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Equity in the context of co-designing sustainable rural maternity services

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Introduction

In July 2016, the Waikato District Health Board (DHB) launched a new strategy document 'Healthy People, Excellent Care'.[1] The stated mission to 'Enable us all to manage our health and wellbeing *and* Provide Excellent care through smarter, innovative delivery' underpins the Southern Rural Maternity Project and the subject of this paper.

Maternity services in rural New Zealand are recognised as being vulnerable and the Waikato District Health Board (Waikato DHB), with a population of 409,000 (60% of whom live rurally) is no exception.

The project was driven by the recognition in 2016 that the existing primary maternity services in the southern rural area of the Waikato DHB catchments of Tokoroa, Te Kuiti and Taumarunui (Southern rural Waikato) were vulnerable to service failure and were unsustainable in their current form.[3] A review of primary maternity services was undertaken by Dr Christine Hendry during 2016[2] and in early 2017 the recommendations were shared with the community through an authentic public consultation process. In May 2017, a final paper was presented to the Waikato District Health Board[4] and the Board mandate was given to proceed with the project. to ensure that women and their whanau in the region were able to have a healthy birth and as healthy a baby as possible.

This paper describes the importance of the role of a community co-design process when creating more sustainable rural maternity services and the focus on the specific governance priorities of Oranga, health equity for high needs populations and Whanaketanga, productive partnerships.

Background

In 2016, the risk to the Waikato DHB of the increasing fragility of the rural maternity services was too great to ignore. A number of papers to the Board in 2016 presented the breadth of the problems in rural health and the predicted consequences of not changing the approach to maternity services.[5] The key issues included the lack of wrap-around services for women and their babies due to broken linkages between the social sector and primary maternity carers, specific relationship issues between some of the lead maternity providers, inadequate investment by the District Health Board in its rural primary maternity facilities and lack of alignment between the DHB and other service providers.[5]

As a result of this evidence, the Board supported a recommendation to independently review the maternity services in the southern part of the DHB area, with a population of approximately 55,000 people and a population density of 3.94 per square kilometre. Waikato DHB serves a total population of approximately 419,000 and covers more than 21,000km^2, with a population density of 19.95 people per km^2.

Table 1 illustrates the birthing numbers per unit from the time of the review through to the end of the co-design process.

Table 1 Birthing numbers by Primary Birthing Unit (Southern Rural) 2015–18

Birthing numbers by unit	2016	2017	2018
Te Kuiti	41	14	*
Tokoroa	56	78	60
Taumarunui	47	65	42

* Closed 29 March 2018

The review concluded that the status quo was not viable for birthing women or midwives and recommended a number of changes to both service delivery models and infrastructure investment. The changes included a proposed new model of care for the Primary Birthing Units (PBUs) that involved moving from a mixed model of DHB employed caseload midwives and self-employed lead maternity carers (LMCs) to a full LMC model supported by Maternity Resource Centres (MRC) for each community in Tokoroa, Te Kuiti and Taumarunui. The closure of one of the primary birthing units due to very low birthing numbers would enable reinvestment into the community-based Maternity Resource Centres in each of the three towns. In addition, recommendations included upgrading the two remaining PBUs, removing barriers to service access and making more services available closer to home for rural women and their whanau (family). Following board recommendation, this model was taken out for consultation in March and April 2017 using an authentic community consultation model.

The community consultation was advertised through media, leaflet drops to shops, public areas and to homes, email chains and social media. The consultation process included public meetings, individual interviews, meetings with key stakeholders and midwives, and an online survey (address made public). Active engagement took place with Maori and Pasifika consumers and stakeholders. The feedback was robust and focussed on the pregnancy journey including access to LMCs. For some, the relationship to the rohe (iwi territory) and spiritual aspects were important, to others, connectedness and support within their community and to strong antenatal support were the key elements.

For both Maori and Pasifika women, not having access to health professionals who were culturally aware was seen as a barrier to access. A survey participant described her view of the future.

> 'Bring the services closer to the community you serve. Bring the services closer to the population you serve. Make sure that the services you are offering are a radical improvement that leads to eliminating health inequities for Maori and those in rural communities. Train your workforce (including Specialists and LMCs) to be culturally appropriate. Remove the barriers so our wahine and pepe are able to access the services they need Let the Maori community have a voice to be heard.'

Table 2 Participation in consultation process by type

	Total participants
10 face to face meetings	117
Surveys	16
Submissions	14

Participant numbers, although small, represent a cross-section of the community. The proposed model was agreed in principle by the majority of participants including community-based providers, the local Maori community, Pasifika people and service users on the understanding that a robust co-design and co-creation process would be put in place. Understandably, there was some resistance from employed midwives and from the NZ College of Midwives to the proposed employment model changes for the primary birthing units. Five key issues that arose from the consultation were access to:

- antenatal services (parenting and pregnancy education)
- ultrasound locally and without co-payment
- smoking cessation services,
- locally delivered lactation services
- secondary level specialist services at Waikato Hospital

The Southern Rural Maternity Project was mandated by the District Health Board in May 2017 following significant discussion related to the perceived risk of disinvestment from a primary, rural birthing facility and reinvestment into a new service model. Consideration was given to the access issues for women and their whanau/family and the lack of robust pre-natal supports, particularly for Maori and Pasifika women. Data from the birthing unit in question showed clearly that the majority of women domiciled in that area were already choosing to birth in a newly opened facility situated 39 minutes north (47 km^2). Resulting in birthing numbers reducing from 41 in 2016 to 18 in 2017. Reassurance was given that women would not be disadvantaged by the closure of the unit as practical transport solutions and support for women and whanau/family were built into the proposal.

From mandate to implementation

This project has followed a disciplined Prince 2 project approach. The project Governance Group was chosen to reflect the key drivers of funding and contracting requirements, the emphasis on equity and the history of maternity services in the rural areas. The membership includes the CEO of a local philanthropic organisation focussed on building the strength of the community sector in the Waikato. Supporting the skill and expertise of the governance board is a Subject Matter Expert Group and key local stakeholders including NZ Police, primary care, social sector leaders, iwi Maori and Pasifika representation. The opportunity to form a local governance group for maternal and child health services will be explored with this group as the project moves to 'business as usual'.

The project plan outlined 5 work streams with linked outcomes but operated separately for accountability; a re-designed facilities (PBU) contract, Primary Birthing Unit refurbishment of two facilities, workforce, community co-design for the MRCs and, funding and contracts.

The co-design process and outcomes

Co-design is defined in this project as a facilitated process in which women, their whanau/family and the wider community are involved in highlighting and exploring issues, finding solutions and identifying the measurable hard and soft benefits. To ensure the optimal outcome, the plan for the co-design Workstream was peer-reviewed by a Masters degree student with experience of health and disability sector co-design in NZ and the USA. There was also a commitment to being culturally appropriate. With a very small budget and a desire to include as many voices as possible, the team leveraged community partners in the co-design process. The co-design workshops were developed to 'double click' on the consultation outcomes in relation to the development of MRCs and to ask the community, women, their whanau and service providers, to explore the concepts.

The community co-design was open to the whole community, publicly advertised using various media and channels and a stronger social media approach than in the consultation. It was a genuine attempt to seek the community's skill and knowledge of their local community. Attendance was robust and included a wide range of women, whanau, grandparents and service providers across sectors. To increase participation, local Māori and Pasifika providers co-facilitated workshops within their communities. In order to encourage attendance, small incentives were organised for women such as a prize draw for a mobile phone, gift baskets and supermarket vouchers. Value-added learning opportunities by a service provider from a pregnancy and parenting class or an exercise programme were sometimes included. Venues included local sports venues, RSAs, community halls, community clubrooms and Maori or Pasifika venues. DHB or health-related properties were not used as venues.

The co-design process occurred consecutively in each of the three towns, commencing in Te Kuiti. The co-design workshops opened with a process known as 'whanaungatanga' or knowing who is in the room, the shared sense of purpose or social/family connections. This was followed by questions related to feelings or emotions such as 'What words spring to mind when you think Maternity Centre?' and moved through more focussed questions for example 'What does 'secure' mean for a woman using the Maternity Centre?' and 'What would make a service provider interacting with the Maternity Centre feel valued?'

At further workshops, prototyping activities for the location and design of the Centres took place and identification of the specific characteristics and values desired in a manager for the Centre. The questions were the same for the first round of workshops in each town and were modified to encompass the outputs and aspirations of each community.

The co-design process built on the concept that a community-based maternity resource centre will provide a physical space focussed on 'the start of the health journey for life'. It will be a community resource that promotes and supports greater collaboration and service interface to assist women and their whanau to navigate services and determine who they need to engage with to achieve positive change. The focus of the centre will be wrap-around services that promote health and wellbeing through pregnancy, birthing and beyond and provide a place for women to meet, socialise, receive and offer peer support.

The centre will be staffed by a manager and an administration person who will work with the community. The ethnicity of the manager and admin staff was identified as less important than attitude and approachability. The top attributes identified by women and whanau were 'warm and friendly, non-judgmental, confidential and respectful'. The role of the manager includes the

development of initiatives and programmes that are meaningful to local women and enable them to improve health and social outcomes for themselves, their babies and whanau.

Table 3 Co-design workshop attendee numbers

Community	Workshop attendees	# sessions offered to the community	# sessions not attended
Te Kuiti	50	5	-
Taumarunui	51	8	2
Tokoroa	49	7	1

Each centre is a product of co-design with the local community. The final design includes a meeting room for education and support groups; baby and child-friendly spaces; multi-purpose small rooms that can be used by health or social service professionals and midwives for consults with women; a well-equipped kitchen; technology to enable learning, access to information, and telehealth. Most importantly the centre will be a place where women can navigate service options and determine a plan for their health and wellness journey. Access to midwives is an issue in rural locations and the Centres will facilitate appropriate access or support from a Lead Maternity Carer (LMC).

For women with more complex medical needs, there is potential to provide a whole of system approach to enable closer relationships with obstetric services. Issues of safety for vulnerable women and victims of domestic violence were also discussed. This led to specific criteria related to exits and entrances being included in the building design.

From co-design to co-creation

The community co-design workstream was pivotal in moving the project towards achieving equity by removing access barriers and providing access to a range of new services and supports for women and their babies in the southern rural area. The co-design process used creative thinking approaches, allowing people from diverse backgrounds to focus on a common subject or goal, to build on each other's ideas and to take the lead in designing solutions. Co-creation in this project emerged from the community's ability to produce ideas that could lead to new and different service options and to stay engaged in developing the service model. In this project, co-design blurred the boundary with the co-creation process as the participants in the process identified where value could be added or created by leveraging existing services linkages, adding other services to prevent longer-term issues and supporting women and child health.

Dedication to equity focus

The project team aligned with the NZ Ministry of Health's framework 'Equity of Health Care for Māori'.[6] The framework focusses on Leadership, Knowledge and Commitment.

In each locality, the centre will work closely with funders and providers to meet the aspirations and needs of Maori. Whanau were clear about their expectations and needs during the co-design process which the Strategy and Funding team paid attention to. Where possible contracts and service expectations have been adapted to support this goal. This is exemplified by developing a new Service Level Agreement for a specialist rural lactation service and the additional funding for pregnancy and parenting education. The latter will enable more sessions to be offered in rural communities rather than women and their whanau having to travel to the nearest city (travel time ranges from 1.25 hours to 2.75 hours). Smoking cessation is another key target as Waikato has a high

rate of maternal smoking, causing the highest modifiable risk factor which disproportionately impacts women in low socioeconomic areas and women of Māori ethnicity, with poor outcomes for infant and maternal health.[5]

Outcomes from the co-design focus the Maternity Resource Centres towards a more holistic model of care, supporting the view that it is important to address the determinants of health. Some surprise has been expressed at the emerging service model as it provides cookery classes for women (baby food and cooking on a budget), the importance of reading to baby, encouraging language development, newly born vision hearing testing, yoga classes pre and post birth, and other wellness programmes. Significantly, if this is what draws women into the Centre, other more traditional messages can be discussed such as immunisation, car seat restraint and milestone development checks. The centre will enable these services to be accessed.

Keeping good data on the services that are delivered and the natural networks that develop in communities is a key focus moving forward. It was a failing of the co-design that a significant number of Maori and Pasifika women involved but specific ethnicity data was not collected.

Summary

The project is committed to removing barriers and has already delivered some of the desired outcomes for women. This will increase as further Maternity Centres open and provide access to health and social service needs. A continued commitment to the three equity focus areas in the NZ Ministry of Health's Maori Health Strategy He Korowai Oranga[7] will challenge the local stakeholder/governance groups and ensures that the whole community benefits. The areas are

- continuing to develop good-quality ethnicity data to measure and report on the health status
- continuing to build the evidence to inform the knowledge base for Māori health
- working outside the health and disability sector from time to time.

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Presenters

Jill Dibble's career progression has focused on the development and provision of health services in community settings. Jill worked as a public health nurse in both urban and rural areas for a number of years before moving into community health management. Since 2006, she has been leading the Waikato DHB's rural and community services and is passionate about the delivery of quality health services and achievement of better health outcomes for people in their own settings. She has a special interest in rural and high need communities, with a strong belief that health services and facilities should support local solutions to local issues and that the way forward for health must include an integrated health approach. To achieve sustainable, resilient communities and the services and changes they need, a paradigm shift in the current propensity to plan 'for' people rather than to plan 'with' people is required.

Bernadette Doube has a governance and strategic focus in the work she does, and to this, she brings experience in senior management positions both in New Zealand and the UK. Her career started in the health sector as a speech and language therapist, transitioning from clinical practice to clinical research and on to senior management roles. As a self-employed project manager, Bernadette has worked across the whole sector, from primary care to emergency departments, in urban and rural settings. She has a particular interest in rural health, and her expertise includes community engagement, service design and project management. Throughout her career, Bernadette has been involved in the management of a number of change projects in the UK and NZ health and disability sectors.