referred to by one woman who shared that she was, "…influenced by her mother and her nanny's Marae and their practices, …it is expected…they are hohonunui, very deep,…..they live way out there in the bush…", a remote rural area. "I don't tell the LMCs, they wouldn't understand…" (11).

Within contemporary society Māori are diverse, both in experiences and in their aspirations (Irwin, 1992; Smith, 1992 ibid p21). However, there are key structures within Te Ao Māori that are enabling and set a foundation for wellbeing. These key structures are whānau, hapū, and Iwi.

Whānau, hapū, and Iwi

The value of including the range, location and identification of the tribal areas is to link the importance of belonging, "…my partner left….when I had my baby I went home…it was cheaper …my whānau are there…" (28).

Significant to the structures of whānau, hapū and Iwi are the dual meanings of 'hapū (pregnancy or conception in the womb/sub tribe) and 'Iwi (people/bone)" ibid (21) "…my grandchildren are my bones…" (7), and the woman who listened to "the expectations of her mother and nanny's marae." (11).

In five tribal areas participants referred to themselves as "Hau Kainga" an expression that means 'home winds', or their 'tūrangawaewae', place to stand' (14, 24). 'Whenua' means both land and placenta, the source of sustenance in the womb and in te ao márama, 'whānau ' or 'whakawhānau' refers to family and to giving birth, bringing new family into the world. "I wanted my whānau there….my nanny wasn't allowed in…" (7).

The whenua (placenta) of the newborn baby is taken and placed into the whenua (earth). This links the child to the land and establishes their 'tūrangawaewae' (place to stand) and preserves the mauri (life force) and mana (prestige, integrity, honour) of a child (Rimene et al., 1998). "She (the LMC) went back to the birthing unit the next day to collect my placenta and bring it to me. It was her day off, she did not need to do that…" (17). These meanings highlight the relationship between Māori societal institutions, such as hapū and Iwi, to processes of reproduction and birth.

Whānau is the societal unit that underpins Māori society (Durie, 2001, Pere, 1988) and provides the basis on which broader structures of hapū and Iwi are dependent. Whānau has been defined as three to four generations living together as an extended family unit (Henare,1988, Pere, 1988, Walker, 1990) within pre European times a common ancestor (Morehu, 2005). Through whānau, Māori societal concepts and practices were both

socialised and reinforced, providing the basis for learning about and imparting the knowledge, values and beliefs essential to both the individual and the wider hapū and Iwi, "My partner and I tried for four or five years to conceive…. I want the best service possible" (26).

She indicated that she is strongly connected to her 'turangawaewae' explaining the significance of the place where she was born. As a principle she is bi-lingual and her daughter will be raised within the context of whānau and enables those closest to the child to provide input and oversight that are essential to her wellbeing and hence to whānau generally. Others said "…we left ourselves (being Māori) at the door..."(of the hospital) (24).

The whānau traditionally provided the first point of learning and socialising for tamariki (children) (Buck, 1949, Pere, 1988). Kuia and Koroua, as grandparents and great grandparents, supported the socialisation and education of tamariki and were instrumental in imparting a wealth of knowledge and skills. Māori children were collectively nurtured, raised and educated in this manner with contributions from males and females (Salmond, 1997). For some women whānau support is unavailable, "afterward there is this Māori place over in … and I got six weeks home care because my partner went to rehab and I was looking after my baby myself" (24).

Access to maternity services

A maternity services survey is conducted periodically to measure women's perceptions of and satisfaction with care received before, during, and after birth (Ministry of Health, 2012b). Information from Māori women is reported, although low Māori response rates (25% in 2011 compared with 51% for Pākehā) may introduce selection bias (Moewaka Barnes et al, 2013, ibid p 47). 41% in this study was creditable, however, Moewaka Barnes et al suggests that "there is considerable capacity to investigate specific issues affecting Māori outcomes and the effectiveness of maternity care, viewed through a Māori centred equity lense" (ibid p47).

Women in one area said there were "no midwives" (14, 33). They enrolled with the DHB midwives or were able to find an LMC who was prepared to travel to where they lived. The Lakes DHB Maternity Review Report (2011) confirms the difficulties women experienced accessing a LMC. One woman interviewed had various providers for her pregnancies over

the years, starting with a local GP, then local midwife and when they were no longer available, did not register with a LMC at all relying on turning up at the nearest hospital to give birth and another time having the baby in the car on the way to the hospital. For her daughter's first pregnancy friends and family insisted they found a LMC. Women are required to travel an average of 52 kilometres to the hospital for antenatal care, education, scans and birth at the primary birthing unit. Most of the women surveyed in this location did not have transport and relied on other family members or friends. There is no public transport in this area to get to the primary birthing unit.

The second area where access to an LMC has been problematic a woman said, "It is difficult to find an LMC…..my partner rang around" (7), another, "I found my LMC at five months…I live out of town….have no transport I made her come to visit me..(7).

The whāngai (adopting) parents connected with an LMC/ hospital midwife at different times. The whāngai uncle met the hospital midwife at his niece's birth… they (the hospital) have excellent guidelines for whāngai adoptions. The midwife also arranged for an LMC to visit us when we returned home. "I now have three of her four children…I asked my eldest son should I bring her home before I agreed to accept this baby…she's beautiful and we love her…" (5).
The second whāngai parents met the birth mother's LMC at five months. "She (LMC) was standoffish with me.….I wanted to be involved in every aspect of her care. She did not warm to me until the birth…." (31). The cycle of whakapapa past and present continues with the whānau in both families. The birth mother's whakapapa links to the adopting whānau.

Professional women were more confident to change LMC if they were unsure, "The second one…we just clicked" (25). For others there was a need for a relationship and connectedness, "I have four children, the baby is five months. I was 18 when I had my first baby, I lived in… I was really connected to my first LMC … she was great, really wanted to know me… and make a friendship" (30). Moving away from home and family leaving her isolated and unsupported, "I moved with my partner to a farm in ……at 7 ½ months….I had no midwife…" (30).

In some areas Māori LMCs were available (24, 25), but in another the back-up LMC came from another area..."she was awesome..." (7).

Access to Māori focussed antenatal classes

Access to Māori specific information was provided in three areas. A long standing successful Māori pregnancy and parenting programme has been provided in one area (11). It is endorsed by the Iwi.

The Te Rangiātea programme was designed by Māori women in partnership with professional Birthing Educators. The programme has been endorsed by the Kuia, Mana Whēnua, the use of Te Reo Māori appropriate, the local presenters LMCs and others are supported. Young women interviewed were enthusiastic in their praise of the programme (14, 33).

The Kia Maumahara Traditional Birthing Practices by Lisa Kelly second edition 2011 and sponsored by Te Puni Kokiri is offered in the third area. The programme was developed with her Kuia.

"Kia Maumahara ki tō Mana Ake" 'Always remember your absolute uniqueness', "they had some interesting stuff like natural stuff, like when they tie the pito they use a bit of flax and they were making clay stuff to put your baby's afterbirth in to the ground (24). The area has several different Iwi in close proximity and presents some challenges. "we can go to a Māori class….it is not for some of us from other areas…." (24).

The programme is accompanied by Te Kura Whānau, Te Kura Whakapapa a Te Reo Māori /English booklet, "Kia tupu ai he totara" - developing potential from birth and "Wahine Marohiroi" Strengthening and stretching exercises for Wahine Hapū and is published by He Rauemi Whakawhanau (T M Kani, 2007). These publications have been developed by another Iwi out of the Midland region.

Kia Maumahara has been developed by Lisa Kelly with the support of her Kuia and Hapū. In another tribal area participants said, "there is a need for a class or a programme but from a Kaupapa Māori perspective", "We are developing our own, 'Whēnua ki te Whēnua'" (7).

Access to birthing facilities

All women had access to primary or secondary birthing facilities. Distances travelled varied from 40 to 60 minutes, while tertiary facilities were up to 2½ hours. Island travel was by ferry or air, fixed wing or helicopter.

Quality of care

A qualitative study by Wilson (2004) identified four key areas that were important to Māori women and their health in general: connecting through whānau, nurturing wairua, using mātauranga (knowledge), and undertaking self-care activities (p.146). In one interview a respondent emphasised the need to be respected, "…a midwife [from a different culture] did not treat me with respect…the second midwife treated us like human beings" (1). Wilson records that other respondents said, "Lack of respect for women's choice for whānau support". Women in this study said, "The midwife had my plan right in front of her sitting on my folder, but the midwife still didn't want me to have my family there" (7), while another said they had no problems, " I was the opposite, where they allowed that many in there all of my whānau" (7), "we got the whānau rooms at……. beautiful whānau rooms in ……." (9).

Antenatal care and classes

In earlier research Māori were less likely than Pākehā to participate in antenatal classes (Dwyer, 2009, Health Services Consumer Research, 2008). The findings in this study suggest that that there is little to no change. "I never went to any antenatal classes because my family don't even go to these things" (30). "I attended the Māori programme for all three children…..it is excellent…"(11). "LMC provided most of the information (classes)…" (1).

Dwyer (2009) found only six antenatal education providers had programmes tailored for Māori and recommended further programmes be developed. This need was emphasised in one area, "there is a need for a class or a programme but from a Kaupapa Māori perspective" (7), "we do have whānau out there who do know Tikanga and know what is appropriate…." (7).

The enthusiastic response to the Rangiātea education programme demonstrated that when culturally relevant information is tailored to the needs of Māori, participation is likely to improve.

In earlier research, Māori women expressed preferences for culturally relevant antenatal education that is held in culturally appropriate venues, customary practices relevant to the Iwi or confederations of Iwi, has a focus on spiritual needs, (karakia and mirimiri) takes a more informal approach, includes whānau, is delivered by Māori women or as in the case of Te Rangiātea, professionals are chosen and supported by whānau, provides opportunities to share experiences, including those of older women (Abel, Finau, Tipene-Leach, Lennan & Park, 2003; Ratima et al., 1994).

These studies highlight the importance of services being able to provide equitable antenatal care that is clinically safe, adheres to best practice, and is respectful and inclusive of the Māori world views and practices (Moewaka Barnes et al., 2013). This study found that there were no specific references to poverty or travel, other than "we live out of town…..petrol is expensive...", or, "we have no transport and there is no public transport." A Māori service provided transport for a group of young women to the Te Rangiātea programme, followed by a visit to the birthing unit. "It was a choice day out…"(14).

Access to information to make choices

Health literacy is about the capacity to access and use information. A 2006 study found that New Zealanders generally have poor literacy skills with Māori on average scoring below the minimum need to meet more complex demands of everyday life (Ministry of Health, 2010c). Māori males had lower literacy scores than Māori females and there were also particular concerns noted about young people. Higher levels of education and income were associated with better health literacy skills. The report states, 'Health literacy is essentially the skills people need to find their way to the right place in the hospital, fill out medical and insurance forms, and communicate with their health providers' (Ministry of Health 2010c).

In the 2007 Maternity Consumer Survey, Māori women were more likely than Pākehā women to say they did not receive enough information from their LMC to make an informed decision about antenatal tests (Health Services Consumer Research 2008). "LMC provided most of the information …" (1).

The Maternity Consumer Surveys 2011 (Ministry of Health, 2012) identified information on selecting a LMC as the main priority for information improvement (Ministry of Health, 2012b). Most Māori women received a list of LMCs from the general practice. In one area

women said, “No LMCs were available…”(14, 33). Other reasons were also given, “not one midwife wanted to take me on because it was the Christmas holidays.” “It was either the Christmas holidays or the midwives didn’t want to go that far to …….That was a big let down for me. I was scared, I knew this was my last one and I was a bit worried. I did manage to find one (midwife)” (2).

Experience and acceptability of care during and after the birth

The way in which mothers were cared for during the birth has the greatest impact on the overall satisfaction with maternity services care. In 2011, a high proportion of Māori respondents to the Maternity Consumer Surveys (86%) reported being ‘quite satisfied’ or ‘very satisfied’ with care during the birth of their baby and with care received at home following the birth (Ministry of Health, 2012b; Moewaka Barnes et al, 2013, ibid p 53).

Of the 26 women all, with the exception of six, experienced a ‘natural’ spontaneous birth. Four women delivered by Caesarean Section, (C. Section) two elective, one an older woman delivered of twins, one with a history of previous C. sections, one undiagnosed breech presentation and one transverse lie. Many women were very happy with the care they received which respected their cultural needs, “Where I went they were good, they asked me about the placenta and if I wanted it, they explained it all” (6). “She was a really good lady to work with and understood the cultural side of things as well”, and “I was present at the birth of my whāngai daughter…”(5), “ my baby was a transverse lie so I had to (leave the Island)…....the birth plan and information was good it was all there when I arrived…..my LMC was lovely…” (28), and “A lady there (the hospital) got all my stuff out of my bag for me , she just set it all up for me….let me go and have a shower….I didn’t have anyone with me for my first three…”(30).

Others were not able to receive the support they expected which respected their culture and found the care unacceptable, “she was going to cut it (the cord) herself and I said excuse me” (7), “Specialist visits began….at 37 weeks I had an emergency Caesar….no one explained it… we were only allowed one person in theatre…..my partner said they were rough with the muscles and yanked the babies out…..he cut the cords.”(22).

While there is evidence of the effectiveness of obstetric procedures during labour and birth in preventing perinatal and neonatal deaths (Darmstadt et al., 2009, Lee et al, 2011), the link

between Māori access to obstetric interventions and inequalities in adverse birth outcomes for the mother or baby is unknown (Moewaka Barnes et al, 2013, ibid p.53). All women were visited by the LMC from three days to daily in the first week, thereafter, weekly for six weeks, and in some cases beyond.

There were varying experiences during the after birth care and the role and support of whanau, “the whānau are very strong up in the … so they had good support systems in the family” (7), “when I had my son I didn’t do anything for two weeks except feed my son, my whole family did everything else for me” (7), and “afterward there is this Māori place over in …. I got six weeks home care because my partner went to rehab and I was looking after my baby myself” (24). Some of the women did not have whānau support, “...so they are all busy, everyone has their own lives really, it’s not really family, family, these days everyone is in for themselves” (30).

Moewaka Barnes et al (2013, p 53) suggests that it is unclear whether the Maternity Consumer Surveys is the appropriate instrument to elicit concerns about or satisfaction with cultural aspects of care form Māori whānau. More information is needed to assess the impact of this development on Māori whānau.

The recruitment and retention of a Māori workforce

Women suggested that more Māori LMCs would improve access to and their choice of provider (7, 24). In 2010, according to the results of the Midwifery Report Updated 2010 (Midwifery Council of New Zealand, 2010), the data showed that LMCs of Māori descent were categorised into their first, second or third ethnic group (134, first; 72, second; 4, third, ibid; p.46). Preferential selection raises the question, ‘who is a Māori’? It harks back to the days when a baby of Māori descent was registered at birth by percentage. There were also eight Māori medical practitioners, 32 nurses and five physiotherapists working in obstetrics and gynaecology (Ministry of Health, 2010b). There is ongoing need to increase Māori representation within the health workforce so that the needs of Māori women are better addressed.

Summary

There is considerable capacity to investigate specific issues affecting Māori outcomes and the effectiveness of maternity care, viewed through a Māori centred lens (Moewaka Barnes et al, 2013, ibid).

Primary maternity services are expected to ensure each woman and her whānau, has every opportunity to have a fulfilling outcome to her pregnancy and childbirth through the provision of services that are clinically and culturally safe and based on partnership, information and choice. Services are expected to 'achieve Māori outcomes and reduce Māori health inequalities' by facilitating Māori access to maternity services, ensuring appropriate pathways through those services and that maternity services address the primary maternity needs of Māori (New Zealand Gazette, 2007: 1052).

The cultural issues are not exclusive to Māori as the voice of Pacifica is also heard (5, 6). One woman shared that her partner is Samoan, "he spoke Samoan to the baby in my puku…." (28).

It is suggested that as the cultural knowledge and practices of all health practitioners improve, the benefits will support Māori women to have a 'fulfilling outcome to their pregnancy and birth', and will be to the advantage of all peoples of different ethnic communities.

Recommendations

The aim of this study was to identify areas where improvements could be made to ensure equitable access to maternity services for rural women living in the Midland region. The following recommendations are suggested as a way this might be accomplished.

1 Access to services

- Develop a strategy to increase the number of rural midwives, in particular Māori and Pacific Island midwives, in the areas where women described difficulty in accessing a LMC.
- Consider a survey of rural midwives to identify what they need to support them in their practice and ways to recruit future midwives into rural areas.

2 Quality of clinical care

- Explore LMCs regular practice in the area of raising awareness of the Code of Rights with their clients to ensure women are aware how to make complaints.

- Consider a survey of rural midwives to identify the back-up support mechanisms and profile best practices that work well for rural LMCs to ensure safety for women and LMCs, and preserving the continuum of care. Explore in the survey the reasons LMCs are advising women to bypass rural primary birthing units and what they would need to feel supported to utilise their local primary birthing unit (for women who meet the criteria).

3 Information

- Develop a Regional Maternity Service website with information for women about the service, access to LMCs, services women may expect to receive, and the Health and Disability Consumers 'Code of Rights' 1996. Provide information on complaints process avenues, including the DHB complaints process, the Health and Disability Commissioner complaints process, Midwifery Council. The website should also have information about pregnancy, birth and the postnatal period, and should have links to support services such as Work & Income New Zealand (WINZ), Healthline, etc.
- Review/search for apps. for mobile phones on pregnancy and birth. These should be provided free of charge to newly pregnant women.
- Explore other avenues of providing information on what women can expect to receive from maternity services, including primary midwifery services such as Health TV in GP practices and similar to Work & Income New Zealand (WINZ) offices.

4 Role of partners, family and friends

- Consider the role of partners, families and friends within a cultural context when planning or developing any aspect of the provision of rural maternity service.

5 Culture

- Strengthen the cultural competency approach to any improvements to maternity services to inform the development of a Hapū Ora service to better meet the needs of Māori women, such as Iwi endorsed antenatal education and information.
- Advise the Ministry of Health that this study raised questions as to whether the Maternity Consumer Survey is the appropriate instrument to elicit concerns about, or satisfaction with, cultural aspects of care from Māori whanau.

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Glossary - Mãori

Hapū	Pregnancy and conception in the womb, sub tribe
Hapū Ora	The health and wellbeing of pregnant women and their babies
Hohonunui	very deep beliefs, (water, ravine,)
Hau Kainga	Home winds, (people at home}
Iwi	People/ bone, Tribe, Nation
Karakia	Prayer, Blessing
Kaupapa	Platform, underlying base
Kuia and Koroua	Grandparents, Elders
Mamae	Illness, sadness
Mana	Prestige, integrity, honour
Māori	Ordinary, (people) a description by others of all Māori people
Marae	Gathering places
Mauri	Life force, life principle
Mirimiri	Massage
Ngā Hau e Whā	refers to the people from the “four winds”, other tribal areas
Pākehā	a description by Māori of European/ Caucasian people
Tamariki	Child, children
Tikanga	Māori practices**, c**orrect practices
Turangawaewae	Place of Belonging, sense of belonging in respect of where you are from, a place to stand.
Wairua	Broadly interpreted as spiritual/spiritual essence
Whakapapa	genealogy
Whāngai	to adopt, bring into the whānau, feed
Whenua	The source of substance in the womb, land and place

Glossary - other

Apps.	Applications
C. section	Caesarean section
DHB	District Health Board
GP	General Practitioner
LMC	Lead Maternity Carer
NZIRH	New Zealand Institute of Rural Health
TV	Television
WINZ	Work & Income New Zealand