20th September 2019

Māori Health Action Plan

New Zealand College of Midwives

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The New Zealand College of Midwives is the professional organisation for midwifery. Our members are employed and self-employed and collectively represent over 90% of the practising midwives in this country. There are approximately 3,000 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to, on average, 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby.

Midwives undertake a four-year equivalent undergraduate degree to become registered followed by a first year of practice program that includes full mentoring by senior midwives. The undergraduate curriculum meets all international regulatory and education standards. Midwives are authorised prescribers in relation to their Scope of Practice as determined by the Midwifery Council.

Midwives provide an accessible and primary health care service for women in the community within a continuity of carer model as Lead Maternity Carers. Midwives can also choose to work within secondary and tertiary maternity facilities, providing essential care to women with complex maternity needs.

The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and wellbeing

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

Ministry of Health

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20th September 2019

Māori Health Action Plan

Tēnā koutou

The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the Māori Health Action Plan.

The adoption of the overarching aim of pae ora which promotes collaboration between all those working in the health and disability sector and aims to achieve wellbeing beyond the usual narrow definitions of health is particularly welcomed by the College. The College has repeatedly called for a wider focus that includes the social and corporate determinants of health in submissions related to public and population health.

The right to health was described in a Ministry of Health report in 2018.[1] This statement recognised the accountability of governments to provide equal opportunities for *"all people to be healthy, meaning that all people attain the highest possible level of mental and physical wellbeing."* The College supports this statement, which is underpinned by human rights principles, and is hopeful that this government will meet their obligations to work towards an end to poverty, and an end to racial discrimination in health care, to actively promote and support the wellbeing of all people in Aotearoa, to support secure warm housing for all citizens, to remove barriers to health care access, and to move towards a full recognition of what the statement "giving every child the best start in life" means in its entirety. A review of the health system will not improve health outcomes without a broader approach that takes into account the social determinants of health.

[1] Ministry of Health. (2018) *Achieving equity in health outcomes: highlights of important national and international papers*. Wellington, MOH.

Te Pae Mahutonga is a health promotion model that highlights significant components of public health and health promotion, as they apply to Māori health.[2] In the context of discussions about Māori health this framework highlights the key issues that government and policy makers need to consider to affect any improvements in health. The pointers include:

- Waiora/Environmental Protection: considers not only issues of housing, over-crowding of existing homes and access to housing for families, but also a wider environmental picture which encompasses water quality, climate crisis and food security.
- Mauriora: Access to Te Ao Māori. Cultural identity is a crucial contributor to health outcomes. This principle considers how services that are culturally appropriate represent the most effective and cost-effective approach, and how developing relationships and connections enhances and supports better health outcomes.
- Te Oranga/Participation: aims to improve access and create the conditions for equity, including gender equity, to reduce barriers to services, to provide care continuity to support wellness, to reduce stigma and alienation, and to eliminate racism.
- Toiora/Healthy Lifestyles: includes removal of the barriers to healthy lifestyle access, which requires an in-depth look at food deserts, the corporate determinants of health, inappropriate marketing of unhealthy food and the need for industry regulatory measures.

The ill effects of colonisation on the health and wellbeing of Māori are well known and gravely significant, and measures to effectively address heath inequities are well overdue. Masters-Awatere and Graham, note that the unjust distribution of the social determinants of health and racism exacerbate health inequalities.[3]

The College has commented on each of the eight priority areas within the Māori Health Action Plan with attention to issues related to maternity and midwifery.

1. Māori / Crown relationships

1.1 The College considers that urgent attention to inequity in funding is necessary. Came, Doole, Lubis, et al, found that Māori and Pacific providers were more likely to have shorter contracts

[2] Durie, M. (1999*). Te Pae Māhutonga: A Model for Māori Health Promotion*. https://www.cph.co.nz/wp-content/uploads/TePaeMahutonga.pdf

[3] Masters-Awatere, B., & Graham, R. (2019). Whānau Māori explain how the Harti Hauora Tool assists with better access to health services. *Australian Journal of Primary Health,* https://doi.org/10.1071/PY19025

than other providers, their funding access was extremely tight, with no extra money, and expectations of more work delivery.[4]

1.2 Institutional racism has been clearly identified within Crown funding and contracting practices. Came et al. identify that discrepancies in funding are "a contemporary breach of Te Tiriti o Waitangi and a colonial legacy of missed opportunities to improve Crown practice." [5]

1.3 Access to sustainable long-term funding and ongoing support enables medium- to long-term planning, which is essential when working in areas of health promotion and wellbeing, and it also improves the likelihood of increased staff capacity, mentoring and the retention of experienced workers.

1.4 A critical component of the Māori / Crown relationship is related to embedding Te Tiriti o Waitangi into all policy programmes and services.

1.5 This needs to include urgent issues related to climate change. It is well accepted that disproportionate threats from climate change exist, and as Dr Rhys Jones (Ngāti Kahungunu), Senior Lecturer, Te Kupenga Hauora Māori, University of Auckland) points out, "socioeconomic deprivation, a greater existing burden of disease, poorer access to, and quality of health care and political marginalisation" are significant factors.[6] Jones (2019) uses a Kaupapa Māori positioning in his analysis, and seeks transformative change which involves critiquing Western knowledges and structures that undermine indigenous rights. Jones also states that transformational change "requires health promotion practitioners to support Indigenous self-determination and recognise Indigenous knowledge as a critical foundation for climate change and health solutions." [7]

1.6 Because "land must be recognised as a fundamental determinant of Indigenous health" (Jones, 2019) and the connections between land and human wellbeing are connected, "health promotion must therefore be grounded in an understanding of the role of colonisation in exacerbating climate-related health impacts for Indigenous people" (Jones, 2019) and this requires amplification of Māori /Crown relationships and a broader view of initiatives.

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[4] Came, H., Doole, C., Lubis, D., & Garrett, N. (2015). *Benchmarking Crown Practice: Public Health Contracting and Funding. Preliminary report for public health providers*. Auckland University of Technology, Massey University, Keruru Research and Evaluation Associates.

[5] Came, H., Doole, C., Lubis, D., & Garrett, N. (2015). *Benchmarking Crown Practice: Public Health Contracting and Funding. Preliminary report for public health providers*. Auckland University of Technology, Massey University, Keruru Research and Evaluation Associates

[6] Jones, R. (2019). Climate change and Indigenous health promotion. *Global Health Promotion*, 26, Supp 3: 73-81.

[7] Ibid

2. Māori health development

2.1 The College is committed to supporting all measures that lead towards an increase in the number of Māori midwives.

2.2 The College supports services and programmes for Māori, created, developed and delivered by Māori, with a Kaupapa Māori focus, and see this model of self-determination as the most effective way of meeting the needs of whānau and upholding the principles of Te Tiriti o Waitangi.

2.3 The College sees Whānau Ora services as providing the means for Māori to create meaningful polices, develop appropriate programme designs and deliver appropriate services with the aim of improving whānau outcomes and working towards health equity.

2.4 Health and wellbeing strategies need to include Māori models of health and wellbeing and include rongoā. It has been encouraging to see the development of Kaupapa Māori services around Aotearoa New Zealand for pregnant women and their whānau which incorporate traditional Māori childbirth practices and parenting within their programmes. One example of a successful programme is Whānau Mai run by Te Puawaitanga ki Ōtautahi Trust.[8] The College would like to see more of these programmes available and accessible to Māori women and their whānau and this require adequate funding nationally.

2.5 Recent evidence from Australia has indicated that indigenous women supported by midwives, Aboriginal health workers, and Aboriginal community controlled health organisation initiatives are bringing traditional culture and spirituality back into contemporary birth situations to foster nurturing birth environments which foster care for pregnant and birthing women and to give babies the best start in life.[9]

2.6 Midwives report the difficulties some rural women have in accessing maternity care due to transport issues and lack of accessible services, and with the lack of support and funding for midwifery over the past years this has been concerning. The College is very aware of areas where DHBs' rapid transport options requested by midwives are not well organised. If these women and babies are to receive recommended care then access to appropriate care facilities must be a priority. Funding shortfalls in the health system need to be comprehensively addressed to meet the needs of all women and their whānau, and to reduce inequalities. In this sense we hope the Māori Health Action Plan will consider these broader issues.

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[8] http://whanauoraservices.co.nz/services/early-childhood-education/

[9] Marriot, R., & Chamberlain, C. (2019). Change is in the air: Reclaiming ancestral wisdom through Birthing on Country in Australia. *Women and Birth*, 32:3810382.

2.7 The Families and Whānau Status Report 2016, highlighted how financial and psychological stressors impact on the ability of whānau to function well.[10] The stress of unsafe and unhealthy living environments and the highly likely deterioration in physical, spiritual, and psychological health places an unacceptable burden on pregnant women, women with newborn infants and young children and their whānau.

2.8 Masters-Awatere and Graham, in their research looking at hospital admissions of tamariki Māori age 0-5 years, describe how delayed engagement with primary care providers and poverty-related diseases are a large contributor to high rates of hospital readmissions for Māori. The Harti Hauora Tamariki Tool facilitated relationship building, matched an indigenous health worker with each whānau and facilitated connections across the health system. This approach was described as providing the key to culturally appropriate service delivery that tackles health inequalities within the existing system.[11]

2.9 Dr Rhys Jones (Ngāti Kahungunu), Senior Lecturer, Te Kupenga Hauora Māori, University of Auckland) commented on the recent Health and Disability Sector Review and suggested that if equity in health outcomes is to be achieved for Māori, *"that has to be a non-negotiable starting point across the entire system. From there, mechanisms are required to hold all health sector organisations to account for delivering equitable outcomes."* Dr Jones goes on to say, *"The recommendations of the review also need to be much stronger in relation to addressing racism. It must be recognised that structural racism underpins the poorer health outcomes experienced by Māori, and also explains why the health system has failed to respond to this inequity. There needs to be a more explicit emphasis on dismantling racism at all levels, and every aspect of the proposed health system reforms must be fundamentally anti-racist and pro-equity."*[12] The College supports this statement about addressing structural and institutional racism as an essential starting point to address the poor health outcomes experienced for Māori.

3. Māori leadership

3.1 Strong Māori leadership is critical and the College look forward to significant changes which will facilitate more appropriate Māori representation in decision making processes throughout the health and disability system. Māori identifying and prioritising the issues that

[10] Social Policy Evaluation and Research Unit. (2016). *Families and Whānau Status Report*. Wellington, Superu.
[11] Masters-Awatere, B., & Graham, R. (2019). Whānau Māori explain how the Harti Hauora Tool assists with better access to health services. *Australian Journal of Primary Health,* https://doi.org/10.1071/PY19025
[12] Jones, R. (2019). *Health and disability sector review – Expert Reaction*. https://www.sciencemediacentre.co.nz/2019/09/03/health-and-disability-sector-review-expert-reaction/

concern Māori, and then creating their own solutions, within their own management of well-funded services is necessary.

3.2 The College recognises the significance of the appointment of Nicole Pihema of Ngāpuhi and Te Rarawa descent as the first Māori President of the New Zealand College of Midwives. (See 6.2)

3.3 The College support the call for DHB boards to regularly report on Māori representation on all committees within their services.

3.4 Monitoring of Māori representation on PHO boards is also necessary

3.5 The College also supports a move to support DHBs, PHOs and health organisations to make decolonisation workshops available to all staff members, including the executive officers. Alongside strong Māori leadership the deconstruction of existing services and practices which continue to perpetuate inequities is necessary.

4. Accountability frameworks

4.1 As previously stated in 1.4 a critical component of Māori health and wellbeing is related to embedding Te Tiriti o Waitangi into all policy programmes and services within health and disability services.

4.2 There is a need for all health and disability services to develop an annual Māori health plan, which contain their proposed strategies for meeting their Te Tiriti o Waitangi commitments and how they plan to achieve health equity for Māori.

5. Cross-sector action

5.1 Attention to the social determinants of health is essential. Health and wellbeing services and health promotion activities are very unlikely to be effective where there are conditions of serious inequity, homelessness, material deprivation, hardship, food insecurity and poverty, even with the best of intentions.

5.2 The College would also like to see recognition of the commercial determinants of health. As noted by the WHO Director-General Margaret Chan, efforts to prevent non-communicable diseases and improve population health are in direct opposition to business interests.[13] Kickbusch et al. in the Lancet note that corporate influence is exerted through four

[13] WHO. (2016). WHO Director-General address, 8th Global Conference on Health Promotion, Helsinki. Geneva, WHO.

channels, marketing to enhance the desirability and acceptability of unhealthy commodities; lobbying which can impede policy barriers; corporate responsibility strategies which can deflect attention and whitewash reputations; and extensive supply chains which amplify corporate influence.[14] Work to counter corporate influence is necessary to achieve health and wellbeing.

5.3 Unsafe and unhealthy living environments, and a deterioration in physical, spiritual, and psychological health, places an unacceptable burden on pregnant women, and women with newborn infants and young children. Midwives have noted the extreme difficulties women and whānau are facing and the challenges midwives also face in the provision of quality care.

5.4 Midwives are one of the only groups of health professionals who regularly visit women and their whānau in their own homes, or place of abode. This enables a primary gaze on the impact of sub-standard housing, and insecure living conditions on women, their pregnancies, labour, birth and the post-birth period, alongside the impact on the newborn infant and other children. Narratives collected by the College from midwives around Aotearoa New Zealand contain evidence of the serious disadvantages and hardship experienced by pregnant women, and new mothers with infants. Below are excerpts from some of the narratives from midwives which describe the continued threats to health and wellbeing due to poverty and deprivation;

- *Fragmented maternity care for a young woman with first baby and partner who shifted accommodation six times during pregnancy and after the birth of the baby.*
- *Transience putting maternity care at risk as the pregnant woman did not go for scans or bloods when required.*
- *Compromised small baby who had to be induced at term for growth restriction.*
- *Seeing a lot of pregnant women who are homeless or living with different relatives, moving on a weekly basis due to having no home to live in, and this is because of the increases in rent prices and the pickiness of landlords this year.*
- *Cold run down houses and many with floor boards collapsing and no decent bathrooms/toilets and kitchens.*
- *Sleeping in cold tin garages with sheets as doors and curtains, run down wooden windy houses, with windows and doors that no longer shut.*
- *Many pregnant mums going without food to feed their children - saying they just don't feel hungry. Not helping the health of the next generation or the outcome of the pregnancy.*

[14] Kickbusch, I., Allen, L., & Franz, C. (2016).

- *Pregnant woman living with her partner in an uninsulated shed with one window.*
- *Twenty year old woman pregnant with her first baby who sleeps at the Women's Shelter at night and stays in her car during the day.*
- *Seventeen year old woman pregnant with her first baby who is couch-surfing.*

5.5 Lead Maternity Carer midwives work hard to stay connected to their clients and their whānau during pregnancy, but homelessness and transient living situations can make regular contact and the necessary midwifery assessments very challenging. Continued attention and urgent action to address conditions of serious inequity, sub-standard accommodation, material deprivation, hardship, food insecurity and poverty is essential, as is action to support the recruitment and training of new midwives and retention of the midwifery workforce by improvement in working conditions.

6. Workforce

6.1 As noted in 2.1 and 5.3 the College is aware of the need to support more Māori to undertake the midwifery degree programme. At the same time the retention of midwives needs to be addressed alongside recruitment concerns. Retention relies on improvements being made in working conditions, funding and remuneration.

6.2 The College recognises the significance of the appointment of Nicole Pihema of Ngāpuhi and Te Rarawa descent as the first Māori President of the New Zealand College of Midwives. This appointment will support the College's ambition to fully realise its commitments under Te Tiriti o Waitangi, and this will include the development and support of Māori midwifery and work towards equitable outcomes for Māori wāhine and pēpi.

6.3 To build a culturally competent and safe health workforce institutional racism and discrimination throughout our health and disability system needs to be addressed and eliminated.

7. Quality systems reflect good practice

7.1 The College has been concerned about the contribution of poverty to the removal of infants from their mothers, and would welcome these issues being addressed within the Māori Health Action Plan. We have repeatedly expressed these concerns in previous submissions

related to child health and wellbeing. A publication from the UK, 'Suffer the little children and their mothers' reports that children are increasingly being removed from their birth families in the UK for reasons of 'neglect', and that this 'neglect' is, in reality, often a "combination of poverty and overwork."[15]

7.2 Bilson et al. discusses a range of studies aimed at identifying the causes of over-representation of minorities in child protection in Western Australia. This work suggests that child protection overlaps with issues of social exclusion and poverty.[16] Rouland et al. recently reported that from a sample of 55, 443 children in Aotearoa New Zealand almost 1 in 4 had been subject to at least one report to child protection services by the age of seventeen.[17] Material and social inequities are causal in outcomes for children, and strategies to alleviate poverty such as sustained income support, affordable, safe and secure housing are necessary. The College has called for an Aotearoa New Zealand based analysis to ascertain the links between poverty and child protection in earlier submissions, and we anticipate the ongoing reviews of Oranga Tamariki services will lead to significant positive changes.

7.3 Improvement of outcomes for Māori requires issues of structural racism and inequity to be addressed within society, and within care and protection services. Paora Moyle identified issues with cultural responsiveness within family group conference (FGC) practice.[18] A significant finding in Moyle's work about Māori whānau views on FGC was that, "by and large, mainstream non-Māori social workers did not know how to engage with them." Moyle notes "little bicultural capability (cultural competence)" within the "youth justice and child protection sectors" and an overall lack of valuing of "fundamental elements of a Māori worldview (i.e. whakapapa – genealogy/family connections)." [19] These issues will require attention within a Māori Health Action Plan.

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[15] Neale, A., & Lopez, N. (2017). *Suffer the little children and their mothers: A dossier on the unjust separation of children from their mothers*. Legal Action for Women, London, Crossroads Books. http://legalactionforwomen.net/wp-content/uploads/2017/01/LAW-Dossier-18Jan17-final.pdf

[16] Bilson, A., Cant, R. L., Harries, M., & Thorpe, D. H. (2015). A longitudinal study of children reported to the child protection department in Western Australia. *British Journal of Social Wor*k, 45(3):771-791.

[17] Rouland, B., & Vaithianathan, R. (2018). Cumulative prevalence of maltreatment among New Zealand children, 1998-2015. *Am J Public Health,* 108(4):511-513.

[18] Moyle, P. (Undated). *New Zealand family group conferencing and the Māori-Lived-Experience*. *Academia.* https://www.academia.edu/10578356/M%C4%81ori-Lived-Experiences_of_the_Family_Group_Conference_A_selection_of_findings

[19] Moyle, P. (Undated). *New Zealand family group conferencing and the Māori-Lived-Experience*. *Academia.* https://www.academia.edu/10578356/M%C4%81ori-Lived-Experiences_of_the_Family_Group_Conference_A_selection_of_findings

7.4 A community care approach recognises that child protection systems are embedded within broader whānau and community services.[20] Partnership with Māori whānau, hapū and iwi, and Māori organisations, is necessary to support Māori children to stay within their hapū. The Maori Women's Welfare League filed a claim in December 2016 to the Waitangi Tribunal challenging policy changes proposed for the care and protection of children and young persons.[21] This claim highlights the paramountcy of rangatiratanga, which encompasses fundamental relationships between Māori culture and identity within the context of a Māori community, and that the responsibility of the Crown under Te Tiriti o Waitangi is to enhance rangatiratanga.[22]

8. Clear evidence of performance

8.1 Support for health professionals (midwives and Tamariki Ora Well Child services) home visiting services, and childbirth / parenting education, are strongly evidence-based in terms of having positive influences on infant wellbeing in the first year.

8.2 Midwifery is both a preventative and an acute response health service which impacts positively on maternal, infant and child wellbeing, both short and long-term. The College urges more attention be paid to the preventative potential of midwifery, which can help to reduce the access and cultural equity gap.[23]

8.3 The College notes that the Australian government has developed a document focussed on the social and emotional development and wellbeing of infants in pregnancy and the first year of life. This document is underpinned by discussion of relationships with parents and caregivers and also uses the GRADE approach to assess quality of evidence for effectiveness of interventions.

8.4 The College notes that there is evidence for the benefits of antenatal and postnatal education, in terms of infant cognitive and social development, infant mental health, parenting

[20] Social Policy and Evaluation Research Unit. (2016*). In focus: Modernising child protection in New Zealand: Learning from system reforms in other countries.* Wellington, Superu.

[21] Maori Women's Welfare League. (2016) *Te Ropu Wahine Maori Toku I Te Ora/Maori Women's Welfare League Inc concerning investing in children legislative reform outlining legislative changes to Children, Young Persons and Their Families Act 1989 and related legislation*. http://img.scoop.co.nz/media/pdfs/1612/CCF04122016.pdf

[22] Ibid page 5.

[23] Continuity of midwifery care provides more effective emotional support and improves outcomes for women with mental health and addiction issues, including higher rates of referral to domestic violence and mental health services and lower rates of pre-term labour low birth weight in comparison with traditional models of care. See, McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ*, 8(10): e022220.doi: 10.1136/bmjopen-2018-022220

support and couple adjustment, reduction in maltreatment, and health promoting behaviours. Home visiting interventions to support parents were also found to be of benefit when started before birth and in the first year of life. These are all aspects of care and support for parents and parenting, delivered by midwives, and delivered in homes around Aotearoa New Zealand. For further results of the interventions assessed using the GRADE approach the link to this document is in a footnote.[24]

8.5 The College would like to emphasis the importance of midwifery care, the continuity model of midwifery care which supports relationship development, home visiting, access to culturally appropriate, accessible and free mental health services, rural services and breastfeeding support services. There is also robust evidence to support midwifery care and breastfeeding as public health imperatives. This includes the contribution of midwifery continuity of care to the prevention of preterm births,[25] [26] and better birth outcomes for women of low socioeconomic position.[27]

8.6 Breastfeeding protection, promotion and support are integral parts of all health planning and improved support for Māori breastfeeding women is necessary. This includes more funding into culturally appropriate antenatal and postnatal care, breastfeeding supportive workplaces and early childhood centres, increasing paid maternity / parental leave, breastfeeding friendly communities and environments, culturally appropriate services and education provision for all health professionals working with whānau and infants.

Conclusion

The College values the principles of whānaungatanga (meaningful, reciprocal whānau-midwifery relationships through cultural respect, connectedness, engagement and inclusion), manaakitanga (valuing the woman / whānau voice, with the goal of a well and healthy pregnancy and birth), kia tupato (culturally safe and reflective practice, while being open to guidance), and titiro, whakarongo

[24] 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. https://aifs.gov.au/cfca/2017/05/08/report-evidence-promoting-social-and-emotional-development-and-wellbeing-infants

[25] Medley, N., Vogel, J.P., Care, A., & Alfirevic, Z. (2018). Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews. Cochrane Database of Systematic Reviews, 11 Art. No.: CD012505. DOI: 10.1002/14651858.CD012505.pub2

[26] Kildea, S., Gao, Y., Hickey, S., Kruske, S., Nelson, C., Blackman, R., Tracy, S., Hurst, C., Williamson, D., & Roe, Y. (2019). Reducing preterm births amongst Aboriginal and Torres Islander babies: A prospective cohort study, Brisbane, Australia. *EClinicalMedicine*, 12:43-51.

[27] McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. BMJ, 8(10): e022220.doi: 10.1136/bmjopen-2018-022220.

and kōrero (listening to women, developing understanding of women's and whānau priorities, and engagement in discussion) as essential components of midwifery care. Attention to the care of pregnant and birthing women, and new parents and their whānau are essential components of an effective Māori Health Action Plan. The midwifery relational model of continuity of care and partnership with women has been shown to significantly improve a range of health outcomes.

The College recognises that progress towards health equity, access and wellness will not be achieved without attention being paid to the broader societal systems, and the systemic and institutional racism and discrimination that affect Māori.

We strongly support a significant investment in the first 1000 days of life, which requires a dedicated focus on health and wellbeing in pregnancy, and early childhood. There is a growing body of evidence showing maternity care is a critical building block for the foundation of health. Giving every baby the very best start in life is crucial to preventative health care and to promoting health equity across the life course. If fully supported, midwives and midwifery care have the potential to reduce some of the significant inequities that continue to threaten health and wellbeing, and this would make a significant valuable contribution to the pathway to health and wellbeing in Aotearoa New Zealand.

Thank you for the opportunity to comment on this significant document.

Ngā mihi

Carol Bartle

Policy Analyst

New Zealand College of Midwives