Briefing for information

Improving Pacific perinatal health outcomes

Date due to MO:	27 September 2024	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Reference:**	H2024050873
To:	Hon Casey Costello, Associate Minister of Health		
Copy to:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		

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Minister's office to complete:

☐ Noted ☐ Seen

☐ Needs change ☐ Withdrawn

☐ See Minister's Notes ☐ Overtaken by events

Comment:

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Purpose of report

1. This briefing provides you with information on the Pacific Expert Advisory Group's (PEAG) recommendations to improve Pacific perinatal health outcomes.

Summary

2. Despite various interventions, poor perinatal health outcomes remain a significant issue for Pacific peoples. This is underscored by a lack of prevention and early intervention, and the influence of wider determinants of health.
3. The Ministry of Health (the Ministry) is collaborating with Health New Zealand (Health NZ) and other agencies to strengthen existing efforts to address consistently poor Pacific perinatal outcomes, including work to improve Pacific health data quality.
4. The Ministry supports the PEAG recommendations to improve Pacific perinatal health outcomes, but scoping is needed to understand the feasibility of implementation. The Ministry will keep you updated on this work.

Recommendations

We recommend you:

a)	**Note** the persistent and inequitable perinatal mortality rates for Pacific peoples, and the recommendations made by the Pacific Expert Advisory Group (PEAG) to respond.	**Noted**
b)	**Note** the Ministry will initiate scoping work to explore the PEAG recommendations and opportunities to build on existing work.	**Noted**
c)	**Note** the Ministry will provide you with further information once the scoping work is complete.	**Noted**

Dr Andrew Old
Deputy Director-General
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Date: 27 September 2024

Hon Casey Costello
Associate Minister of Health
Date:

Improving Pacific perinatal health outcomes

Background

1. The PEAG is a group of experienced Pacific health and community leaders who provide advice to the Ministry and the Minister of Health around Pacific health matters. The PEAG provides a platform to draw attention to key issues impacting Pacific peoples' health, and to advise on strategies to mitigate these. For further information on the PEAG, see briefing attached at **Appendix 1** (H2023034113 refers). Note that the PEAG has had two resignations since the time of this briefing, from Vui Mark Goshe and Dr Siro Fuata'i. Subsequently two new members have been appointed to the group, Dr Fiona Perelini (Paediatrician and Paediatric Intensivist, Starship Hospital) and Abel Smith (Director of Nursing Pacific, Auckland, Health NZ).

2. On 29 July 2024, the PEAG met and raised their concerns around the lack of improvement in Pacific perinatal mortality rates despite decades of investment.

Poor perinatal health outcomes persist

3. Since 2007, the National Mortality Review Committee (NMRC) has published annual reports on perinatal and maternal mortality trends along with recommendations to address these. Across all population groups there has been little change in perinatal related mortality rates (PMR)[1] between the period 2007-2021, except for a slight decrease in the stillbirth rate (SBR) up to 2012.

4. In New Zealand, inequitable perinatal health outcomes persist for Māori, Pacific and Indian ethnic groups compared to New Zealand European mothers. Similar trends can be observed for mothers aged 20 years and younger, as well as those living in the most deprived areas compared to older mothers and those living in the wealthiest areas, respectively. These disparities indicate the health system's inability to meet the needs of these groups and respond in a timely manner.

5. For the decade 2012 to 2021:

    a. Pacific mothers experienced the second highest PMR[2] (12.57) and SBR (6.68), after Indian mothers (PMR 14.41, SBR 6.92). Pacific rates are higher than Māori (PMR 10.69, SBR 5.24) and NZ European mothers (PMR 10.57, SBR 5.07)

    b. the age of the mother is a risk factor. The PMR was highest among mothers aged less than 20 years (PMR 16.63) and mothers aged 40 years and over (PMR 14.46) for the overall population, with similar trends observed for Māori and Pacific mothers

[1] Perinatal mortality is fetal and early neonatal death from 20 weeks' gestation (or weighing at least 400 g if gestation is unknown) until midnight of the 6th day of life. Perinatal related mortality is fetal deaths (including terminations of pregnancy and stillbirths) and neonatal deaths (up to midnight of the 27th day of life) per 1,000 total babies born at 20 weeks' gestation or beyond and weighing at least 400 g if gestation was unknown.

[2] The perinatal related mortality rate (PMR) and stillbirth rate (SBR) is given as the number of deaths and stillbirths per 1000 total births, respectively.

c. the PMR among those living in the most deprived areas was 1.46 times greater than those living in the least deprived areas, with respective PMRs of 12.88 and 8.85

d. excluding congenital anomalies, leading causes of perinatal death classification with specific PMR for Pacific mothers or as a percentage of all Pacific perinatal deaths, were:

   i. spontaneous preterm labour or rupture of membranes (the PMR associated with this classification was 2.24 per 1,000 births, and accounted for 22% of all Pacific perinatal deaths)

   ii. unexplained antepartum foetal death (PMR 1.57 or 16%)

   iii. antepartum haemorrhage (PMR 1.53 or 15%)

   iv. maternal conditions (PMR 1.24 or 12%)

   v. placental dysfunction or causative placental pathology (PMR 1.00 or 10%).

   vi. specific perinatal conditions (PMR 0.59 or 6%)

   vii. perinatal infection (PMR 0.52 or 5%)

   viii. complications of multiple pregnancy (PMR 0.51 or 5%)

   ix. hypertension (PMR 0.49 or 5%)

e. if the rates of perinatal infection, hypertension, antepartum haemorrhage, and maternal conditions were the same as the observed European group, this would mean a 46% reduction in perinatal mortality, which corresponds to 110 fewer Pacific babies dying over this period.

6. Therefore, there is strong rationale to investigate actions required to address these long-standing inequities and to drive positive shifts in both burden of disease and mortality trends.

7. See **Appendix 2** for summary information on maternal health outcomes.

Approach to improve Pacific perinatal health outcomes

Strategic direction

8. The *Government Policy Statement on Health 2024-2027* outlines specific expectations to improve lead maternity carer (LMC) enrolment rates in the first trimester of pregnancy and early intervention.

9. *Te Mana Ola: The Pacific Health Strategy (Te Mana Ola) (2023)* and the *Women's Health Strategy (2023)* also highlight perinatal and maternal health as a focus area, with the objective to see all Pacific women receive high-quality maternity care during pregnancy.

10. Additional cross-agency collaborative efforts include the *Child and Youth Wellbeing Strategy (2020)*, a national strategy to improve the wellbeing of all children and young people aged less than 25 years.

Progress at the operational level

11. In 2022, Health NZ introduced Kahu Taurima, a programme that builds on the Well Child Tamariki Ora Framework and relevant reviews.

a. Kahu Taurima focuses on driving the integrations of maternity and early-years services for a child's first 2,000 days of life, from conception to five years of age.

b. The programme supports 42 providers to deliver integrated care for families, including five Pacific providers across Auckland, Wellington, and Christchurch.

c. Six-monthly reporting focuses on service provision rather than specific deliverables, to give providers the flexibility to deliver holistic models of care that meet the needs of the populations they service. Examples include reporting on the number of Pacific peoples accessing the services and the type of supports used.

d. Lessons from both Pacific providers and Hauora Māori partners will help to inform the universal model of care for Kahu Taurima. This includes the recent establishment of a technical advisory group that will play a pivotal role in finalising the National Perinatal Bereavement Care Pathway in March 2025.

12. Counties Manukau has the highest perinatal mortality rate in the country. To address this, Health NZ is working to establish a working group to improve midwifery service provision and accessibility for the Northern region by:

a. identifying rapid and tangible actions to enable early accessibility of care in the community

b. establishing an approach to leverage existing community providers (both Pacific and primary health care and midwifery collectives to improve early access to health services for mothers and babies

c. considering innovative ways to effectively use existing resources and models of care to focus activities on the high-needs population (mixed model funding)

d. addressing major underlining regional issues such as workforce shortages

e. establishing an overarching governance group to include development of quality assurance processes.

Robust data quality and infrastructure will support better outcomes

13. Pacific ethnicity classification and denominator selection across government agencies, non-governmental organisations (NGOs), and academic institutions remains a challenge. The integrated data infrastructure (IDI) has been slow to adapt, and fails to capture the evolving demography of a growing Pacific population. This impacts the ability of analysts to accurately describe and monitor the extent to which perinatal and maternal mortality rates and trends are being influenced, and where best to target resources.

14. The Ministry is aware of this issue and is actively working to strengthen its Pacific health intelligence function as part of the implementation of *Te Mana Ola*.

Key recommendations from the PEAG

In addition to existing interventions, the PEAG recommends the following:

15. Greater accountability to be placed on health agencies around collecting, analysing, and reporting of accurate data on Pacific peoples. Inaccurate and/or poor data quality hinders effective perinatal and maternal interventions.

16. While the NMRC provides mortality data, there is merit in investigating morbidity measures that may provide insight on opportunities to prevent perinatal deaths including 'near miss' events.

17. A multiagency approach that includes health, housing, social service, and income support providers to deliver effective and holistic services to support Pacific families with young babies to be and remain well.

18. The Ministry to explore an intentional monitoring process to enable timely identification and resolution of issues to ensure positive shifts in Pacific perinatal outcomes.

The Ministry supports these recommendations, however further scoping is needed

19. There is clear direction and rationale to prioritise these recommendations. However, additional work is required to understand how they may be realised through existing work programmes and initiatives.

20. Officials will provide you with further information on scoping work related to the PEAG recommendations.

Next steps

21. The next PEAG meeting will be held on 30 September 2024. Hon Minister Reti will be attending this meeting. Further opportunities can be sought for you to engage with the PEAG on issues highlighted in this briefing as a combined effort to address issues within your delegations and Hon Minister Reti's delegations, including Pacific health, women's health and maternal health. Ministry officials can coordinate this with your office.

22. The Ministry will begin scoping work to assess the feasibility of implementing the PEAG recommendations and its alignment with existing work programmes.

ENDS.

Appendix 2: Pacific maternal health outcomes

Why this is important

Research shows that investing in antenatal care and life in the first 2,000 days can make the biggest difference to lifelong, and intergenerational wellbeing.

Pacific peoples want to see Pacific women have better access to high-quality maternity care that is timely, easy to navigate and culturally safe. This will contribute to more Pacific women receiving the critical assessments, screening, prevention and early interventions they need, ultimately resulting in improved Pacific maternal and child outcomes.

Maternal mortality

For the years 2006 to 2021:

16%

Of all **maternal deaths** were Pacific

The **maternal mortality rate** (MMR) per 100,000 for Pacific mothers is

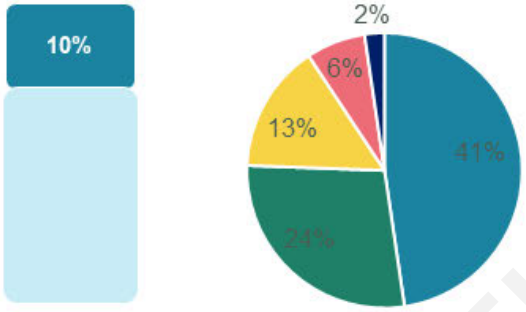
21.19

...**the second highest MMR** after Māori and almost twice that of European mothers.

If Māori and Pacific mortality rates were the same as European rates, overall maternal mortality in NZ would **decrease** by

30%

Pacific ethnicity breakdown of babies born in 2022



In 2022, of the 57,700 babies born live in NZ, 10% (n=5,860) were Pacific.

The number of Pacific live births every year is steadily falling reflecting declining trends for global and national fertility rates.

National initiatives that potentially impact perinatal outcomes

- Small for Gestational Age and Fetal Growth Restriction in Aotearoa New Zealand – Clinical Practice Guideline (update; 2023) and national roll-out of GROW 2.0 tool (2023)
- Guidelines for Consultation with Obstetric and Related Medical Services (updated in 2023)
- Mandatory fortification of flour with folic acid (2023)
- Revised smoking cessation guidelines (2014 and 2021)
- Immediate postnatal observation guidance (2012)
- Hypertension in pregnancy guidelines and update (2018 and 2022)
- Neonatal encephalopathy consensus statement (2019)
- NZ consensus statement on the care of mother and baby(ies) at peri-viable gestations (2019)
- Gestational diabetes guideline (2014 – being updated)
- NZ College of Midwives (2022) Intermittent Auscultation
- Royal Australian and NZ College of Obstetricians and Gynaecologists (2019) fetal surveillance guidance
- National Perinatal Pathology Service panui (2020)

Maternal health outcomes

Only 48% of pregnant mothers, and about **one in five Pacific pregnant mothers receive the influenza vaccine and pertussis vaccine**. Ensuring pregnant Pacific women and their whānau are well-informed and supported to make positive decisions to vaccinate in pregnancy remains important for those involved in their care. Establishing accurate maternal immunisation coverage data is critical.

Of all live births in 2022, **15% of Pacific mothers had diabetes in pregnancy**. Regarding preterm births, 28% of Pacific mothers had diabetes in pregnancy. The establishment of robust follow-up screening programmes for diabetes, cardiovascular risk factors, and renal disease are an essential requirement for all women diagnosed with GDM. This includes access to culturally appropriate dietary and lifestyle support measures.

Pacific mothers experience higher rates of antenatal depression compared to non-Pacific mothers. One third of Pacific women with antenatal depression are aged less than 25 years. Antenatal depression is more likely to occur in Pacific women who are indifferent to Pacific culture and traditions and **over four times likely if they are not enrolled with a GP**. Pacific women require antenatal support that recognises their mental health needs and the associated psychosocial and socioeconomic factors that influence these, and services that facilitate timely access to effective non-discriminatory support measures.

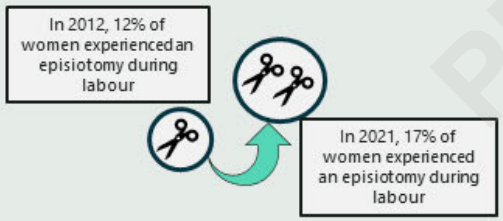
In a study across three districts in NZ: 1) **Postpartum anaemia (PPA)** Hb < 100 mg/L was detected in 38% of mothers but **was higher for Māori (49%) and Pacific mothers (44%).** 2) While the percentage of all mothers with Hb <90 g/L was 15%, this proportion was higher for Māori (18%) and Pacific mothers (20%). 3) **After adjusting for deprivation and region, Pacific mothers were 30% more likely**, and non-Māori non-Pacific 37% less likely, to experience PPA compared to Māori mothers.

Appendix 2: Pacific maternal health outcomes

Birth interventions

In the decade 2012 to 2021

Pregnant women in NZ	Pregnant Pacific women in NZ
	
In 2021, the percentage of births associated with induction was 30%, an increase of 32% since 2012.	In 2021, **one third of Pacific mothers experienced induction** of labour, an increase of 46% (24% in 2012).
	
In 2021, the percentage of births associated with augmentation was 20%, a decrease of 28% since 2012.	In 2021, **one in four Pacific mothers experienced augmentation** of labour, a decrease of 34% (30% in 2012).



In 2021, the percentage of women experiencing an episiotomy during labour increased by 42%.

Over this period, **the percentage of Pacific women receiving an episiotomy increased** from

8% → 13%

However, proportions have been lower than the national average.

In the years 2009 to 2021

The percentage of births that are caesarean section continue to increase for all mothers in NZ. However, in 2021 **lower percentages of caesarean sections were experienced by Māori and Pacific mothers** compared to non-Māori non-Pacific mothers.

A **higher and increasing proportion of Pacific mothers receive blood transfusions** after vaginal birth and caesarean section compared to their peers.

In 2021, Pacific mothers were almost

2x

as likely to receive a **blood transfusion** peaking at 4.2% (n=181), compared to 2.4% among non-Māori non-Pacific mothers.

Pacific postpartum mothers are more likely to experience anaemia and receive treatment (blood transfusion, intravenous iron) during the peripartum period, **but less likely to report symptoms of postpartum anaemia.**

The percentage of mothers receiving a **blood transfusion after caesarean section** has also been **persistently higher** for