New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

BREAKING THE DISADVANTAGE CYCLE STARTING IN PREGNANCY

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Maternity Care in Aotearoa

- The maternity service in NZ is an integrated system of primary, secondary & tertiary care.
- Primary maternity care is provided by Lead Maternity Carers (LMCs) working under Section 88 of the NZ Public Health & Disability Act 2000.
- 92% of women choose a midwife LMC.
- LMC midwives take responsibility for the care provided to women throughout pregnancy, labour and birth & for up to 6 weeks post-birth.
- They provide care in community clinics and in clients' homes.

Midwifery continuity of care

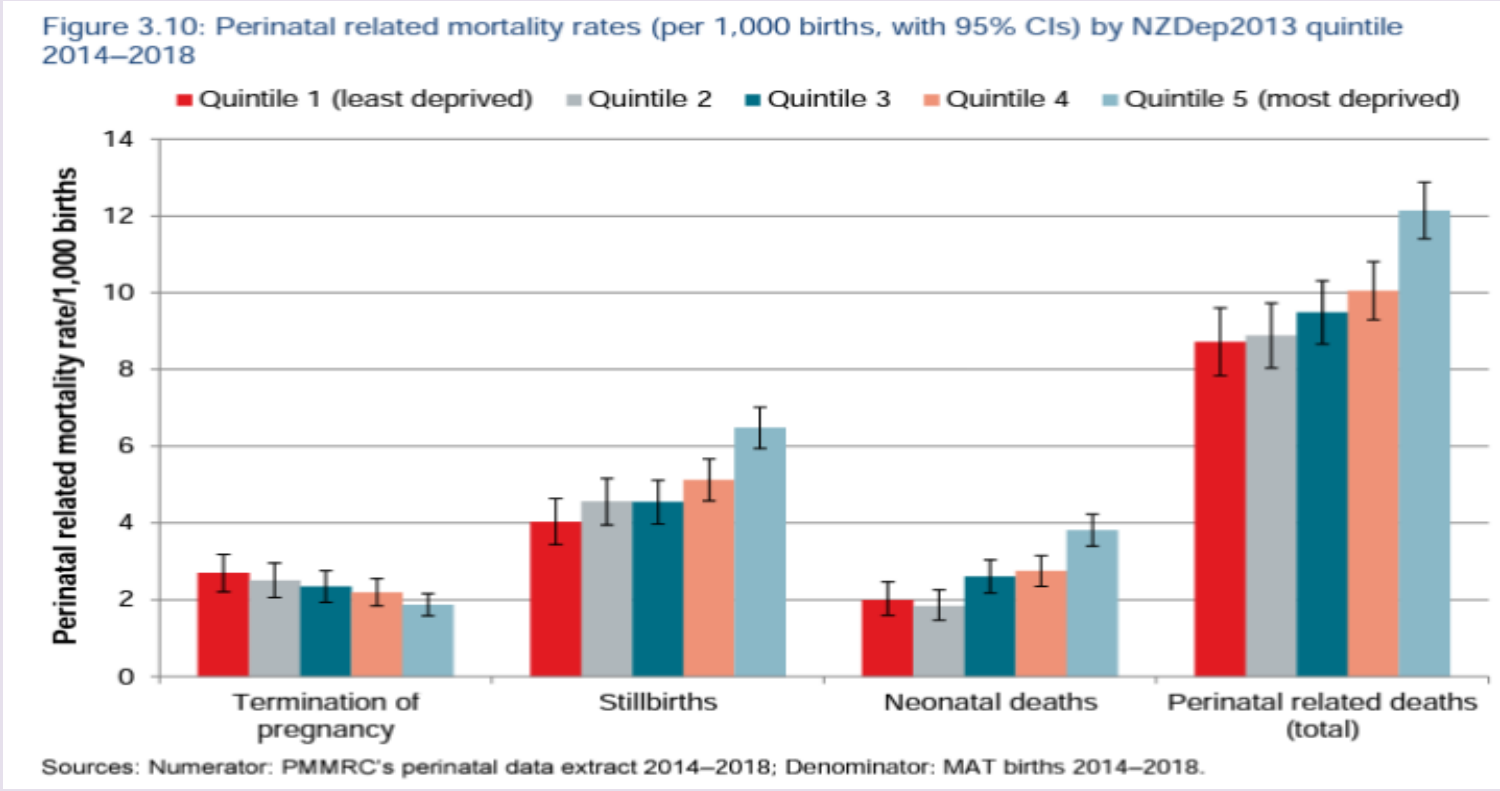
- Midwifery continuity of care contributes to the prevention of preterm births, and better birth outcomes for women who are disadvantaged. (Medley, et al, 2018; McRae et al, 2018)
- Antenatal/postnatal education can improve infant cognitive and social development, infant mental health, parenting quality and couple adjustment, reduction in maltreatment, and health promoting behaviours.
- Home visiting interventions were also found to be of benefit starting before birth and in the first year of life. (Australian Government / National Health and Medical Research Council. (2017). *NHMRC Report on the evidence: Promoting social and emotional development and wellbeing of infants in pregnancy and the first year of life.)*
- These are all aspects of maternity care provided by midwives in Aotearoa.

Maternity Care in Aotearoa

- In Aotearoa New Zealand 22.3% of women who gave birth in 2017 lived in the most deprived quintiles (Ministry of Health, 2019b).
- Midwives have always provided care to women living with disadvantage.
- Care has been provided to pregnant homeless women at parks, roadsides, brothels & rehabilitation centres for many years (Māori Midwife Mahia Winder in picture)

Perinatal Outcomes

- Women living in most deprived quintiles are over represented in maternal and perinatal mortality and morbidity outcomes (PMMRC report 2021)



Poverty and pregnancy study

- **Question:** How does poverty affect pregnancy, midwives and midwifery care in Aotearoa New Zealand?
- **Study** undertaken in 2018 as a collaboration between the Maternal Equity Action - (Dr Eva Neely & Bryony Raven) and the NZ College of Midwives.
- **Aim** was to identify the key factors that relate to poverty for women during pregnancy and childbirth (as identified by midwives), the effects on women during maternity care and the subsequent impact on the midwives providing that care.
- **Method**: Survey methodology and inductive thematic analysis of open ended question.

Survey Findings

- 436 midwives responded to the survey.
- 125 (28.6%) survey respondents were hospital midwives, 245 (56%) were community (LMC) midwives, 67 (15.3%) were midwives in other roles.
- Midwives are often at the interface of deprivation and poverty when providing care to pregnant women living with disadvantage.

Survey findings

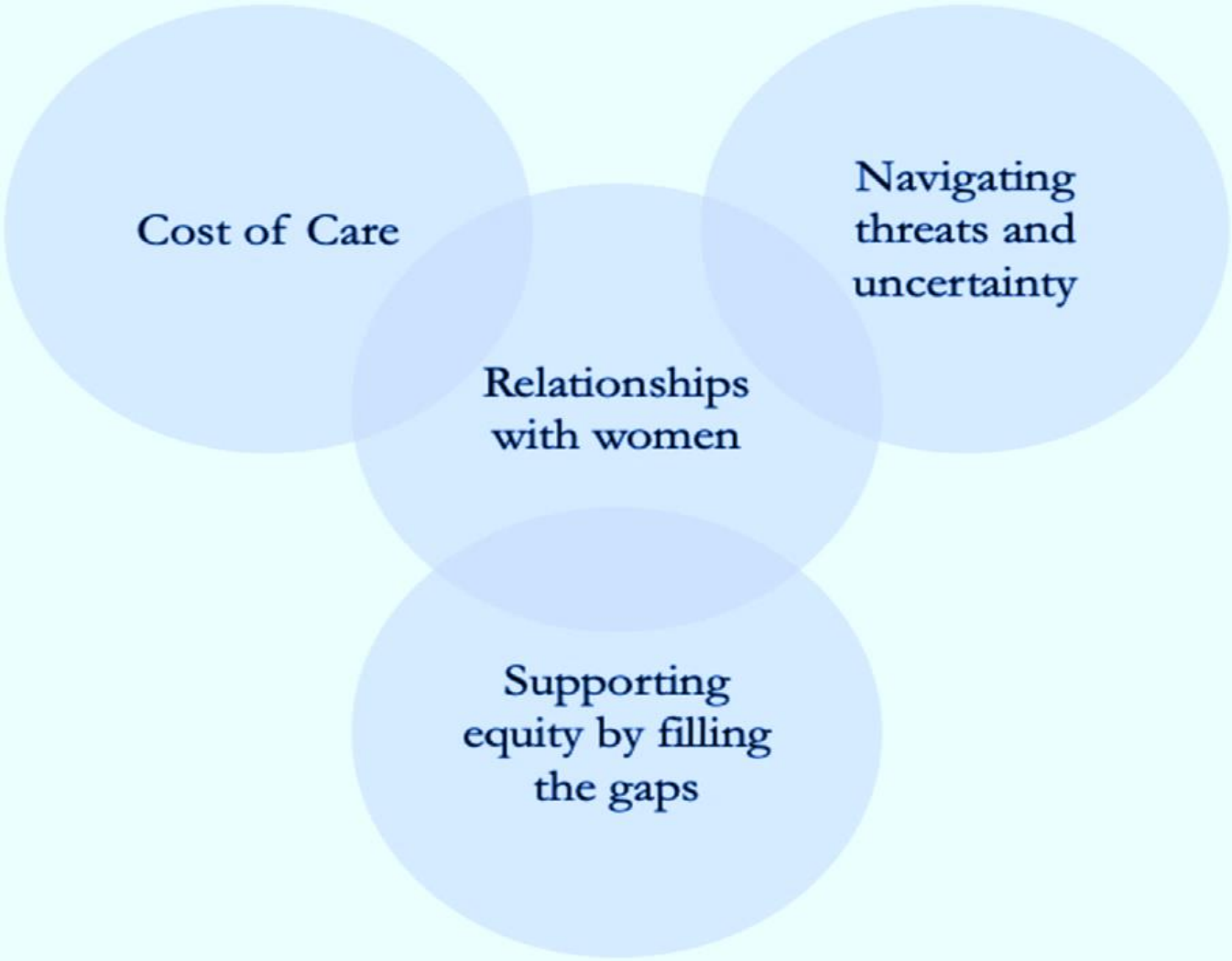
- 70% of the midwives had worked with women living with family/friends.
- 69% of the midwives had worked with women who had moved house during pregnancy due to the unaffordability of housing.
- 66% of the midwives had worked with women who lived in overcrowded homes.
- 56.6% of the midwives had worked with women who lived in emergency housing, in garages (31.6%), in cars (16.5%) or on the streets (11%).

"I was caring for a woman / wahine readmitted at day 15 for an MRSA infection in her caesarean wound. She had a toddler and a newborn. When she initially was discharged from hospital she and her family were living in the car. During the period of her readmission she was able to obtain emergency housing in a motel. The impact of major surgery and hospital acquired infection in the context of extreme poverty was devastating for her and her family, and negatively impacted her personal wellbeing, breastfeeding, and ability to parent well."

"Pregnant with twin pregnancy. Has missed scans due to lack of transport, car being used by someone else, no money for petrol, car broken down or too tired to go to appointments and no money on phone to notify scan/obstetric clinic"

"Living in rental accommodation with inadequate heating, too much damp, mould growing on walls. Landlords unwilling to fix these issues."

Thematic analysis



Costs of care

- Women's appointment non-attendance was due to lack of transport / lack of money for phones, resulting in a limited ability to communicate.
- Midwives reported going to women's homes to provide midwifery care to optimise the chances of making contact.
- Midwives reported needing to spend more time than usual referring and liaising with other services and agencies, to ensure that the woman and her baby/ family had the necessities of life and health.

"Often we as midwives will pay for prescriptions and at times, even food for these families just to help out. Better for me if a prescription of nitrofurantoin or Fe (iron) tablets are paid for by me than for things to develop into something more serious."

"I visit people at home with transport issues or if they've missed more than 2 appointments (we're not funded for antenatal home visits). I buy them their prescriptions for things like Iron because I know they won't get it otherwise, I buy phone top ups so I know they can contact me if there is something wrong and sometimes buy clothes for the baby or grocery voucher."

"I have lost many hours of sleep due to concern for the wellbeing of women and babies in my care."

Navigating threats & uncertainty

Midwives explained how they balanced different needs and worked in uncertain circumstances. They were sometimes exposed to high risk situations themselves.

"Client lives in a very remote area with no transport or services. Family violence issues with mother who lives nearby and brother in same residence. Did not attend several antenatal appointments . . . due to transport, would not attend scans. Could not attend antenatal visits and did not answer her phone, I didn't see her for 12 weeks, as it was an unsafe environment in her home for me to access and she lived an hour away, I ended up seeing her at home risking my own safety."

Supporting equity by filling the gaps

- LMC midwives tried to mediate inequity by ensuring individual needs were met and women were kept safe both medically and socially.

"At the first visit a woman who was 28 weeks pregnant, who had no prior antenatal care and sleeping in her car required me to organise an emergency referral. I organised a referral to refuge with consent and was referred to emergency women's homeless trust as the refuge was full at that time, but worked with her to secure a council flat. She lived in the fifth floor with a broken lift and an abusive neighbour she would page us about feeling unsafe in her flat. I spent more time with my client antenatally writing letters and doing advocacy."

The disadvantage cycle

- LMC midwives work hard to stay connected to their clients during their pregnancies.
- Homelessness & transient living situations can make regular contact & the necessary clinical midwifery assessments very challenging.
- Homeless women - because of their difficult living situations, also find it challenging to attend visits at clinic rooms.

Midwifery as a health intervention

- Midwives and continuity of midwifery care could be viewed as positive health interventions.
- Health inequities and social disadvantages are persistent and disproportionately affect women during pregnancy.
- Midwives providing care to these women may experience additional workload and strain.

The disadvantage cycle

- The genesis of child poverty is maternal /whānau poverty, which is frequently caused by, and exacerbated during pregnancy and childbirth in families who are already experiencing disadvantage.

- Recognising the impact of poverty on maternal health, welfare and wellbeing is important to the improvement of both maternal and child health.

Invisibility of pregnancy and infancy

- The updated Living Standards Framework states an intention to better reflect children's wellbeing and culture, and acknowledges that the 2018 LSF Dashboard *"may not fully capture the distinctive nature of wellbeing in Aotearoa New Zealand or the wellbeing of children."*

New Zealand Government. (2021). *The Living Standards Framework 2021*. Wellington, The Treasury.

- Although the term "children" is likely intended to include infants, not mentioning pregnancy or infants can render maternal and infant issues invisible.

- We thank all the midwives who took the time to complete the survey about pregnancy and poverty, and the College of Midwives for supporting the project.

- We acknowledge our primary co-researchers – Dr Eva Neely & Briony Raven, and the valuable input we received from co-authors Carmen Timu-Parata and Dr Clive Aspin.

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Providing maternity care for disadvantaged women in Aotearoa New Zealand: The impact on midwives

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Article

"Ashamed, Silent and Stuck in a System"—Applying a Structural Violence Lens to Midwives' Stories on Social Disadvantage in Pregnancy

Eva Neely [1,*], Briony Raven [2], Lesley Dixon [3], Carol Bartle [3] and Carmen Timu-Parata [4]