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Maternity Services Consumer Council

WELCOME, TENA KOUTOU KATOA, KIA ORANA, TALOFA LAVA, MALO LELEI, FAKAALOFA ATU.

Welcome to the fourth issue of the Maternity Services Consumer Council's Newsletter for 2010.

As reported in the September issue of the newsletter this year was the year that the Ministry of Health rediscovered their responsibilities for the oversight of the maternity sector. It was a very demanding year for the MSCC as members worked on a number of MOH projects such as the expert working group revising the referral guidelines, the revising and updating of the MOH's *Your Pregnancy* booklet, the maternity standards advisory group, and the maternity service specifications working party.

However, the return of some degree of confidence in the Ministry's turn around has recently been seriously undermined by the news that history was about to repeat itself and the maternity team within the MOH is once again about to be decimated. This daft move is part of the major restructuring of the Ministry that the Acting Director-General of Health is undertaking just prior to the arrival from Scotland of new DG. Someone needs to explain what that is all about!

MSCC's new *Epidurals during labour* leaflet
The MSCC has produced a new leaflet, the second in its ***The Facts*** series – *Epidurals During Labour.* The leaflet follows the production of the *Caesarean Section: The Facts* leaflet last year, and funding is being obtained for a third leaflet, this one on inductions. There is a charge for these leaflets – refer to the MSCC website www.maternity.org.nz. We also request a donation to cover postage and handling costs for orders over 50.

What's in this issue of the newsletter
The December issue of the newsletter features a report on the results on antenatal HIV screening in 2009, an article on the draft NZ Maternity Standards document which has now been released for consultation, an item on the two new postnatal distress support groups being run by the PND Support Network, an article on pain relief in labour, a report on foetal growth surveillance, and much more.

Don't forget to check the dates for the MSCC's Steering Group meetings for next year and put them in your diary. Then we recommend that you all take a well earned break over the summer holidays. See you in the New Year.

Happy Reading!

Lynda & Jennie

ANTENATAL HIV SCREENING IN 2009

It took several years and many hundreds of thousands of dollars to roll out New Zealand's antenatal HIV screening programme. Some of those involved in this lengthy process were extremely sceptical about whether the programme would be cost effective. There were also major concerns repeatedly expressed about the informed consent aspect of antenatal HIV screening as initial reports revealed that many women were unaware that they were also being tested for HIV when they having their first round of antenatal blood tests.

In March 2010 the AIDS Epidemiology Group (AEG) at the University of Otago Medical School issued its report on HIV infection and AIDS diagnosed in NZ during 2009.

The report revealed that 151 people were diagnosed with HIV in 2009. Of these 73 were men infected through sex with other men; 50 (24 men and 26 women) through heterosexual contact; 5 men through injecting drug use; 3 through mother-to-child transmission; and 2 through possible health care related infection overseas. For the remaining 18 people the means of infection was unknown or unreported.

A further 48 people were reported with HIV through viral load testing. They were mostly people who were previously diagnosed overseas.

Mother-to-child transmission

Three children (two siblings) were diagnosed in 2009 with HIV that had been acquired through mother-to-child transmission. One of the mothers was of Asian ethnicity and the other African. All three had been born in New Zealand to women whose HIV had not been diagnosed during pregnancy. The children were aged between 5 and 8 years at the time of being diagnosed with HIV.

A further two children, who had been previously diagnosed overseas, were reported through a viral load test.

Since 1995 there have been 84 births to women known to be infected with HIV at the time of giving birth. None of the children have been infected with HIV.

Antenatal HIV screening in 2009

In response to an Official Information Act request – the AEG report did not mention antenatal HIV screening – the AWHC was advised that three women were diagnosed with HIV in 2009 as a result of antenatal HIV screening. Two of the women were African and one was Maori. Two of these women were from the northern region (Northland and Auckland) and one woman was from the lower North Island.

In 2009 there were just over 62,250 births in NZ. An undiagnosed and/or untreated HIV+ woman has a 25% chance of infecting her infant during the birth process. Given such figures the increased cost of introducing an antenatal HIV test that pregnant women now wittingly or unwittingly have is hard to justify.

- http://dnmeds.otago.ac.nz/departments/psm/research/aids/pdf/65%20AIDS-NZ%20March%202010.pdf

DRAFT NZ MATERNITY STANDARDS

The Ministry of Health has produced a draft set of standards to guide the planning, funding and monitoring of maternity services by the Ministry, National Health Board and District Health Boards. The Ministry is now calling for feedback on the document.

The Maternity Standards are part of the project to improve the quality and safety of New Zealand's maternity services, and the 18-page draft document has been prepared in consultation with health professional and consumer representatives.

There are three Standards.

Standard 1
Maternity services provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.
There are eight audit criteria applicable at a national level – Ministry of Health, National Health Board, and the professional colleges. They include regular reviews of maternity service specifications and evidence-based clinical guidelines documents, the development of a national electronic maternity record and the annual publication of a national maternity report.

Another four audit criteria apply to the District Health Boards. They include the requirement that all DHBs produce an annual maternity report, implement the evidence-based clinical guidelines and the maternity service specifications, and increase the proportion of women with additional health and social needs receiving continuity of midwifery care.

Standard 2
Maternity services ensure a woman-centered approach that acknowledges pregnancy and childbirth as a normal life stage.
There are three audit criteria applicable at a national level. They are that women have access to nationally consistent information on maternity issues and services; that national service frameworks support women being provided with continuity of care, and women are able to provide feedback on their experience of using maternity services.

Another four audit criteria apply to the DHBs. They are that women have access to childbirth education services, that all DHBs obtain regular consumer feedback on maternity services, that maternity services are culturally safe and appropriate, and that women can access continuity of care from an LMC for primary maternity care.

Standard 3
All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.
There two audit criteria applicable at a national level, and five that apply to the DHBs.

Submissions are due by 28 January 2011. Please email the MSCC for a copy of the document and submission guidelines.

PERINATAL & MATERNAL MORTALITY IN 2008

The Perinatal and Maternal Mortality Review Committee (PMMRC) has released its report on perinatal and maternal mortality in New Zealand for the year 2008. This is the committee's fourth PMMR report.

Maternal mortality
There were four direct maternal deaths and five indirect maternal deaths in 2008. A direct maternal death is one that is the result of obstetric complications during pregnancy, birth and up to 42 days postpartum, and from interventions, omissions or incorrect treatment. An indirect maternal death is one that is the result of a pre-existing disease or a disease that developed during pregnancy that was not due to obstetric causes, but was aggravated by the physiologic effects of pregnancy.

The four causes of the four direct deaths were amniotic fluid embolism, postpartum haemorrhage, pulmonary embolism, and preeclampsia.

The five indirect deaths include four suicides and two pre-existing medical conditions.

The nine maternal deaths included:
- 3 antepartum and 6 postpartum
- 6 occurred in hospital and 3 in the community
- 8 births and 1 undelivered baby
- 6 with potentially avoidable factors present, 2 with none, 1 unknown.

The factors relating to the potentially avoidable deaths involved slow recognition of the severity of the woman's condition and the need to act appropriately, delay in recognising a need for action in response to mental health problems, lack of interdisciplinary communication and handover of care, and inadequate documentation.

The report notes that because the number of direct maternal deaths over the past three years is so small – 6 direct deaths in 2006, five in 2007 and 4 in 2008 – it is not really possible to identify any trends. This is also the case with the indirect maternal deaths – there were 7 such deaths in 2006, 5 in 2007 and 5 in 2008.

The section of the report on maternal mortality concluded with a number of recommendations in reference to hypertension in pregnancy, major haemorrhage, obstetric emergencies, a team approach to care for women with complex medical conditions, the wearing of seatbelts in pregnancy, and maternal mental health. They include the recommendation that national guidelines should be developed for the management of postpartum haemorrhage, encompassing a massive transfusion protocol.

Maternal Mental Health
Maternal mental health was the major focus of last year's PMMRC meeting as a result of the emerging statistics on suicide. Over the past three years 20% (7 out of 35) of the maternal deaths was the result of suicide.

The report recommends the integration of maternal mental health services into maternity services, and confirms the need for a mother and baby unit in the North Island, two initiatives that the MSCC has supported and lobbied for since the mid 1990s.

However in addressing the need for accurate antenatal screening and documentation of mental health history, the suggested screening questions remain fixated in the medical model of maternal mental health, and this needs to be changed.

Perinatal mortality
In 2008 the perinatal mortality rate was10 per 1000 deaths – perinatal mortality being foetal or early neonatal deaths after 20 weeks gestation and up to 7 days after the birth. This is comparable to the rates in 2007 and to rates in both Australia in 2007 and the UK in 2008.

Some of the key points in the report are:

- The intrapartum stillbirth rate continues to be of concern as the majority of these babies are term and not small for gestational age and may have been preventable deaths.
- There were 10 neonatal deaths (up to 28 days of age) in 2008 of healthy babies due to sudden unexpected death in infancy (SUDI). Smoking and co-sleeping are risk factors for SUDI. In 8 of these deaths, there was co-sleeping and 9 of the babies had mothers who smoked.
- A combined analysis of 2007 and 2008 data found that Maori and Pacific women were more likely to have a stillbirth or neonatal death compared with NZ European and Asian (not including Indian) women. The reasons for these inequalities are unknown and require further investigation.
- Maori and Pacific women and those women living in areas of high socioeconomic deprivation are more likely to have a stillbirth or neonatal death as a result of spontaneous preterm birth.
- Women under the age of 20 and over the age of 40, Pacific and Maori women and women residing in areas with deprivation deciles of 8 or higher all independently have an increased risk of stillbirth.
- In 2008, 49% of women who had stillborn babies and 45% of mothers of neonatal deaths were overweight or obese. Lack of national data on all mothers who give birth in New Zealand make it difficult to draw conclusions about the role of obesity in perinatal related death

Future PMMRC reporting
The report has two recommendations for future PMMRC reporting. They are:

- The PMMRC should undertake further analysis and discussion on the ways of reporting ethnicity and perinatal deaths
- The PMMRC should analyse the data collected in 2009 for potentially avoidable factors, with an emphasis on intrapartum stillbirths.

A full copy of the PMMRC report can be accessed at:
www.pmmrc.health.govt.nz/moh.nsf/pagescm/7743/$File/pmmrc-4th-annual-report2009.pdf

PND NETWORK NOW RUNNING TWO SUPPORT GROUPS

The Postnatal Distress Support Network is now running two support groups in Auckland. The Tuesday morning group is held weekly at the West Auckland Women's Centre at 111 McLeod Road in Henderson from 10am till noon, and a second group is now being held from noon till 2pm on Monday afternoons in Green Lane.

The support groups provide a gentle and safe environment for women struggling with ongoing feelings of distress and depression after the birth of a baby. Women often find that being with others who have similar experiences and feelings and being able to share what is going on for them is very helpful and supportive. Both groups are open to women from anywhere in Auckland and women can attend as often as they want to.

The Henderson group provides a creche for the duration of the group in which child care workers take care of pre-schoolers on the premises, while mothers enjoy a relaxed, safe and flexible atmosphere in a professionally facilitated, peer support group of women who are at various stages of recovery.

The Green Lane group is a babes-in-arms group that does not have a crèche.

Both groups provide a **free** service and women do not need a referral from a doctor or any other health professional in order to attend.

As well as the two support groups the PND Network provides telephone support and drop-in support for women at the PND Network office.

The PND Network has recently been approached about running a group at the North Shore Women's Centre as those working with mothers report a need for a support group for women on the North Shore.

For further information contact Anniina Ballantine on (09) 836-6967 or email: info@postnataldistress.org.nz. The PND Network website can be accessed at http://www.postnataldistress.org.nz/support-services.php

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WHAT DO WE TELL WOMEN ABOUT OPTIONS FOR PAIN RELIEF IN LABOUR?

The pain, the pain, oh the terrible pain. The vast majority of pregnant women spend some part of their pregnancy worrying about the pain of labour. How bad will get? Will I be able to cope? How soon before I can get an epidural? Is it really as terrible as they say it will be? As each woman travels through her maternity care, does she receive consistent support, advice and information in relation to her pain relief options? It can certainly be argued that she does not. Information is slanted by the views of the person providing it – swaying from one extreme; there is no need to suffer unnecessarily, through to the other; pain is a normal part of the experience of birth; and everything in between. For a woman and her whanau, they have to navigate their way through these varying philosophies, attempting to place themselves and their own world views into the philosophy of the person seated across from them.

In an ideal world all those involved in the maternity sector would sing from the same song sheet. Advocates, Childbirth Educators, Midwives regardless of the setting, Obstetricians, Anesthetists, GP's and community organisation, would have an agreed set of principles that information was based on. They would be both evidence based and woman friendly and they would above all else be consistent.

So in this mythical "ideal world" what would be the key messages on the song sheet?

1. **Childbirth is a normal physiological process**
   Shocking perhaps, but true. All those working at the coalface need to be aware of their own tendency to become risk averse and lose sight of the fact that for many, birth is not an illness and women are not patients.
2. **Pain is a normal part of this process**
   Pain in labour is not abnormal. It serves a multitude of purposes, its primary one being to provide essential feedback to the woman and her support team. Throughout labour there are a number of interdependent hormonal players whose sole job is to bring about a safe and healthy outcome. Pain is a vital aspect of this process.
3. **A woman's body is beautifully designed to cope with labour and birth**
   Is the blueprint so flawed that it requires medical assistance every time? Those suffering diabetes or heart disease have a glitch in their blueprint but does that mean medicine should treat everyone as though they have diabetes or a cardiovascular disease? Trust in the process of birth is essential.
4. **For some women more medical forms of pain relief can be a necessary part of her experience, however these interventions may not be without risk**
   In spite of the normality of birth, it would be unreasonable to suggest that for some women more assistance may not be necessary; however it is also unreasonable to suggest that this assistance is without risk.
5. **Epidural medications may significantly interfere with the normal and finely tuned balance of labour, birth and breastfeeding.**
   We ignore the role of the key birthing hormones – prostaglandin, oxytocin, beta-endorphins and catecholamines – at our peril.

6. **While medical forms of pain relief may be requested, a woman needs to make a fully informed decision which includes being made aware of the risks.**
   The Code of Rights talks about providing a level of information that a "reasonable person" would expect to receive. This includes the good, the bad and the ugly – women are capable of balancing the information to reach decisions that are right for her and her right to do so must be respected.

It is well accepted that there is actually little in the way of solid evidence supporting much of maternity care and many clinicians are guided by a "knowing" littered with ever growing pockets of evidence-based practice. The gold standard however is to utilise evidence to support both the information given and the care recommended. The difficulty lies in finding a body of evidence that can be accepted and utilised by all those working within the maternity sector.

The NICE guidelines for Intrapartum Care of healthy women and their babies, 2007 (updated June 2008), is perhaps the only current document that comes close to meeting the needs of both women and practitioners. There is a significant body of evidence supporting the recommendations with a large multi-disciplinary team involved in the development of the guidelines. There are a number of recommendations contained with the guideline with regards to pain relief options in labour and these can be utilised to ensure that women are receiving consistent, evidence-based information:

- Healthcare professionals should consider how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.
- Women who choose to use breathing and relaxation techniques in labour should be supported in their choice.
- Women who choose to use massage techniques in labour that have been taught to birth partners should be supported in their choice.
- The opportunity to labour in water is recommended in labour.
- Accupuncture, acupressure and hypnosis should not be provided, but women who wish to use these techniques should not be prevented from doing so.
- The playing of music of the woman's choice in the labour ward should be supported.
- TENS should not be offered to women in established labour.
- Ethonox should be available in all birth settings as it may reduce pain in labour, but women should be informed it may make them feel nauseous and light-headed.
- Opiods should be available in all birth settings. Women should be informed that these will provide limited pain relief during labour and may have significant side effects for both the woman (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days.)
- Women should be informed that opiods may interfere with breastfeeding.
- Before choosing epidural analgesia, women should be informed about the risks and benefits, and the implications for labour:
    - it provides more effective pain relief than opiods
    - it is associated with longer second stage of labour and an increased chance of vaginal instrumental birth
    - it is not associated with long-term backache
    - it is not associated with a longer first stage of labour or an increased chance of caesarean birth

  - it will be accompanied by a more intensive level of monitoring and intravenous access
  - modern epidural solutions contain opiods and, whatever the route of administration, all opiods cross the placenta and in larger doses may cause short-term respiratory depression in the baby and make the baby drowsy
- Women in labour who desire regional analgesia should not be denied it, including women in severe pain in the latent first stage of labour
- Women with regional analgesia should be encouraged to move and adopt whatever upright positions they find comfortable throughout labour
- Once established, regional analgesia should be continued until after completion of the third stage and any necessary perineal repair
- At full dilatation, pushing should be delayed for at least one hour and longer if the woman wishes unless the woman has the urge to push or the baby's head is visible

Until all those working with women during the childbearing year get onto the same page, what women are told about pain relief is subjective and heavily influenced by personal values and beliefs leaving women are in the middle, questioning who to believe.

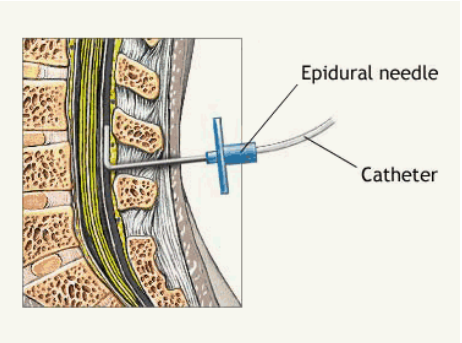
Perhaps the focus instead needs to be on empowering women to believe enough in themselves and their own bodies so they can make a decision that is right for them.

The NICE guideline of Intrapartum Care can be download from:
http://www.nice.org.uk/CG55

EPIDURALS DURING LABOUR: THE FACTS

The Maternity Services Consumer Council (MSCC) has produced another new pamphlet on the risks and side effects of the use of epidurals during labour. The pamphlet is the second in the ***The Facts*** series and it contains information on:

- What is an epidural
- How is it given
- The benefits of epidural analgesia
- The disadvantages of epidurals
- Epidurals and caesarean sections
- The hormones of labour
- Side effects on the baby
- Positive birth experiences
- Minimising the risks of epidurals
- Informed consent



Copies of *Epidurals During Labour: The Facts* are available for $1 each for orders up to 20 copies. Postage and handling costs are also invoiced at the time of fulfilling your order.

FOETAL GROWTH SURVEILLANCE

Pregnancy is no longer a normal event to be enjoyed by women as they embark on the next stage of their life journey. It is instead a continuous screening episode where the maternal "host" needs to be checked and re-checked to ensure that she brings no harm to the foetus on board. The baby too, has become a matter of surveillance rather than a growing human being who needs a maternal bond sufficiently strong enough to protect him or her from harm once born.

While it cannot be argued that many screening tools bring significant information to the table, the impact of these interventions on the way women feel about their pregnancies, their bodies and their ability to nurture and protect their growing infant must not be lost in murky "need to know" waters.

GROW (Gestation Related Optimal Weight) is the software used to generate a customised antenatal growth chart. The chart is based on the calculation of an individualised weight standard for the duration of the pregnancy, adjusted for the physiological variables of maternal height, weight in early pregnancy, parity and ethnic group. The purpose of collecting and charting this information from 24-26 weeks of pregnancy is to ensure the timely identification of babies whose growth is restricted and which can lead to increased risk of stillbirth, preterm labour, distress during labour and neonatal complications. More importantly by having the data customised to recognise the woman's weight, height, parity and ethnicity, those babies who are designed by nature to be "small" will not be unnecessarily investigated.

But when does information become "too much?" Given that most norms have been established utilising data from Pakeha women, it is gratifying to see the pregnancies of South East Asian and Pacifica women being normalised to the extent that it is expected that there will be smaller babies in South East Asian women and larger babies in Pacifica populations. But what happens for the women who grow healthy "small" babies and "large" babies but who do not fit into their customised growth chart? The potential exists for these women to become unnecessarily concerned.

While GROW is concerned particularly useful for identify SGA (small-for-gestational age) infants, the evidence suggests that customised charts may be less useful for identifying babies that are large for dates. In fact most women are still in the mind set that small babies are "better" because they are easier to give birth to and large babies often bring about fear and thoughts of long painful births ending in surgery.

Technology that reduces unnecessary investigations and interventions while readily detecting those babies at risk of growth restriction appears on the surface to have much going for it. However this needs to be balanced with the emotional and psychological needs of the woman, whose autonomy and belief in herself needs to be promoted and protected throughout her pregnancy.

RCOG Small-for-Gestational-Age Fetus, Investigation and management (Green-top 31) paper can be found at: http://www.rcog.org.uk/womens-health/investigation-and-management-small-gestational-age-fetus-green-top-31

GROW can be found at: http://www.gestation.net/

HEALTH AND DISABILITY COMMISSION
Summary – January to March 2011

Case 09HDC01311 – Released 17 January 2011

This is yet another case that highlights the importance of listening to women's concerns, ensuring appropriate assessments are carried out and most importantly that all interactions and investigations are well documented.

Executive Summary (page five of the report)

1. Mrs A, aged 30, became unwell with vomiting around 37 weeks into her first pregnancy. She made contact with her independent midwife and lead maternity carer, Mrs B, at least twice in two days regarding her symptoms. Mrs B had two other clients in labour during this period. She considered Mrs A had a gastric bug and did not visit her. Mrs B did not routinely perform urinalysis during the pregnancy.
2. Mrs A's symptoms persisted. The following day she visited a GP, who considered she had signs of pre-eclampsia and sent her for urgent blood tests. The abnormal results of the tests indicated that Mrs A was unwell and should be hospitalised that evening. Mrs B was advised of the results, but decided that Mrs A could wait and see her at the hospital the following morning — an appointment that had been previously scheduled.
3. On the following morning, Mrs A had further tests and saw a specialist at the hospital. Her condition had worsened overnight and severe pre-eclampsia was diagnosed. Mrs A's baby had to be quickly delivered, three weeks early, by emergency Caesarean section under a general anaesthetic.
4. Mrs B was the designated LMC and responsible for her client's pregnancy care. She failed to recognise, and react in an appropriate fashion to, Mrs A's ongoing symptoms. The midwifery care provided was substandard, and Mrs B was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights. She also breached Right 4(2) as her documentation was not of an appropriate standard or completed in accordance with professional midwifery standards.

A copy of the report can be found on the HDC website: www.hdc.org.nz

Action Taken (page 15 of the report)

69. Mrs B informed HDC that the Midwifery Council undertook a review of her competence in December 2009. She accepted its findings and is currently continuing to implement a programme set down for her by the Council. This included her attending the New Zealand College of Midwives' *Dotting the i's, Crossing the t's (midwives and record keeping)* workshop in mid-2010. She was enrolled for an APEC (Action on Pre-eclampsia) study day in November 2010. The balance of the programme's components are being undertaken and she continues to participate in professional re-certification requirements on an ongoing basis.
70. Mrs B supplied HDC with a letter of apology for forwarding to Mr and Mrs A.

Recommendations (page 22 of the report)

110. I recommend that Mrs B:

- continue to review her practice in light of my expert's comments and the competence programme set down by the Midwifery Council, and report back to me her learnings in relation to the APEC (Action on Pre-eclampsia) study day and the New Zealand College of Midwives workshop on documentation by **28 January 2011**; and
- provide me with a progress report, including examples, on all changes made to her practice as outlined in her responses to this complaint, by **28 January 2011**.

MSCC Meeting Dates for 2011

Our MSCC Steering Group is growing and this can only mean great things for the women of New Zealand. Make sure your voice is heard - please make a note of the following dates for the coming year in your diary and come along to our monthly meetings. You can be assured of a warm welcome. The MSCC meets on a Tuesday morning – meetings start at 10 am – and the days have been fitted around school holidays.

The meetings are held on the 2nd floor, 27 Gillies Avenue, Newmarket. The meeting dates for 2011 are**: 12 April, 10 May, 14 June, 12 July, 9 August, 13 September, 4 October, 8 November and 13 December.**

So if you have an issue of concern or would like to share information about women's experiences of maternity care then do come along. Babies and toddlers welcome.

We look forward to seeing you – on the 2nd floor, 27 Gillies Avenue.