Mokopuna Ora

Healthy Pregnancy and Baby

CONECTUS
Working together for maternal, child and family health.

Te Marautanga o ngā Akoranga Hapūtanga me te Mātuatanga

The Pregnancy and Parenting Information and Education Curriculum

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TAHA Well Pacific Mother and Infant Service provides support and services to health professionals working with Pacific families. TAHA developed a pregnancy and parenting curriculum – Tapuaki, for educators working with Pacific families. Tapuaki formed the basis of this new pregnancy and parenting curriculum.

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TAHA Well Pacific Mother & Infant Service

Whakawhetū Mokopuna Ora

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The Pregnancy and Parenting Information and Education Curriculum (PPIEC) is one component of a broader programme designed to support mothers, fathers/partners and their whānau with their information needs during pregnancy and parenting. The **Mokopuna Ora – Healthy Pregnancy and Baby** programme introduces a range of tools (such as a website and smartphone app) to cater to the various information-seeking preferences of mothers, fathers/partners and their whānau. Furthermore, the curriculum on its own is limited without the appropriate facilitation values and skills, and education services available in partnership with their chosen midwife or birth educator.

Although *Mokopuna Ora* provides a structured framework, it is contingent upon an assessment of the information needs of mothers and whānau at the point of engagement, and consequently the tailoring of the information to meet their requirements. Childbirth education approaches are no longer limited to a series of group sessions – opportunities can arise for brief discussions, home visits and community workshops. Effective approaches discourage didactic teaching and encourage participation and discussion. Interactions should be whānau led wherever possible.

Mokopuna Ora – Healthy Pregnancy and Baby focuses on whānau living in the Auckland region, although much of the information presented will be relevant to whānau across New Zealand. *Mokopuna Ora* acknowledges New Zealand's bicultural framework through the Crown and Treaty partnerships. *Mokopuna Ora* utilises Māori models of health and throughout the curriculum reflects both Indigenous and English languages. *Mokopuna Ora* has a core component comprising an introduction section plus six modules.

The modules are:

1 **Hapūtanga, Ka Aha Ināianei? – Pregnancy, Now What?**
- Provides pregnant women and their whānau with an understanding of the multiple changes expected during pregnancy, foetal development and their pregnancy entitlements and rights in New Zealand. Other key elements of this module include pregnancy support avenues and services and an introduction to maternity and midwifery services.

2 **Hapūtanga Hauora – Healthy Pregnancy**
- Promotes healthy eating and appropriate exercise and describes the effects of smoking, alcohol and drugs during pregnancy.

3 **Tauwhirotia te Hapūtanga – Care During Pregnancy**
- Encourages early engagement with a midwife to ensure regular antenatal checks and pregnancy screening, and to plan for the birth of a healthy baby. Describes conditions that can be associated with pregnancy, such as gestational diabetes, high blood pressure and antenatal depression, and explains the importance of vaccinations during pregnancy.

4 **Whakamamae me te Whānautanga – Labour and Birth**
- Prepares parents for the process of labour and birth of their baby, and to be aware of their choices and options where they are available. Key elements of this module are preparing a birth plan in partnership with the lead maternity carer, signs and stages of labour, pain management options, birthing positions, complications and what happens immediately after baby arrives. Practical tips are also included, such as when and what to prepare for baby's arrival.

5 **Ngā Rā Tōmua – Postnatal Care**
- Explains what to know for the arrival of baby including mother's self-care and family support, normal body changes from pregnancy to motherhood, a mother's rights and responsibilities and how to maintain a healthy mother and baby.

6 **Whāngai Ū me te Haumarutanga o te Moe – Breastfeeding and Safe Sleep**
- Emphasises the importance of breastfeeding, gives advice on infant nutrition and introduces safe sleep practices for babies.

The *Mokopuna Ora* framework begins during pregnancy and ends postnatally in the care of infant, mother, father and whānau. The introduction section provides an overview of *Mokopuna Ora* and introduces the basic principles for the understanding and use of all modules.

In addition to the core curriculum, two modules have been developed to further support facilitators' understanding and engagement with Māori parents and teen parents. These two modules are to be used in conjunction with the core curriculum:

7 **Mai te Wheiao ki te Ao Mārama – Māori Module**
- Provides narratives of mothers' experiences and offers considerations for when working with Māori parents and whānau using Te Whare Tapa Whā as a framework.

8 **Te Hapūtanga o te Taitamawahine – Teen Pregnancy Module**
- This module focuses on teen parents and explains the varying needs and issues that teen parents may face, offering considerations for when working with teen parents.
- New modules are proposed for improving understanding and engagement with migrant whānau and whānau of other ethnic descent.

Kupu Whakataki
Introduction

Mā tōu rourou, mā tōku rourou, ka ora ai te iwi

Literal: *With your food basket and my food basket, the people will live.*

Explanation: *With your contribution, and my contribution, the people will prosper.*

I. Mokopuna Ora – *Healthy Pregnancy and Baby*

1. Tirohanga Whānui – Overview

The *Mokopuna Ora – Healthy Pregnancy and Baby* (Mokopuna Ora) programme is a package of tools designed to meet the information needs of women and whānau during pregnancy that ultimately leads to positive parenting outcomes. Currently, the tools include the Pregnancy and Parenting Information and Education Curriculum (PPIEC), a website and a smartphone app.

Having the knowledge and information required to have a healthy pregnancy that leads to having a healthy mother and baby is critical. This knowledge is the foundation for building on parenting skills and subsequently improving infant and maternal health outcomes.

2. Goal and Objectives

The main goal of *Mokopuna Ora* is *to **ensure all babies have the best possible start to life during pregnancy and their first year of life.***

The key objectives are to:

1. Utilise a tailored targeted approach to pregnancy education and support services for whānau – a multi-pronged approach that focuses on engagement first and the use of engagement principles effective for different groups such as Māori and youth.
2. Deliver effective health promotion that introduces the need for early engagement with a midwife, antenatal screening and early detection of risk factors in pregnancy that increase related mortalities and morbidities for mother and baby.
3. Introduce the changes from pregnancy to motherhood, and postnatal maternal and infant care.
4. Promote the whānau and extended family approach – engagement with as many members of whānau as possible, especially fathers/partners and grandparents.
5. Have a preventative focus – utilising key elements of social innovation to help provide an environment of knowledge, awareness and empowerment that impacts on all members within whānau.

3. What Some Whānau Have Told Us

Mokopuna Ora places a huge emphasis on creating and facilitating effective approaches to ensure achievement of its objectives and outcomes. This is dependent firstly on engaging effectively with participants and understanding the needs of the target beneficiaries. *Mad Ave,* a community group located in Glen Innes, was engaged to consult and conduct focus groups consisting of young Māori mothers and whānau in Auckland. The findings from this consultation have assisted with the development of the *Mokopuna Ora* curriculum, website and smartphone app and we draw on these findings throughout this curriculum document. Six focus groups were conducted over a two- to three-hour period, each having between 8 and 12 participants.

Focus groups were conducted during September 2015 at the following locations:

1. Glen Innes – whānau
2. North Shore – young mothers
3. South Auckland – young mothers and whānau
4. Online, face to face and cluster groups – young mothers and whānau
5. Kanohi ki te kanohi (face to face) interviews – young mothers
6. Kanohi ki te kanohi (face to face) interviews – whānau.

Many of the participants admitted to not attending childbirth education classes and instead receiving education from their mother, sisters and wider whānau members.
Many suggested that if a class was organised, it needed to be delivered by a culturally competent facilitator (see Section 1.2.6) with culturally appropriate content, tailored resources and tools.

Most pregnancy and parenting workshops are delivered in a classroom-type setting with a group of strangers. However, many of the participants felt the following suggestions would assist in the successful delivery of a class:

- Share information in 'bite-size pieces' to reduce feelings of being overwhelmed, stress and fear.
- Use te reo Māori and tikanga in the delivery of education.
- Provide child care during pregnancy and parenting classes.
- Include Māori worldviews.
- Allow bringing of peers.
- Provide it at a location close to the women's homes that is also in familiar surroundings.
- Provide home-based antenatal classes.
- Ensure the classes are interactive.
- Use stories to describe pregnancy and parenting.
- Provide classes that are similar to a holiday programme, where mothers can drop in, and pick and choose what topics they would like more information about.
- Allow women to attend classes regardless of the number of children they've had.

It is important to note that information for classes is to be tailored to meet the actual needs of those attending each session.

Other suggestions include:

- Meet and talk in a conversation style and avoid the classroom/teacher style. Avoid words like 'workshop' or 'session' – try questions.
- Set the scene and acknowledge the safe space for this encounter – 'being here to serve'.
- Hold sessions in a culturally appropriate location.
- Use an informal group style, be respectful and use humour in an appropriate manner.
- Hold sessions in different languages as appropriate for the group.
- Provide healthy refreshments. Hospitality is important as it links to reciprocity between parties who intend to build and maintain relationships.
- Provide practical life examples, demonstrations and experiences so the women can relate.
- Utilise modern technology where appropriate – show DVDs and online videos, use the internet and use innovative ways to deliver key messages (e.g. do not deliver in a lecture theatre scenario).
- Hold sessions in a safe environment and encourage discussion and debate.

The above consultation process has informed the development of:

1. the Pregnancy and Parenting Information and Education Curriculum (PPIEC)
2. a one-day workshop and one-hour online training course for health professionals who will implement the PPIEC with pregnant women, fathers/partners and whānau
3. a new website designed for both whānau and health professionals
4. a smartphone application.

The *Mokopuna Ora* programme seeks to develop a range of mechanisms and approaches that are age appropriate, linguistically and culturally responsive, and relational.

5. He Tīro Arotahi – Focus

The Pregnancy and Parenting Information and Education Curriculum (PPIEC) has four key focus areas:

- whānau
- teen parents
- healthy pregnancies
- infant care.

a) Te Whānau

Although we often refer to mothers, *Mokopuna Ora* recognises that, for many whānau, 'it takes a whole village to raise a child' and thus values the collective approach to pregnancy and parenting education. The PPIEC acknowledges the wider context of whānau, extended whānau (including the multiple and diverse configurations of whānau that exist outside of the dominant nuclear family) and the community, and considers the important role of fathers/partners and other caregivers in ensuring the wellness and safety of both mother and baby.

Mokopuna Ora promotes:

- whānau and extended whānau forums
- fathers/partners-only forums
- ethnic-specific forums and resources.

b) *Ngā Mātua – Young Parents*

Mokopuna Ora promotes:

1. input from young whānau
2. development of innovative tools and resources purposefully targeting young whānau
3. adoption of communication systems reflective of youth (and society's) subcultures, e.g. Facebook, YouTube, Twitter.

c) *Hapūtanga Hauora – Healthy Pregnancies*

What do pregnant women, fathers/partners and their whānau understand about pregnancy? Do they know where they need to go to get help with their pregnancy? What do they need to know to raise a healthy baby? Provision of pregnancy care, education and support for whānau is individually based on their values, beliefs and practices, and giving more opportunities for whānau to talk and ask questions. Receiving culturally appropriate advice is also required.

Mokopuna Ora promotes:

1. evidence-based health promotion that translates robust and current research findings into key messages for whānau
2. tailored education forums based on an open delivery approach, delivered in community settings, using the PPIEC
3. co-ordination in the sector of existing initiatives and identifying areas for growth and opportunity, including research and workforce development.

d *Tiakitanga o te Pēpi – Infant Care*

When a baby is born, parents and whānau face new challenges when caring for their new baby. New parents are experiencing parenthood for the first time. Many parents turn to their parents, whānau and friends for advice. Ideally, health promotion and positive parenting activities should be introduced before baby arrives. Reinforcing the need for ongoing promotion of key messages such as breastfeeding, safe sleeping and immunisations is essential.

Mokopuna Ora promotes:

1. support for Tamariki Ora Well Child Services through existing and new initiatives
2. a range of existing and new postnatal tools and resources
3. research and workforce development that looks to support positive health initiatives targeting babies, e.g. breastfeeding, safe sleeping and immunisation.

All of these areas make up key elements of an overall programme that aims to support new parents and their whānau, respond to their cultural needs, appeal to their senses and acknowledge their values and beliefs. While the programme seeks to support existing organisations, services and health professionals, there will be a simultaneous process of inciting change and revolutionising thinking, attitudes and, most of all, conditions that have been barriers – real or perceived – to achieving equity in care, education and support of new mothers, fathers/partners and their whānau.

6. Te Hunga e Whāia Ana – Target Audience

Mokopuna Ora has two groups as its target audience. First, elements of the curriculum, such as the curriculum e-learning tool and train-the-trainer forums, which includes workshops with potential facilitators, are targeted at health professionals, providers of maternal education and potential facilitators of the PPIEC.

The second group that the programme is aimed at is pregnant women in New Zealand and their whānau. Components targeted to this group are the face-to-face forums, public pregnancy website, smartphone application and other online and social media.

When I was pregnant with my son my friend joined me to this group that was called April mums...it was all mums around the world who were due in April. It was amazing, like everything that was happening with the mums, they were putting on there. It was a massive help and it was just a Facebook group. Still to this day people upload photos of their kids. Like my son's two now and he's doing XYZ and this happened. You kind of feel like this emotional attachment to these women and these babies you've never met. A Facebook group is good.

7. Te Tūtakinga – Engagement First

No amount of tools, resources, clinical systems and capacity will make a difference to health outcomes without a focus first on engaging with mothers, fathers/partners and whānau. It is acknowledged that pregnancy may be an event that introduces a woman to the health system for the first time. Each woman's needs are individual. There is no single correct approach for engaging with pregnant women as many will exhibit wide-ranging levels of health literacy and diverse health needs; hence, consideration needs to be given to several strategies in order to reach all whānau, particularly young mothers and those identifying as Māori, Pacific, Asia and Middle Eastern Latin American African (MELAA). Service providers need to consider how they support diverse cultural and religious needs that could clash with their established ways of doing things within an assimilatory health system.[1]

Mokopuna Ora is about employing direct strategies for reaching our whānau, and joining the dots in the sector to improve access to pregnancy education, support and care.

These strategies include:

- identification of local facilitators with skills to deliver PPIEC pregnancy and parenting education programmes
- delivery of community-based pregnancy and parenting education forums, with a train-the-trainer format to ensure sustainability and promote expansion
- promoting partnerships with lead maternity carers (LMCs), particularly midwives, with district health boards, existing primary health care providers and other pregnancy and parenting support services to sustain and expand the programme once established
- web-based education and support, e.g. website and social media sites that will assist with recruitment to the programme.

II. Te Marautanga o ngā Akoranga Hapūtanga me te Mātuatanga – The Pregnancy and Parenting Information and Education Curriculum

1. Te Pūtake – Purpose

The Pregnancy and Parenting Information and Education Curriculum (PPIEC) is a tool developed to meet the information needs of pregnant women, fathers/partners, whānau and other carers, including adoptive parents. It aims to improve access the delivery of pregnancy and parenting education in Auckland. Two key mechanisms of the PPIEC are:

- Targeting & engagement – an outreach programme that is delivered by an experienced practitioner directly to the pregnant woman, ensuring whānau engagement to support her individual learning needs, utilising a range of resources with associated techniques and tools for maximum learning opportunities.
- Delivery that identifies – individual antenatal and postnatal priority issues relevant for the pregnant women, fathers/partners and whānau. Education is to start as early as possible in the pregnancy.

The main aim of the PPIEC is:

To enhance participation and empowerment of pregnant women, fathers/partners, whānau and other carers to make informed decisions about their health, and that of their newborn baby. Empowerment aims to increase the clinical, spiritual, political, social, educational and economic strength of individuals in pregnancy and parenthood.

Pregnancy can be an overwhelming and challenging time, particularly for first-time mothers, putting them into a vulnerable position. Fear of the unknown, uncertainty about what is normal and what isn't, and continuous physical changes to the body associated with a growing baby are constant challenges faced by pregnant women. Women display different levels of empowerment needs. The choices they make are dependent on personal, social, cultural and situational factors.[2] For many women, cultural beliefs and practices have a major influence on pregnancy care and parenting.

Decisions are heavily influenced by how involved women choose, and are enabled and supported, to be in the management of their maternity care. Studies show that while some women show disempowerment in this situation (i.e. they place trust in others to make decisions for them and their baby), empowerment is hugely important for a positive birthing experience.[3,4] Furthermore, empowerment through enhancing self-esteem, developing life skills through education and knowledge about their pregnancy, birth and after-birth experience enables a pregnant woman to make informed decisions.[5]

2. Ngā Kiko o te Marautanga – Curriculum Content

The PPIEC is a pregnancy and parenting education guide that covers each of the topics outlined in the Ministry of Health service specifications, providing information, methods, advice and/or tips that will increase the likelihood of participation.

The PPIEC identifies cultural worldviews and traditional beliefs about pregnancy, labour and birth to incite discussion with pregnant women and their whānau about what they know and believe about pregnancy, and how to nurture the development of a healthy baby. The PPIEC prioritises antenatal and postnatal issues that are significant to all mothers, fathers/partners, whānau and other carers.

When a woman becomes pregnant, her awareness of pregnancy entitlements (Module 1) and understanding of the benefits of healthy eating, weight management, the effects of tobacco and alcohol (Module 2), and pregnancy care (Module 3) are essential. Details of labour and birth options are covered in Module 4. Once baby is born, mother care – physical and mental (Module 5), breastfeeding and safe sleep (prevention of sudden unexpected death in infancy [SUDI]) (Module 6) are all key factors in providing baby with a healthy start to life.

It is important to note here that the curriculum is insufficient as a stand-alone tool. The success of a pregnancy and parenting education programme focused on key groups is dependent on many factors, but of significant importance are the skills and expertise of the facilitator. A good facilitator will adhere to the guidelines and prepare for each session accordingly. A great facilitator will also have the skills to encourage discussion between participants and draw on recent research evidence to enhance discussion. They will be culturally aware and responsive to the needs and perceptions of the target group.

3. Ngā Kīanga – Terms Used

'Pregnancy and parenting education' is used to replace other terms that are used in the sector such as 'childbirth education' or 'antenatal education', neither of which are favoured by different health professionals or whānau. The term 'education' is also viewed negatively by some as it denotes a one-way learning process, when in fact effective programmes are a two-way process. 'Forums' is used in place of 'workshops', 'classes' or 'sessions' as an interim means of removing the stigma associated with existing pregnancy and parenting classes of being teacher/student/classroom oriented.

4. Ngā Tikanga Mahitahi – Engagement Principles

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Te Tiriti O Waitangi
The Treaty of Waitangi

Māori have a long history of maintaining the health of populations through concepts and practices such as tapu, noa and rāhui, protecting the water supplies, food sources and safety of whānau.[6] Māori public health is action premised on improving the health of the whole Māori population. It is driven by the right to health as Indigenous peoples and Treaty partners, and takes account of the disproportionate health needs of Māori.[7]

The Treaty of Waitangi is the founding document of New Zealand and describes the special relationship between Māori and the Crown. The Treaty relationship is based on the principles of partnership, participation and protection, which in the context of health are understood as follows:

- **Partnership:** working together with iwi, hapū and whānau and Māori communities to develop strategies for Māori health gains including appropriate health and disability services.
- **Participation:** involving Māori at all levels of the sector in decision making, planning, development and delivery of health and disability services.
- **Protection:** working to ensure that Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

The Treaty allows for Māori to be able to define and provide for their own health priorities, and to improve their capacity to develop and deliver services for their own communities (tino rangatiratanga).

Māori service provision was conceived at a time of significant and continuous structural and policy change within the health sector of New Zealand. Those changes provided both opportunities and threats for Māori, who were keen to engage as providers of services to their own communities. Therefore, although Māori were cautious as to the effects of the 'health reforms' and the contestable environment that had been created, they embraced the chance to develop and deliver 'Kaupapa Māori' services. Despite a number of health sector structural and policy iterations since inception, we are still faced with the challenges of lack of Māori engagement in health services.

5. He Horopaki – Context

Māori health must be understood in the context of the social, cultural and economic position of Māori in the present day, combined with acknowledgement of the legacies and consequences of our inherited past. Health status cannot be separated from broader societal changes and requires an understanding of 'philosophical and cultural parameters, an appreciation of social and economic positions, and the ability to plait together the many strands that influence health'.[8] Central to the notion of Māori health development is Māori control and self-determination. This assumes that Māori will both control and lead in the determination of strategies appropriate to the wider economic and social arenas as well as the health sector itself.

Although there is no single measure of Māori health status, correlations between socioeconomic, cultural, mortality and morbidity data can be made to give approximations of the Māori position. Advances in Māori health can be directly attributable to strong Māori leadership; however, we are still faced with relatively small numbers who make up the Māori health workforce, particularly in maternal health. For example, only 5.2% of midwives are Māori, even though they make up 15% of the population (Table 1).[9] Similarly, the percentage of Māori doctors is 2.9% and nurses 6.6%.[10] Māori midwives are in demand, particularly in rural areas, where anecdotal reports suggest workloads are rising because of the increasing expectations of whānau.[11]

Table 1. Midwifery workforce statistics, 2013[12]

Midwifery workforce*								
Size	**Age 50+**	**Gender split**		**Ethnicity^**		**Workplace#**		**Qualified outside New Zealand**
3,072	42.4%	Female	99.8%	European	88.9%	DHB employed	54%	34%
		Male	0.2%	Māori	5.2%	Self-employed LMC	32%	

** Annual practising certificates, 31 March 2013, and the Midwifery Council's September 2012 survey.*
^ This figure relates to primary identified ethnicity.
 # Main place of employment.

Throughout the past century and to the present time, Māori have responded creatively to a range of challenges that have beset them. A fundamental and consistent feature of the Māori response has been resistance to attempts at assimilation in favour of asserting a distinctive Māori identity and demanding a greater measure of self-determination. Māori self-determination is about the advancement of Māori people as Māori, and the protection of the environment and whakapapa for future generations.[13]

I always call on my whānau. I told my mum that I needed her to come over so she came over, you know, when I was giving birth.

You click a lot more with the people who are closest in age with you. You're not going to talk to a 40 year old going through pregnancy. You're just not doing that.

In summary, Māori models have been developed as a pragmatic response to cement the provision of services for Māori. Working in an integrative and collaborative way with Māori to enable and increase Māori engagement has to be the way forward. Māori programmes or programmes designed to engage Māori have to be designed and delivered by Māori for Māori in culturally appropriate ways.

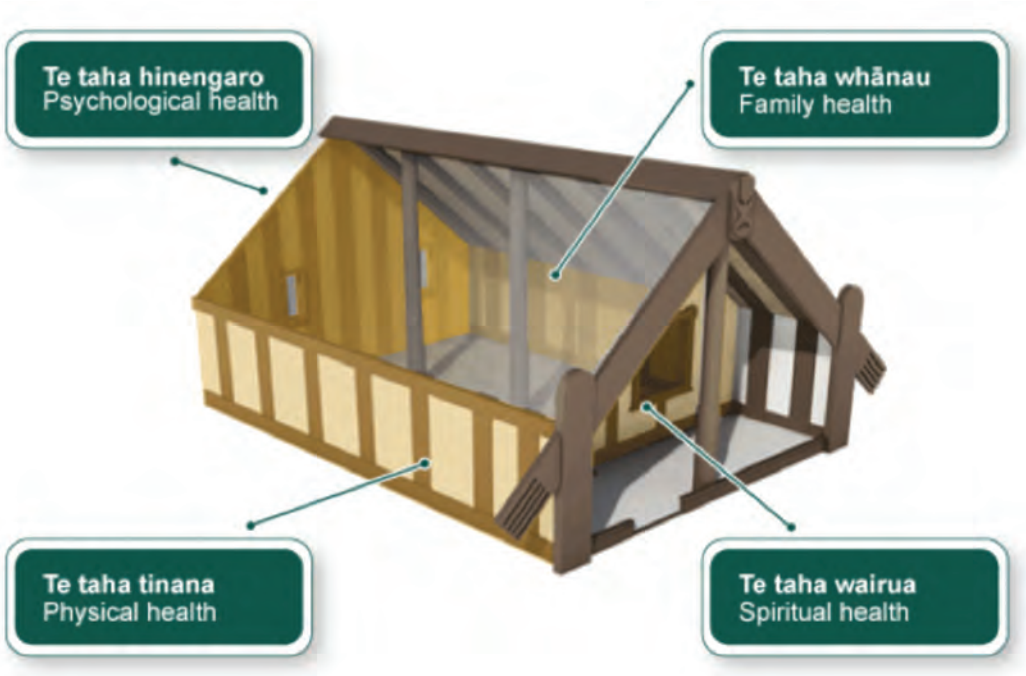
I like a wānanga at a marae. Something that, I guess the biggest part culturally is talk about how Papatūānuku and Ranginui gave birth and it's in myths and legends that created our world that we live in today.

a) Te Whare Tapa Whā

Developed by Dr Mason Durie in 1982, Te Whare Tapa Whā (Durie, 1998) is an Indigenous model of Māori health and is the overall model used to develop this curriculum and resources. For many Māori, modern health services lack recognition of taha wairua (the spiritual dimension). In a traditional Māori approach, the inclusion of the wairua, the ihi of the birth, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness.

Refer to Mai te Wheiao ki te Ao Mārama (Māori module – Module 1a) for an in-depth discussion about the application of Te Whare Tapa Whā to the mother, father, whānau and other carers.

Figure 1. Te Whare Tapa Whā (Durie, 1988).



b) *Tūranga Kaupapa*

In 2006, a set of health principles and values considered culturally appropriate for Māori was developed by Ngā Maia Māori midwives. This set of health principles and values support the standards for practice in the *Midwives Handbook for Practice* issued by the New Zealand College of Midwives (NZCOM, 2008) and the Council's competencies for entry to the register of midwives (Midwifery Council of New Zealand, 2007).

The Tūranga Kaupapa are:

- Whakapapa (genealogy by ancestral connection): The wahine (woman) and her whānau (family) are acknowledged.
- Karakia (prayer): The wahine and her whānau may use karakia (prayers).
- Whānaungatanga (extended family): The wahine and her whānau may involve others in her birthing programme.
- Te Reo Māori (Māori Language): The wahine and her whānau may speak Te Reo Māori.
- Mana (authority and control that encompasses honour, dignity and respect in the way it is exercised): The dignity of the wahine, her whānau, the midwife and others involved is maintained.
- Hau Ora (holistic wellbeing): The physical, spiritual, emotional and mental wellbeing of the wahine and her whānau are promoted and maintained.
- Tikanga Whenua (manners, beliefs, practices, customs pertaining to land/placenta): The continuous relationship to land, life and nourishment is maintained, and the knowledge and support of kaumātua (respected elder) and whānau are available.
- Te Whare Tangata (the house of the people): The wahine is acknowledged, protected, nurtured and respected as te whare tangata.
- Mokopuna (child): The mokopuna is unique, is cared for and inherits the future, a healthy environment, wai ū (breast milk) and whānau.
- Manaakitanga (obligation to offer appropriate hospitality, consideration for others): The midwife is a key person with a clear role who shares with the wahine and her whānau the goal of a safe, healthy, birthing outcome.

Tūranga Kaupapa is a tool that supports the knowledge of midwives who work alongside Māori whānau to consider aspects of their own cultural norms in relation to Māori and thus be open to the wishes of whānau by exploring the ways that they can retain their customs during pregnancy and childbirth within the wider culture of health provision.[14]

c) *Cultural Awareness and Competence*

Cultural Awareness

Cultural awareness means the process of conducting self-examination of one's own biases towards other cultures, which involves in-depth exploration of one's cultural and professional background. It also means being aware of documented ethnic discrimination in health care delivery.[15]

Cultural Competence

Cultural competence means the ability to understand and appropriately apply cultural values and practices that underpin one's worldviews and perspectives on health.[16]

Values and Their Role in Prevention

The values and belief systems of social and cultural groups determine:

- how and what you think
- your attitudes and behaviour
- ways of looking at the world
- institutions and the way systems operate
- what you treasure and consider important.

The engagement principles as outlined within this section (Te Whare Tapa Whā, Tūranga Kaupapa, and cultural awareness and competence) are essential components of care as they explicitly demand that health professionals and other workers acknowledge gender, cultural, ethnic and social contents of groups and individuals that are different from their own. The principles provide a process whereby individuals can work effectively across different cultural settings, by acknowledging, understanding and validating that other people have their own worldview.

6. He Kāhui Mahi Kounga – Quality Workforce

The array of skills required to provide effective care and health promotion within changing contexts and to adequately engage peoples of all ages, ethnicities and localities is vast. Influencing and advocating for capacity building to grow the Māori, Pacific and other ethnic minorities workforce in midwifery and pregnancy and parenting education, as well as providing training for all existing health professionals and students to build their capability in working with different ethnicities are essential workforce development activities. Health professionals should feel confident to call upon, or to refer to, other health professionals who may assist with engagement. Although the numbers of Māori and Pacific childbirth educators are unknown, but undoubtedly low, partnership models help to provide a full set of services that cannot always be expected from one person.

7. Ngā Kaiako/ Kaiwhakahaere/ Kaiwaewae – Educators / Course Facilitators / The Messenger

The Ministry of Health National Service Specification for Pregnancy and Parenting Education of July 2014 requires educators and course facilitators:

- to have knowledge, skills and experience in the maternity and early childhood areas
- to have completed or be working towards a recognised qualification in childbirth education
- to have completed or be working towards a recognised qualification in adult education or childbirth education or have a demonstrated ability to facilitate group education
- to meet and maintain the required competencies
- to have strong links with the communities of the parents and other service providers within these communities.

Training and professional development must be provided to enable educators and facilitators to maintain the required competencies.

The specifications also state that each programme will ideally be co-ordinated by one person (the educator or facilitator). Guest speakers, other parents and pregnancy and parenting experts will also contribute as appropriate.

While the above facilitator requirements are important, participants from the six focus groups conducted also felt the following were key for facilitators:

- Culturally and age appropriate – for young people and for Māori, having someone that was able to engage and understand them at a cultural level was important, particularly when expressing traditional worldviews about pregnancy and parenting.
- Being relatable – if facilitators are working with a young group of people, or Māori, their experiences and age need to reflect this.
- Interactive – facilitators need to be active and not just teach information. It is important to be creative and keep the content alive.
- Simple – participants want simple information; however, they do not want to have this dumbed down.

Good teaching is more of giving of right questions than giving of right answers.

— Josef Albers —

a) A Two-Person Buddy Approach

A two-person buddy approach is recommended because it is difficult to find one person that meets all of the necessary requirements to make an excellent facilitator. The standard practice with community health education is to have two people lead meetings – one to provide the technical information and the other to act as a cultural liaison person. This approach provides the benefits of bringing together a set of skills, provides a wider breadth of experiences and perspectives to draw on and provides more individual one-on-one time to assist with effective engagement with the pregnant woman and her family members. It also enables facilitators to assess and reflect on their roles and jobs with other individuals.

b) Cultural Facilitator / Buddy

Either the childbirth educator / midwife delivering the course or the 'buddy' to the person co-ordinating the course can act as the facilitator, or they can take turns to deliver portions of the programme.

The array of skills required of a facilitator (or facilitators for buddy system) is vast but also essential to the success of the programme. In addition to the Ministry of Health competencies for educators/facilitators, essential facilitator traits include the following.

Training, Skills and Knowledge

- preferably is of the same ethnicity of the group OR has a strong understanding of best practice engagement with the ethnic group
- preferably is fluent in their language when an ethnic-specific group has been targeted
- has good technical base knowledge of maternal and infant health
- has good life skills and understanding of 'lived realities' of whānau with different ethnicities
- engages well with young parents
- has local knowledge and connections
- is skilled in time management and working to deadlines
- has the ability to create a feeling of safety and security for participants
- is connected to and able to find guest speakers when required, including someone to host or facilitate a fathers/partners session
- has proven computer skills in the Microsoft Office Suite and PowerPoint
- is familiar with technological advances, e.g. cell phone application use
- is familiar with diverse worldviews relating to pregnancy and parenting.

Personal Qualities

- is trustworthy and reliable
- preferably is savvy and charismatic in delivery of sessions
- shows and earns respect
- is available and accessible
- is enthusiastic and hardworking
- is adaptable and flexible
- shows initiative and is self-motivated
- has empathy, is passionate and is committed to pregnant women, infants, fathers/partners and their whānau
- uses humour often and appropriately
- has strong interpersonal communication skills and easily relates to others
- creates a feeling of safety and security
- is creative
- is relatable
- is reflective and aware of their own practice and willing to engage with feedback.

8. Te Hunga e Whāia Ana mō te PPIEC – PPIEC Target Audience

The target audience of the PPIEC is childbirth educators, midwives and any health care professionals including district health board staff working with pregnant women, infants and family. Childbirth educators, facilitators and co-ordinators need to focus on the engagement and delivery of PPIEC to pregnant women, fathers/partners and whānau.

Women most at risk, such as those who are Māori, Pacific, young and/or of low socioeconomic background, are of particular interest and should be a focus for the childbirth educators engaging and delivering this PPIEC.

Those most at risk may need to be targeted differently because the current form of pregnancy and parenting education classes doesn't appear to be working. The easiest way to access this at risk group is through existing health avenues, such as marae, church groups and home visits by midwives. In a programme currently piloted at South Seas Healthcare in which women who have positive pregnancy tests are directly referred to an LMC who follows up with the pregnant woman, the LMC is the best avenue to promote the PPIEC. Advertising and key messages should be promoted through multiple avenues all at once.

Ideally, engagement with the mother and her whānau would start as early as possible during her pregnancy. However, it is a reality that many mothers will not engage with childbirth education until much later in their pregnancy.

Targeting and engagement can include outreach programmes that are delivered where the pregnant mother lives, and ensuring the entire whānau participates where possible, with appropriate techniques and tools being utilised for maximum exposure.

Table 2. The Pregnancy and Parenting Curriculum Summary

This table provides a summary of the target groups, locations, mechanisms and key messages for each module.

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 1: **Hapūtanga – Ka Aha Ināianei?** Module 1 **Pregnancy – Now What?**	All pregnant mothers, fathers/ partners, whānau and other carers	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau.	• Pregnancy entitlements • Coping with life changes • Coping with physical changes • Managing relationships • Care options & what they mean
Mai te Wheiao ki te Ao Mārama **Module 1a Māori**	All pregnant mothers, fathers/ partners who identify as Māori; whānau and other carers	Marae, colleges, tertiary education providers, work places, churches and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and Primary Health care nurses, Church, Multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Celebrating being hapū • Acknowledging the importance of whakapapa and ensuring holistic wellbeing for themselves and their pēpi • Te whare tangata • Fathers/partners and whānau manaaki and their role in supporting te wahine hapū • Tāne Māori and te whakawhānau pēpi • Pregnancy entitlements
Te Hapūtanga o te Taitamawahine **Module 1b Teenage Pregnancy**	All pregnant mothers and fathers/partners who identify as a teen parent; whānau and other carers	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Supportive environments for pregnant teens • Pregnancy entitlements

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 2: **Hapūtanga Hauora** Module 2: **Healthy Pregnancy**	All pregnant women	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Healthy eating and safe food preparation during pregnancy • Appropriate exercise during pregnancy • Avoiding smoking (including passive), alcohol and drugs • Creating smoke-free environment
	Fathers/partners, whānau and other carers	Sports clubs, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Healthy eating and safe food preparation during pregnancy • Appropriate exercise during pregnancy • Avoiding smoking (including passive), alcohol and drugs • Creating smoke-free environment • The role of support people
	Children	Schools, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Schools	• Healthy eating and safe food preparation during pregnancy • Appropriate exercise during pregnancy • Avoiding smoking (including passive), alcohol and drugs • Creating smoke-free environment • The role of supporting people

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 3: **Tauwhirotia te Hapūtanga** Module 3: **Pregnancy Care**	All pregnant mothers, fathers/ partners, whānau and other carers	Colleges, tertiary education providers, work places, church, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• How to identify warning signs and what to do • The importance of regular checks • Medical conditions that can arise during pregnancy

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 4: **Whakamamae me te Whānautanga** Module 4: **Labour & Birth**	All pregnant women	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Being familiar with the signs and stages of a normal labour • Being familiar with pain management and birthing options • Being familiar with common complications of labour and birth and possible interventions
	Fathers/partners, whānau and other carers	Sports clubs, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Church and/ or multi-media interaction and promotion including the Internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• The role of the support person • Being familiar with the hospital and how to get to the maternity ward • Being familiar with the signs and stages of labour • Being familiar with pain management and birthing options • Being familiar with common complications of labour and birth and possible interventions

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 5: **Ngā Rā Tōmua** Module 5: **Early Days**	All pregnant women	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Awareness of common discomfort • Understanding physical and emotional changes • Where and how to get support • What to expect in the early days • Early parenting skills and strategies
	Fathers/partners, whānau and other carers	Sports clubs, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• Identifying a mother's physical and emotional changes and the support she may need • What to expect in the early days • Awareness of personal feelings due to relationship changes, the birth experience and their new role as a father and knowing where and how to get support • Early parenting skills and strategies
	Children	Sports clubs, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Schools	• Mother's physical and emotional changes and the support she may need • What to expect in the early days

Content	Target Groups	Target Locations	Advertising Mechanisms	Key Messages
Wāhanga 6: **Whāngai Ū me te Haumarutanga o te Moe** Module 6: **Safe Sleep & Breastfeeding**	All pregnant women	Colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units and social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• The benefits of breastfeeding • The importance of exclusive breastfeeding for the first six months, good breast and nipple care • How to identify the signs baby is hungry and getting enough • Safe sleep practice using PEPE • Infant nutrition – the signs for when to start solids (from six months), what type of food to start with, what amount to give, how to prepare it, when and how to feed baby safely
	Fathers/partners, whānau and other carers	Sports clubs, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Links and referrals from LMCs, GPs, community and primary health care nurses, churches, multi-media interaction and promotion including the internet (Facebook, Twitter, Instagram, mobile phone application), TV, radio and whānau	• The benefits of breastfeeding • The importance of exclusive breastfeeding for the first six months, good breast and nipple care • How to identify the signs baby is hungry and getting enough • Safe sleep practice using PEPE • Infant nutrition – the signs for when to start solids (from six months), what type of food to start with, what amount to give, how to prepare it, when and how to feed baby safely.
	Children	Schools, colleges, tertiary education providers, work places, churches, marae, community clinics, centres and halls, teen parent units, social service hubs	Schools	• Benefits of breastfeeding • Safe sleep practice using PEPE

9. Te Kiko me te Roanga o Ngā Akoranga – Content & Timing

Table 3 provides guidance on how the pregnancy and parenting programme could be delivered such as the timing of each session (e.g. which trimester the session is held in) and the length of the programme (e.g. six weeks). The length and content of each session will be determined by the facilitator and will be tailored to participants' needs. In determining a pregnant woman's needs, the educator should prioritise and/or indicate which modules are most relevant to them based on their individual pregnancy requirements.

For example, for the majority of pregnant woman who don't smoke or drink and are aware of the need for a smoke-free environment, this portion of Module 2 should be summarised quickly and the educator can move on to the next topic. Further, the educator may want to consider combining Modules 1 and 2 as Module 1 covers pregnancy basics and entitlements, which may not take long depending on the group.

A two-hour time frame is a guide for the length of time required to deliver the content of each module. Additional time should be provided for discussion and networking opportunities where and if necessary.

Depending on the group, Module 1a (Māori) and Module 1b (Teen) provide ethnic- and age-specific information that can be weaved throughout Modules 1–6 within each trimester of pregnancy. For Pacific women, fathers/partners, whānau and other carers, refer to the *Tapuaki* pregnancy and parenting education curriculum.

What we recieve is information,
What we preserve is knowledge,
What we use is intellegence,
But what, when and how it is wisdom!

Table 3. PPIEC Timing Guidelines

Content	1st trimester (0–12 weeks)	2nd trimester (13–27 weeks)	3rd trimester (28–42 weeks)
Module 1	✔ (1 hr) Plus additional questions/ support session (x 1 hr)		
Module 1a – Māori	Information to be woven through all modules	Information to be woven through all modules	Information to be woven through all modules
Module 1b – Teen	Information to be woven through all modules	Information to be woven through all modules	Information to be woven through all modules
Module 2	✔ Alcohol & tobacco (1 hr) ✔ Eating healthily and exercise (1 hr)		
Module 3		✔ (1 hr) Plus additional questions/ support session (x 1 hr)	
Module 4		✔ (1 hr x 2)	
Module 5			✔ (1 hr x 2)[2]
Module 6			✔ Breastfeeding (1 hr) and safe sleep and final party session (x 1 hr)
TOTAL HOURS	**4**	**4**	**4**
ALTERNATIVE Block Course Modules 1–6		12 hr over 2 or 3 days	
Block, one-off or drop in education sessions on individual topics/modules	Details outlined in the DHB service plan and agreed between the education service provider and funder.		

[2]*The second session is in addition to delivery techniques outlined in Module 1. It is recommended that a separate fathers/partners/ male session be held specifically targeted at fathers/partners. The session should be held by a father role model at a suitable, comfortable location (e.g. a sports club). The aim of this session is to discuss the additional stress and financial pressure that will be placed on the father/partner once the baby is born and coping mechanisms and techniques.*

10. Preparation

In preparation for delivering the pregnancy and parenting sessions, the following seven steps are recommended.

Step 1. *Undergo PPIEC training designed for health professionals.*

Training consists of three parts – the initial training and then a follow-up survey and refresher training.

PPIEC Training

Attendance at a PPIEC training session is recommended. The training is designed for pregnancy and parenting facilitators, midwives and all health care professionals, including DHB staff working with pregnant women, fathers/partners, babies and whānau.

The training involves a one-day workshop and one-hour online training programme that:

- provides a general overview of maternal and infant health in New Zealand
- discusses the importance of understanding cultural/social beliefs and how they impact on pregnancy and parenting behaviours (including reflecting on one's own beliefs and assumptions)
- gives advice on effective health promotion and engaging with whānau
- summarises the Pregnancy and Parenting Information and Education Curriculum
- provides access to resources.

Follow-Up Survey

It is recommended that a follow-up survey be completed six months after the train-the-trainer course has been undertaken to check how health professionals and child birth educators are progressing and to see how key messages have been applied.

Refresher Course for Facilitators

A refresher course should be offered one to two years following the initial training to provide an update on information and key messages.

Step 2. *Identify the participants.*

Pregnancy and parenting facilitators should determine who the target group will be by considering the following criteria:

1. Age – for example, young mothers.
2. Language – will the class be held in a particular language? Māori, Pacific or other minority ethnic group? If most attendees are from one ethnic group, then an ethnic-specific speaker will be preferred.
3. Background/potential common groupings – gender, ethnicity, women and whānau from the same church or doctors, women from the same extended family, friends, women who live in the same area?

The most successful groups are whānau/extended groups, friends or a homogenous group of women (e.g. women of the same age, stage of life, e.g. young, Māori women) to facilitate the growth of friendships and social support networks.

Step 3. *Find a suitable location, date and time.*

Once the target group is selected, the facilitator, using local knowledge and connections or assistance from local LMCs, will identify a suitable venue for the forums.

The venue does not need to be the same for each meeting.

The Ministry of Health (MOH) National Service Specification for Pregnancy and Parenting Education (2014) provides the following guidance for the location of a group meeting: in an appropriate community-based venue, such as youth hubs, teen parent units, social service hubs, marae, churches, community clinics or halls, and so on.

The venue should also meet the following criteria:

- be easily accessible (within walking distance, e.g. 2.5 km radius or accessible through public transport)
- be located in the community, local, popular and in or near a location that is used frequently, preferably with or near playgrounds or crèches for other children to use
- have a relaxed and inviting safe atmosphere
- allow for privacy, for example, have a door that closes
- be comfortable, with chairs and tables for food
- have safe and easily accessible toilets within the facilities
- preferably have a kitchen or sink space with a kettle or zip.

Potential locations other than those listed in the MOH pregnancy and parenting specifications of 2014 include Well Child/Tamariki Ora provider rooms, libraries, child-friendly places for pregnant women with children. If targeting a family group, then a family member's home could be best.

The day and time of the workshop will need to be carefully chosen; after school and early evening would suit most students and employees.

The content is likely to take an hour to deliver; however, additional time should be programmed for whakawhanaungatanga (relationship building) and discussion.

Step 4. *Contact general practices, midwives, nurses and colleges with antenatal education workshop information.*

Prior to the start of the delivery of the PPIEC, the following organisations and clinicians need to be contacted in each district health board:

- general practices
- midwives
- primary health care nurses at the grassroots level, parish nurses (where relevant)
- colleges (particularly those with separate mother and infant areas or classes).

The facilitators will also be able to utilise their existing local networks.

Service Linkages

The following organisations are listed in the MOH pregnancy and parenting service specifications as education providers where facilitators would need to have relationships within the area.

They include:

- lead maternity carers (LMCs) and other local health care providers including Well Child/Tamariki Ora (WCTO) nurses, general practitioners (GPs) and practice nurses, nurse practitioners, primary health organisations (PHOs), public health nurses, Māori health providers, Pacific peoples health providers
- teen parent units, family centres such as Plunket
- local providers of social and community services, such as local schools, non-government organisation (NGO) social service providers, and the Ministry of Social Development and Child and Youth and Family
- local maternity facilities, neonatal and paediatric units
- physiotherapists
- public health unit activities and other public health programmes for well child health, Māori health promotion, parenting, nutrition, immunisation and sudden unexpected death in infancy (SUDI)
- smoking cessation service providers
- prevention of family violence service providers and networks
- relationship service providers
- housing and social services organisations and services, including Family Start
- specialist health and mental health services, particularly perinatal mental health services
- primary and community mental health service providers
- providers of evidence-based parenting education programmes for older children in the family (Triple P and Incredible Years)
- community oral health and dental outpatient services
- other relevant NGO, Māori and Pacific service providers
- other Whānau Ora programme providers.

Through relationships with these organisations, facilitators will make them aware of the pregnancy and parenting sessions schedule so that they can refer pregnant women to them and encourage early contact.

Step 5. *Advertise.*

Word of mouth, email groups and referrals are the most effective means of advertising. Encourage each pregnant attendee to bring along another pregnant person to the next session. Family members, support people and other children are welcome and essential.

Health professionals (primary health care nurses at the grassroots level of the community) looking after pregnant women are another significant source of referrals.

Social media advertising, such as Facebook, Twitter, mobile phone application, and radio advertising are recommended. Provide opportunities for online registration. Ideally, to target the relevant audiences, advertising should occur in marae, colleges and tertiary education providers (flyers can be pinned to student health centre notice boards) (for young women) and at churches.

Step 6. *Get people to the venue.*

Where possible, offer free transport or petrol vouchers to those who will benefit significantly from transport assistance. If the venue is local and accessible through public transport (bus) or walking, this won't be necessary. For those who work within a PHO, there may be 'transport to care' funding available for pregnant women to use a taxi to get to the sessions.

Step 7. *Utilise resources.*

There are many resources that exist in different languages, including Māori, various Pacific languages and other minority ethnic groups. It is strongly recommended that these are sought out and utilised.

Teaching materials in different languages are also beneficial and should be developed.

11. Quality Requirements

The MOH pregnancy and parenting service specifications require the education service to comply with the provider quality standards described in the *Operational Policy Framework* or, as applicable, Crown Funding Agreement variations, contracts or service level agreements. Section 28 of the Ministry of Health pregnancy and parenting specifications contains access and acceptability quality requirements for the education component.

III. He Tūāpapa – Background

The following information provides context for the childbirth educators/facilitators in delivering this curriculum. Some of the statistics will assist in supporting the key messages highlighted in the modules.

1. Pregnant Women in New Zealand

New Zealand's population (4.2 million according to the 2013 Census) is made up of approximately 3 million Europeans (74%), 600,000 Māori (15%), 470,000 Asians (12%), 300,000 Pacific (7%), 47,000 Middle Eastern, Latin American and African (1.2%) and 68,000 other ethnicity (1.7%).[3]

In 2013, there were approximately 59,227 women recorded as giving birth in New Zealand (Table 4).[17] This number remained stable throughout 1996–2013. Of the women giving birth in 2013:

- More than half were between the ages of 25 and 34 years.
- Almost half were European and about a quarter were Māori.
- The median age for Māori and Pacific women giving birth was five years younger than for Asian and European women.
- Over a quarter resided in the most deprived areas.
- Māori and Pacific women giving birth had a lower median age in comparison with Asian and European women by five years.

Table 4. Number of women giving birth and maternal age by ethnicity for 2013[18]

	n	Mean (years)	Median (years)	Mode (years)	Standard deviation (years)	Range (min to max)
Māori	14,619	26.5	25	22.0	6.32	13–56
Pacific	6,407	28.1	28	28.0	6.26	14–53
Asian	8,190	30.7	30.0	30.0	4.74	15–59
European/Others	29,974	30.6	31.0	32.0	5.77	11–55
All (combined)	59,227*	29.3	29.0	31.0	6.12	11–59

** Includes a small number of missing values for ethnicity (data not shown).*

[3]*Note that these numbers and percentages add to more than 100% as people could choose more than one ethnicity.*

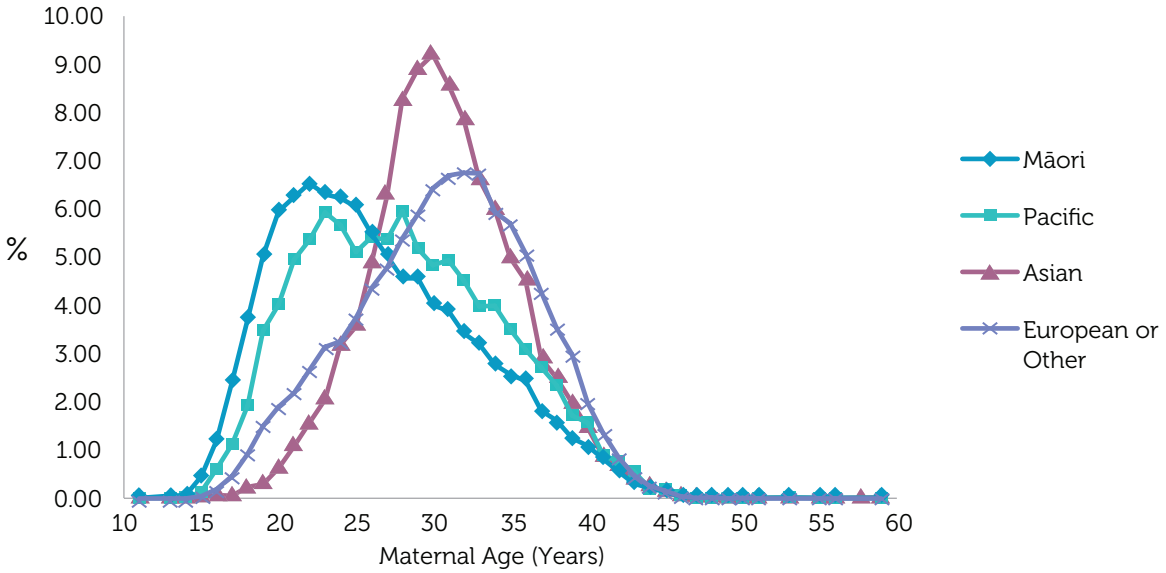
1.1 *Maternal Age*

The median age of women giving birth in 2013 was 28 years, and more than half of the women giving birth in 2013 were either in the 25–29 years or the 30–34 years age groups (25.7% and 28.2%, respectively).[19]

Figure 1 shows the number of women giving birth by their ethnic group in New Zealand in 2013. Māori and Pacific women tended to give birth younger (median age of giving birth: 25 and 28 years, respectively), whereas women of European and Asian/Indian ethnicity tended to give birth slightly later, at around 30 and 31 years, respectively.

Pacific and Māori women had higher overall birth rates and gave birth over a wider age range than Europeans or Asians, as shown in Figure 1. A higher proportion of Māori gave birth under 20 years of age than any other ethnic group.

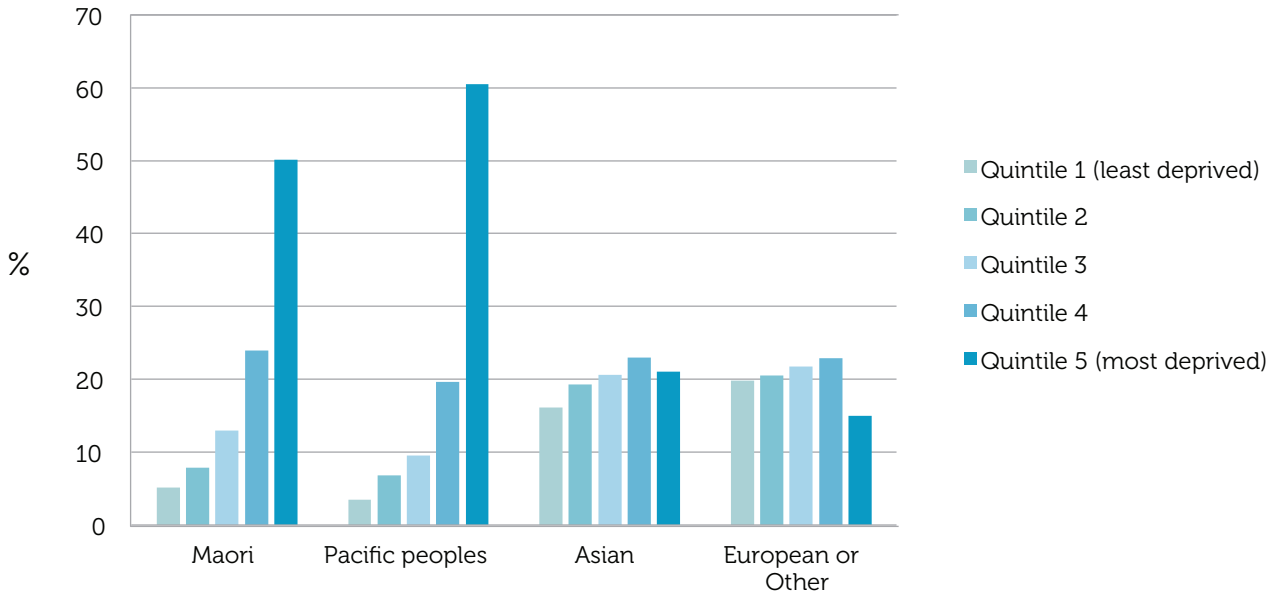
Figure 1. Percentage of women giving birth for each ethnic group, by age group, 2013[20]



1.2 *Maternal Deprivation*

Half the women giving birth resided in the more deprived areas (i.e. quintiles 4 or 5 of the 2006 New Zealand Deprivation Index). Less than 15% of women giving birth came from the least deprived area (quintile 1).

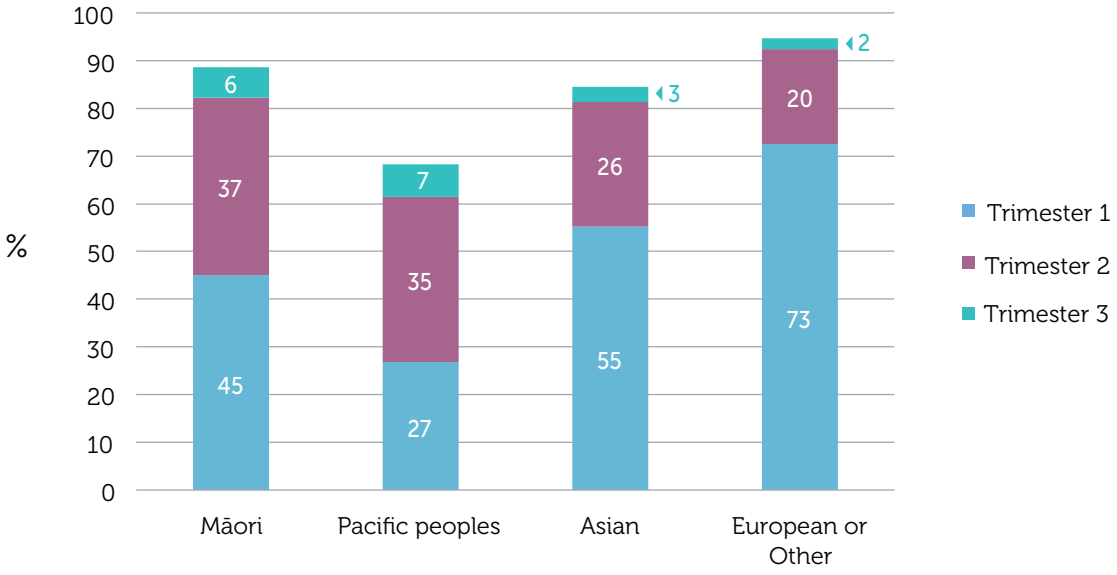
Figure 2. Percentage of women giving birth, by deprivation quintile of residence and ethnic group for 2013



1.3 *Registered with a Lead Maternity Carer*

Most women had received care from a lead maternity carer (LMC), the majority of whom were midwives. Over half had received care in the first trimester of their pregnancy, and this statistic increased across all district health boards in 2012 compared with 2008.[21] Although the majority of women gave birth in a secondary or tertiary setting (87%), a small number of women had a home birth (3%) and this was more common among women in the 30–39 years age group, Māori and European women, and women residing in the West Coast DHB region.

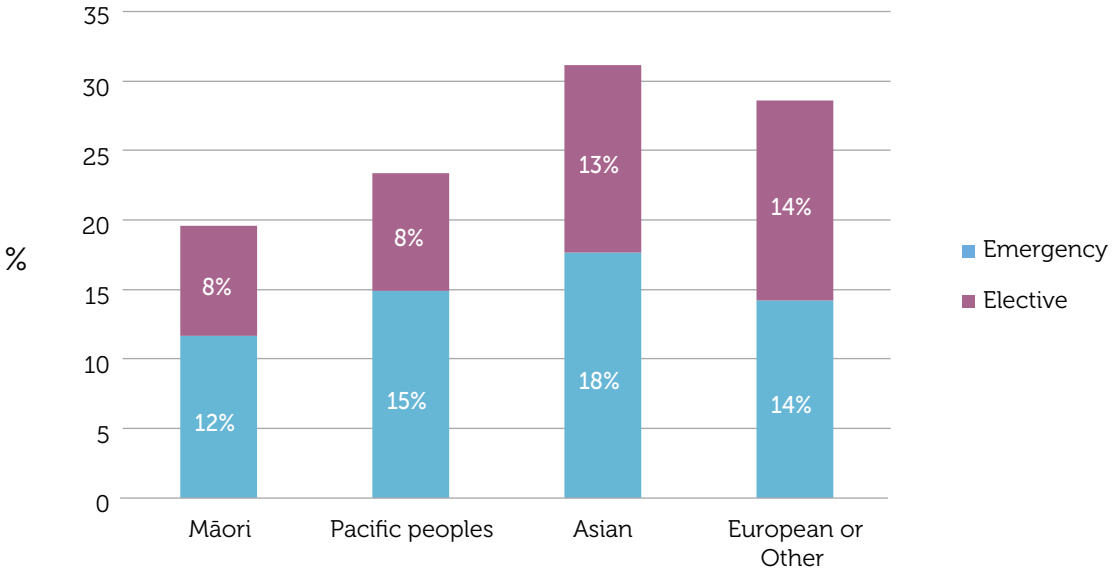
Figure 3. Percentage of women registered with an LMC, by trimester of registration and ethnic group for 2013



1.4 *Type of Birth*

Spontaneous vaginal births continue to be prevalent among two-thirds of women giving birth. Between 2003 and 2012, there was an increase in the number of women having elective caesarean sections.[22] Women who had a higher proportion of caesarean sections were aged 35 years or more, in the Asian or the European or Other ethnic groups and residing in the least deprived areas. Māori women had the lowest total of percentage of caesarean sections (20%) and lowest percentage of emergency caesarean sections (12%) compared with non-Māori ethnic groups.

Figure 4. Percentage of caesarean sections, by type of caesarean section and ethnic group, 2013



1.4.1 Interventions at Birth

About a quarter of all New Zealand women giving birth have an induction, their labour augmented or an epidural each year. A smaller proportion have an episiotomy. Of the four interventions, an epidural was most common in 2013 (27% of women giving birth), followed by augmentation (27%), induction (24%) and episiotomy (13%). Māori women were less likely to have an induction, epidural or episiotomy compared with other ethnic groups.[23]

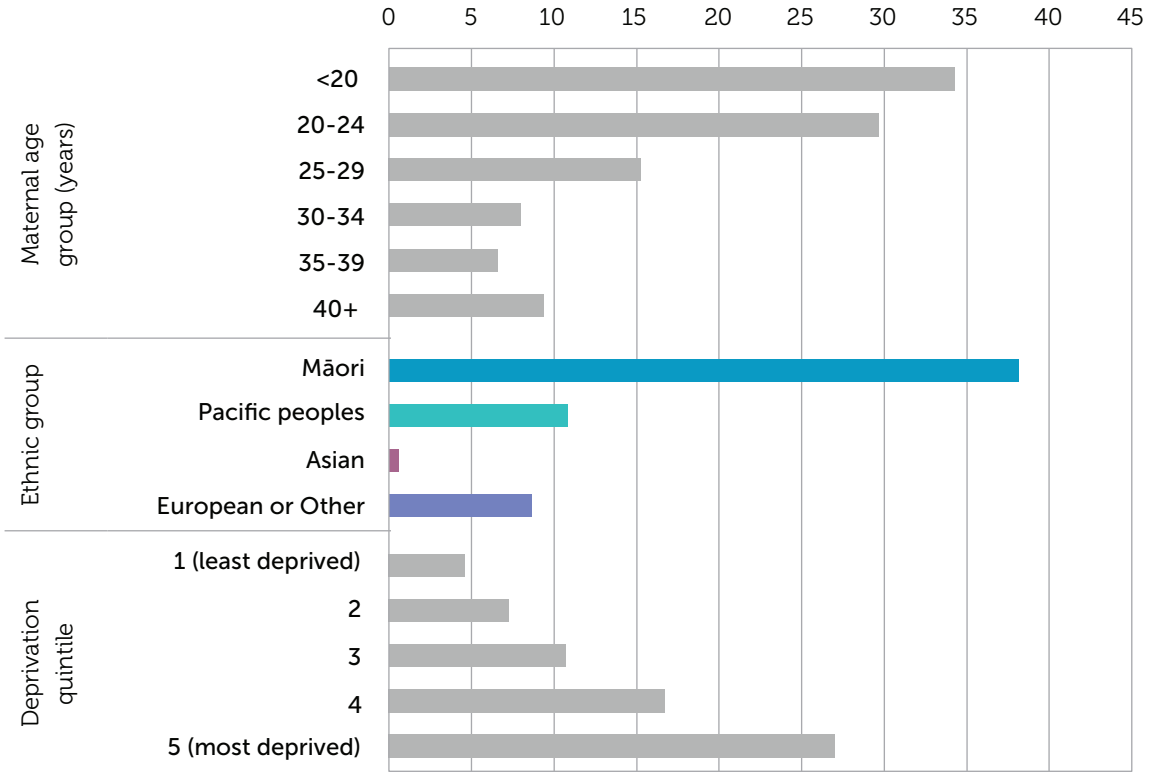
Figure 5. Percentage of obstetric interventions, by type of intervention and ethnic group, 2013

Women undergoing intervention						
	Induction	Augmentation	Epidural	Episiotomy	Women giving birth, excluding elective caesarean sections	Women giving birth, excluding caesarean sections
Māori	2,665 (20.3)	3,370 (25.7)	2,358 (18.0)	645 (5.6)	13,129	11,466
Pacific peoples	1,495 (26.0)	1,648 (28.7)	1,173 (20.4)	432 (9.0)	5,740	4,805
Asian	1,838 (26.3)	2,235 (32.0)	2,538 (36.3)	1,449 (26.1)	6,991	5,562
European or Other	6,463 (25.6)	6,439 (25.5)	7,750 (30.6)	3,178 (15.1)	25,290	21,084

1.5 *Tobacco Smoking and Pregnant Women*

A higher percentage of smokers was identified in younger women (31.8% of women aged under 20 years) and Māori women (34.0%). The proportion of smokers was also higher for women residing in the most deprived areas (23.6% of those residing in quintile 5) compared with those residing in the least deprived areas (4.0% of women residing in quintile 1).[24]

Figure 6. Percentage of women giving birth identified as smokers at two weeks after birth, by age group, ethnic group and deprivation quintile of residence, 2012.

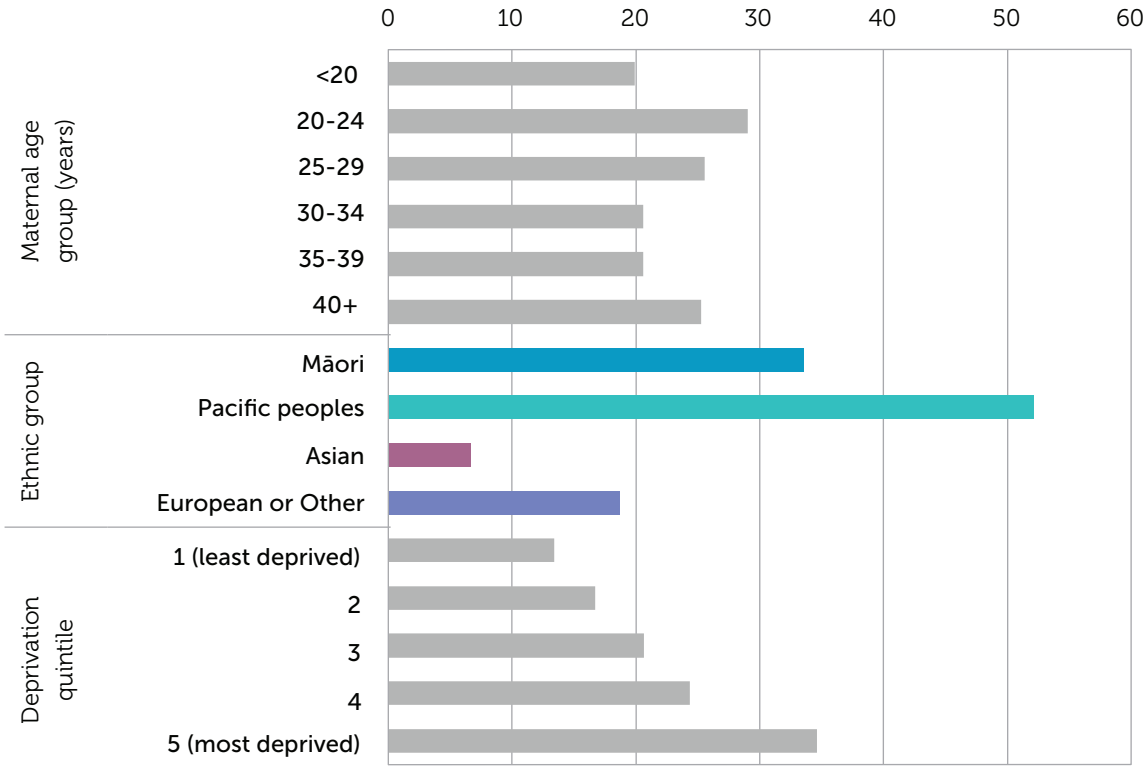


Notes: The denominator used to calculate percentages is the number of women giving birth for that demographic group, excluding those with unknown smoking status.] Smoking status is only available for women registered with a lead maternity carer (LMC).

1.6 *Body Mass Index (BMI)*

The proportion of women with high BMI has been steadily increasing over the past 10 years and is expected to continue rising into the future. The proportion of women identified as obese was highest among Pacific women giving birth (50.0%), followed by Māori women (31.8%). Women residing in the most deprived areas had a higher proportion of obesity compared with women residing in the least deprived areas (32.6% of women residing in quintile 5, compared with 14.7% of women residing in quintile 1). There was little variation in the proportion of obese women giving birth across age groups.[25]

Figure 7. Percentage of women giving birth identified as obese when registering with a lead maternity carer, by age group, ethnic group and deprivation quintile of residence, 2012.



1.7 *Maternal Mortality and Morbidity*

There were 12 maternal deaths in 2013. The maternal mortality ratio in New Zealand for 2011–2013 was 16.8/100,000 maternities, which is one maternal death for every 6,000 babies born at 20 weeks or more. There has been no statistically significant change in the maternal mortality ratio in New Zealand since data collection by the Perinatal Maternal Mortality Review Committee began in 2006.

Key points:

1. Suicide continues to be the leading 'single' cause of maternal death in New Zealand.[24]
2. Pre-existing medical disease, suicide and amniotic fluid embolism were the most frequent causes of maternal mortality in New Zealand in 2006–2013.[24]
3. There were 12 cases of amniotic fluid embolism in New Zealand in 2010–2013, giving a rate of 0.5/10,000 maternities. This is higher than rates reported in the UK and the Netherlands, but is similar to Australia.
4. There were 69 cases of placenta accreta in New Zealand in 2010–2012, giving a rate of 3.6/10,000 maternities. Sixty-five per cent of these women had had a previous caesarean section and 58% required a hysterectomy for treatment.[26]
5. The risk for maternal mortality is higher for women 40 years and older than for younger women.[24]

1.8 *Foetal Deaths*

In 2013, there were 446 foetal deaths (comprising 139 terminations of pregnancy and 307 stillbirths) out of 60,039 births. The national foetal death rate was 7.4 per 1,000 births, which included terminations and stillbirths.[24]

Table 5. Foetal Deaths 2013[24]

Ethnicity	Terminations	Rate per 1,000	Stillbirths	Rate per 1,000 births
Māori	24	1.8	82	6.1
Pacific	9	1.5	45	7.3
Indian	8	3.0	18	6.7
Other Asian	23	3.8	15	2.5
NZ European	58	2.2	121	4.6
Other	17	3.1	26	4.8

In Auckland (in 2009), contributing factors linked to stillbirth were high pre-pregnancy BMI (obesity), hypertension, maternal age, smoking, fewer than four antenatal visits, ethnicity, foetal growth restriction and low socioeconomic status.[25]

Obese women in Auckland were twice as likely as normal weight/underweight women to have a late stillbirth. Women who attended fewer than half of the recommended antenatal visits were almost three times as likely to have a late stillbirth compared with women who accessed the recommended number of visits.[27]

1.9 *Perinatal Deaths*

There were 598 perinatal deaths in 2013 out of 60,039 births, giving a rate of 10 deaths per 1,000 births – the lowest rate since 2007 when the Perinatal and Maternal Mortality Review Committee (PMMRC) first started gathering data.[24]

The overall perinatal-related death rate for Māori, Pacific and Indian mothers is statistically significantly higher than among Other Asian, Other and New Zealand European mothers.[24]

Table 6. Perinatal Deaths 2013[24]

Ethnicity	Perinatal-related deaths	Rate per 1,000 births
Māori	155	11.5
Pacific	83	13.5
Indian	37	13.7
Other Asian	46	7.7
NZ European	230	8.8
Other	47	8.6

The risk factors for perinatal deaths were:

- Congenital abnormality, socioeconomic deprivation, obesity, smoking and alcohol consumption. In addition, barriers to access and/or engagement with care accounted for 16–20% of perinatal-related deaths in 2009–2013.[25]
- Teenage mothers (<20 years) and older mothers (>40 years) had significantly higher risk (or rate) of perinatal deaths than mothers aged 20–40 years. This pattern of risk shows an apparent U curve when graphed with age.[25]
- Although there was an increase in the rate of perinatal death among teen mothers in 2013, one-third fewer teen mothers (3,436) gave birth than in 2007 (5,091).[24,25]
- Young age is not directly associated with perinatal-related death per se, but is indirectly related because young mothers are more likely to be having their first baby, to smoke, to be overweight and to live with socioeconomic deprivation. In contrast, older mothers (>35 years) are at risk because of genetic (chromosomal) abnormalities.[24]
- Māori, Pacific and Indian mothers have higher risks of perinatal deaths than mothers of Other Asian and New Zealand European ethnicity for reasons other than having their first baby, smoking, obesity or socioeconomic deprivation, but it is not known why.[24]

Indian and Asians had the highest rates of death from congenital abnormalities and Māori had the lowest. For chromosomal abnormalities, Asians also had the highest rate and Māori the lowest. Indians had the highest euploid rate and Māori the lowest.

Table 7. Rates of perinatal deaths from congenital abnormality (per 1,000 births) 2007–2011 (terminations included) by maternal prioritised ethnicity

Ethnicity	Total births	Congenital abnormalities (total)		Congenital abnormalities (chromosomal)		Congenital abnormalities (euploid)	
	Number	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000
Māori	74,681	187	2.50	51	0.68	136	1.82
Pacific	34,415	114	3.31	31	0.90	83	2.41
Indian	11,300	47	4.16	10	0.88	37	3.27
Other Asian	23,567	94	3.99	32	1.36	62	2.63
Other/Not stated	28,943	84	2.90	27	0.93	57	1.97
NZ European	149,962	467	3.11	147	0.98	320	2.13

The rate of spontaneous preterm deaths between 2007 and 2011 per 100 births for babies of Māori mothers was 3.56, compared with 2.79 for Pacific, and 1.54 for NZ European.

Table 8. Eclampsia, placenta accreta and peripartum hysterectomy rates (per 10,000 maternities), 2010–2011.[4]

Ethnicity	Total number of births	%	Eclampsia		Placenta accreta		Peripartum hysterectomy	
			Number	Rate	Number	Rate	Number	Rate
Māori	74,681	22.8	5	1.7	10	3.4	10	3.4
Pacific	13,831	10.8	2	1.5	4	2.9	5	3.6
NZ European	149,962	45.5	8	1.4	21	3.6	13	4

1.10 Neonatal Deaths (Less than 28 Days)

There were 152 neonatal deaths in 2013, with a rate of 2.6 per 1,000 live births. This rate had remained unchanged since 2007.[28] Of the 152 deaths,32 (21%) were associated with congenital abnormality. Of the remaining 120, approximately half (63) were born at 20–23 weeks, and 55 of these babies died in the first day of life. All 63 died of complications of extreme prematurity. Fifty-one of these cases were associated with antecedent spontaneous preterm birth and/or antepartum haemorrhage. Progress in preventing these antenatal conditions holds the key to an improvement in neonatal death at early gestations.[26]

Primary causes for neonatal mortality during 2004–2008 in New Zealand were other perinatal conditions, 62 (rate of 131 per 100,000 deaths); extreme prematurity, 43 (rate of 91 per 100,000 deaths); and congenital anomalies: other, 189 (rate of 38 per 100,000 deaths). Research suggests that other factors, including care during pregnancy, access to primary health care and infections, are all identified risk factors for neonatal death.

1.11 Infant Mortalities and Morbidities (Post Neonatal 29 Days to 1 Year) Particularly SUDI and Respiratory Illnesses

There were 36 deaths recorded as sudden unexpected death in infancy (SUDI) in 2012, including 18 sudden infant death syndrome (SIDS) deaths. These SUDI deaths included 22 males and 14 females.

The SUDI rate in 2012 was 0.6 per 1,000 live births, a 40% decrease from the rate of the previous five-year period (2007–2011) of 1.0 per 1,000 live births. *(Fetal and Infant Deaths 2012,* MOH)

Primary causes and environmental contributing factors:[29]

- sleeping baby on their front or side to sleep
- smoking
- alcohol
- lack of breastfeeding
- bed sharing
- sleeping baby on unstable surfaces such as couch or pillow.

2. Pregnant Women in Auckland

Between 1996 and 2012, pregnant women in Auckland identified most with the European ethnicity (48–55%), followed by Pacific (22–24%) and more recently Asian (24%) (Table 9). From 2006, Māori birth rates steadily declined from 3,890 in 2006 to 3,597 in 2012. In 2012, Asian had the biggest growth in births, of around 2%, slightly more than Pacific.

Table 9. The number of pregnant women in Auckland 1996–2012

Year/ Ethnicity	European			Māori			Pacific			Asian			Other		Total	
	Number	% of total	% Change	Number	% of total	% Change	Number	% of total	% Change	Number	% of total	% Change	Number	% of total	% Change	
1996	10,554	55%		3,358	17%		4,274	22%		2,204	11%		609	3%		19,194
2001	10,602	54%	0	3,523	18%	4.9	4,614	24%	8.0	2,714	14%	23.1	314	2%	-48.4	19,533
2006	11,404	53%	8	3,890	18%	10.4	4,769	22%	3.4	3,716	17%	36.9	614	3%	95.5	21,569
2011	11,213	49%	–2	3,675	16%	-5.5	5,499	24%	15.3	5,031	22%	35.4	588	3%	–4.2	22,862
2012	10,948	48%	–2	3,597	16%	-2.1	5,302	23%	-3.6	5,361	24%	6.6	574	3%	–2.4	22,724

With respect to the three district health boards in Auckland, in 2012, Counties Manukau had the largest proportion of Māori and Pacific babies registered, as well as the largest absolute number of Māori (n = 1,961 or 23%) and Pacific (n = 3,035 or 36%) births. This was followed by the Auckland District Health Board. Asians were more likely to give birth in the Auckland DHB, followed by Waitemata and Counties Manukau. More European women gave birth in the Waitemata DHB. Overall, more women gave birth in Counties Manukau than at the other two DHBs.

Table 10. Number of births in Auckland, Counties Manukau and Waitemata District Health Boards in 2012[30]

Ethnicity	Number of Births	% of Births	Number of Births	% of Births	Number of Births	% of Births
	Waitemata		Auckland DHB		Counties Manukau	
Asian/Indian	1,786	23	1,826	29	1,749	21
European	4,917	62	3,123	49	2,908	34
Māori	1,026	13	610	10	1,961	23
Other	207	3	221	3	146	2
Pacific	996	13	1,271	20	3,035	36
Total	**7,871**	**100**	**6,396**	**100**	**8,457**	**100**

[1] *Statistics New Zealand. (2014). Maternity tables.*

3. Women's Pregnancy, Birth Experiences and Babies

From the groups of young Māori women who were interviewed for this curriculum,[31] the positive experiences of whānau and friends played a big role in choosing who they would have as their LMC and where they would give birth. A connection needed to be made, whether it was through a personal link with whānau or through tribal affiliation, as one mother describes below:

I chose it 'cos most of my sisters went there, and they had like good feedback about it when they came out of it. And because I found out in doing research on it that it was given from my actual tribe, the Tainui tribe.

The negative experiences of care during pregnancy and birth discussed by mothers occurred mostly during the labour and birthing process. While they appreciated having a midwife who was culturally aware of their needs and Māori worldviews towards pregnancy and parenting, they also just wanted someone that was able to connect and respect them for who they were, regardless of age and ethnicity:

What was awesome about my midwife was she didn't really understand me being Māori or my needs around being Māori but she was really respectful and she was really. I don't know, I just felt really safe with her. I felt really safe, you know...so we connected on another level...which was interesting. But I think regardless of if you're Māori or not, there must be a connection.

A study that looked at the initiation of maternity care for young Māori women under 20 years of age[32] found that participants often relied on whānau to assist them in determining how, where and who they were going to access to confirm their pregnancy. The participants also based their interactions with health professionals on previous experiences and were unwilling to use services when they perceived that the provider would respond to them poorly.[33] These findings are important as they highlight that maternal provider experiences have a huge impact on health care engagement, even if it is indirect and experienced through whānau and friends.

In 2013, a report that explored the maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers was undertaken at Counties Manukau District Health Board (CMDHB).[34] The research highlighted that these mothers living in areas of high socioeconomic deprivation in the CMDHB perceived significant shortcomings and expressed dissatisfaction with the quality of services they received throughout the maternity care pathway. Dissatisfaction of care was related to:

- young mothers feeling as though they were stereotyped, judged and stigmatised by staff who were interacting with them
- feeling vulnerable during labour, delivery and after baby was born and the lack of staff understanding of family support needed during this time, especially if delivery was at night
- needs not being met by women who had English as a second language or low literacy levels and not being able to access resources according to their need
- rivalry and tension among hospital staff and LMCs.

Despite the shortfalls, a significant finding of the research was that high-quality relationships were the key to addressing the significant challenges to providing quality maternity health services for the diverse populations of Counties Manukau Health (CMH). This was a reflection of mothers who provided many examples of long-term relationships they had with maternity providers across a number of pregnancies. These findings also echo themes that were expressed by the young Māori women who were consulted for this PPIEC project: that relationships and connection were important during pregnancy and maternity care.

4. Pregnancy and Parenting Education

Not all women are able to access good antenatal education and support. A New Zealand study that describes women's access to and perception of childbirth education services offered by providers across NZ[35] found that just over 41% of pregnant women attended childbirth education in NZ. Māori and Pacific women were under-represented, mainly because of cultural, transport, child care and language barriers. Women most likely to attend were first-time mothers, tertiary educated, of NZ European ethnicity and high income earners.[36]

With respect to the different regions across NZ, the proportion of parents accessing pregnancy and parenting education was highest in Capital and Coast (52%) and Canterbury (51%), followed by Auckland (46%), Southland (35%), Lakes (32%) and Waikato (31%) district health boards.

In 2011, in the CMDHB, 132 parenting and pregnancy courses were held with 1,233 mothers registered. The largest proportion of those accessing pregnancy and parenting classes in the CMDHB were of NZ European ethnicity (39%) followed by Pacific and then Māori (12%). Most of these mothers lived in Howick/Pakuranga (28%), Manurewa/Clendon (15%) and Papatoetoe (14%). Very few mothers in the CMDHB accessed childbirth education from Clevedon (1%), Other (Otahuhu) (5%), Otara and Franklin (6% each).[37] Access to pregnancy and parenting classes in specific suburbs is likely to reflect the age range and socioeconomic position in each suburb.

Between January 2008 and June 2012, two providers were contracted to provide pregnancy and parenting classes within the Auckland DHB (ADHB) area and had 7,379 registrations. Of these, the majority were of NZ European ethnicity (61%), followed by Asian (23%), Other (9%), Māori (5%) and Pacific (3.5%).[38]

The research found that pregnancy and parenting education classes needed to be relevant to and accessible for women from different cultural groups and backgrounds. Recommendations included providers developing innovative ways to engage with whānau and looking at how to break down barriers to their participation.[39]

It was acknowledged by the young women who were consulted for this PPIEC[40] that although the majority didn't attend any formal pregnancy and parenting education classes, their knowledge was gained through whānau and friends:

After I first got pregnant, I didn't worry about it much...but my sister... she started researching and she's the one that told me everything I needed to know about pregnancy.

Mum...yeah she taught me...taught me everything. Cooking, nappies, bathing. She taught me how to budget which I'm not very good at. Yeah and just taught me how to put my kids first.

In addition to the support and experiences whānau and friends are able to offer, pregnancy and parenting education provides an important opportunity for parents to prepare for labour and birth, early days with baby, promoting healthy behaviours, increased social support and an opportunity for parents to hear other women's birth stories.[41] Pregnancy and parenting education is, however, only one small part of a bigger maternity system a woman must navigate through to ensure her pregnancy begins and continues as a positive healthy experience.

4.1 Counties Manukau District Health Board Review: Summary

The CMDHB commissioned a panel to identify why its perinatal mortality rates, particularly among Māori and Pacific women, were higher than the national rate. The panel identified nine key areas where changes could assist in improving the outcomes, especially for the high-needs population of the district. The panel emphasised that the report was not a criticism of maternity services by the DHB, but a review to help the board to understand the areas where a high-needs population needs extra input in order to improve the health of mothers and their babies.

Counties Manukau has large Māori and Pacific peoples' populations, large numbers of women who have their children at a younger age and high levels of maternal obesity, smoking and diabetes, all of which contribute to high perinatal mortality. This is compounded by issues of access to good quality maternity care early enough to make a difference.

The panel's recommendations regarding pregnancy and parenting education and care include:[42]

- Educate the community on the importance of early pregnancy assessment, preferably before 10 weeks of pregnancy, and early engagement with a midwife.
- Educate the community on the importance of early pregnancy assessment, preferably before 10 weeks of pregnancy.
- Review ultrasound services to ensure adequate access is available to all pregnant women.
- Prioritise vulnerable and high-needs women and ensure they get continuity of care with a consistent care provider.
- Improve the ability of LMC care throughout the district.
- Urgently seek a review of Section 88 of the Public Health and Disability Act 2000 by the Ministry of Health to seek incentives for midwives to be able to provide services in a high-needs, high–deprivation area.
- Review the specific delivery of services to Māori and Pacific women to ensure that the education material is appropriate and reflects the cultural needs of these groups.
- Reinforce strategies to reduce the number of pregnant women who smoke and to reduce pre-pregnancy obesity and optimise weight gain in pregnancy.
- Implement an integrated IT system that enables all of a woman's care providers to access the same information.

4.2 National Service Specifications

The *Ministry of Health – National Service Specification for Pregnancy and Parenting Education* was updated in July 2014 and sets out the service components programme for pregnancy and parenting information and education in New Zealand. Each district health board and service provider develops their own curriculum based on the service specification.

There are two service components to the specification:

1. The education service component is focused on additional support or education for first-time expectant parents and populations with high needs within each DHB region. Key to achieving this is improving access and acceptability for these groups. A group-based education programme session may include first-time parents and adoptive parents, and their whānau, as appropriate.
2. The information component provides all expectant and new parents with information and resources about key pregnancy and parenting topics.

a) Education Component

The service specification requires each group education programme to:

- be conducted over a number of sessions throughout pregnancy and, as appropriate, until the newborn child is six weeks old
- be developed with their community and designed to meet the needs of the individual parents, including consideration of specific programmes for different groups of parents, such as young/teenage parents, Māori, Pacific, Asian, and parents with limited comprehension of the English language
- include participants at a similar stage in their pregnancy, where possible
- use a health literacy approach that supports and enhances parents' confidence to make informed decisions throughout pregnancy, childbirth and parenting
- reflect evidence-based best practice, apply principles of respectful and non-blaming communication, and be delivered in the spirit of partnership
- draw from key messages
- advise participants about the information component and how to access it
- encourage participants to exchange contact details and form ongoing informal postnatal support groups
- have programme co-ordinators who are preferably childbirth educators with a recognised qualification in childbirth education

b) Information Component

The information component of the specification provides a directory of pregnancy and parenting related services within each DHB or region and is linked to the National Pregnancy and Parenting Information and Resources Curriculum.

The information component service provider will:

- use existing community maternity or child health service structures as the conduit for the pregnancy and parenting information and resources, and/or advise other health, education and social service providers in their area about the information component and how to access it for their clients
- integrate information with other services being delivered in the community to ensure improved accessibility for their contracted population
- provide access to and/or distribute this information to all parents across their contracted population
- maintain the currency of DHB/regional information and resources.

c) Current Practice

Although the MOH pregnancy and parenting service specifications have been updated, they are still in the process of being given effect. A number of DHBs throughout the country are reviewing their services in light of the new specifications. However, current courses are offered in six- to eight-week blocks of classes for two hours each (typically on a weekday evening), or a one-off Saturday all-day course for women who are around 28–30 weeks of gestation. The existing curriculum is based on the provision of pregnancy and parenting education information. This is one strategy used to educate pregnant women and fathers/partners and support self-management.

Other potential strategies include:

- understanding the social, emotional and physical effects of pregnancy
- motivating people to self-manage using targeted approaches and structured support
- helping people to monitor their condition and know when to take action
- promoting healthy lifestyles.


Ricochet

IV. Proposed Services

1. Ministry of Health Focus on Improved Access & Acceptability of Pregnancy and Parenting Education

The MOH pregnancy and parenting services specification focuses on improved access and acceptability of pregnancy and parenting education through two components: (a) information and (b) education.

Information Component

The information component will be undertaken by service providers, who will work with relevant health, education and social service providers to facilitate how they and their pregnant women, fathers/partners and whānau can best access the information component of the service.

The following access and acceptability quality requirements apply:

- Information is available to service users at all times and is written in language that is easily understood by the reader.
- Information is culturally appropriate for the varied groups of service users and is available in a range of languages.
- Resources are current, and use communication methods and technology most appropriate to each audience.
- Assessment of the service accessibility and acceptability is routinely undertaken through surveys of service users and local maternity service providers, and measures are taken to address barriers to access.

Education Component

The service will improve its access and acceptability for pregnant women, fathers/partners and whānau by:

- responding to the individual needs of pregnant women while meeting the service component requirements detailed in the pregnancy and parenting specification
- acknowledging different life situations and needs of pregnant women to encourage their participation and completion of the programme
- considering education needs of fathers/partners
- ensuring the service and information is culturally appropriate, is safe and upholds the principles of the Treaty of Waitangi.

Acceptability is assessed by pregnant women's participation in ongoing evaluation of the service, and feedback contained in annual surveys to assess their satisfaction with:

- the quality and outcome of services they received
- the appropriate level of information provided on their care or support service
- their level of involvement in the planning and delivery of their care, including their transition into and discharge from the service
- how well their cultural and linguistic needs were recognised and met
- the timeliness of the information and education they received.

With the new service specifications in place, DHBs around New Zealand are retendering Pregnancy and Parenting contracts. This provides a timely opportunity to tailor services to high-needs groups such as Māori and Pacific peoples. This PPIEC provides a solid evidence base, tools and guidance on engaging with pregnant women, fathers/partners and whānau and delivering key tailored messages to meet their needs.

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