ISSUE 84
September 2011

Maternity Services Consumer Council

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

This is the third issue of the MSCC's Newsletter for 2011.

After completely running out of money in early June, the MSCC was extremely pleased to get a letter in mid June – followed by the cheque – from Lottery Community stating that they were granting us the full amount that we had applied for. The cheque for $38,500 was immediately banked, putting an end to the MSCC's financial crisis.

Several other grant applications for small amounts were declined. Then the MSCC received almost $6,000 from Pub Charity for office equipment which meant that we were able to replace the old printer that only agreed to print some of the time with a new one, purchase a laptop plus a couple of other small items. So for a few weeks it felt a bit like Christmas in the MSCC office.

The shift of the MSCC office out to Waitakere Village is working well and has enabled savings to be made on our telecommunications costs. It also makes for a very quick trip to work for Nicola who also lives out West.

Child Protection Alert System (CPAS)
The MSCC has major concerns about the placing of alerts on the National Health Index (NHI) number of pregnant women and on using the NHI's Medical Warning System for child protection alerts that remain until the child turns 17. See page 10 for more about this.

What's in this issue of the newsletter
The September issue of the newsletter contains a summary of Waitemata DHB's maternity services report for 2009, an article on the risks of IV fluid during labour, an outline of the findings of the Perinatal and Maternal Mortality Review Committee report for 2009, a item on HIV screening during pregnancy, and the proposal for a national roll out of the system of placing an Child Protection Alert on the child's National Health Index number that many District Health Boards have already implemented.

Don't forget to check the dates for the MSCC's Steering Group meetings for the rest of the year.

Happy Reading!

Lynda + Nicola

WAITEMATA DHB'S MATERNITY SERVICES REPORT 2009

In April 2011 Waitemata DHB issued its fourth annual report on women's health services (includes maternity and gynaecology) for the year 2009. At the beginning of the document Linda Harun, the General Manager of Child, Women and Family Services states that "clinical leadership within the Women's Health Service remains committed to improving health outcomes for women and part of this commitment includes provision of an annual report."

The report refers to the significant challenges faced in continuing to publish annual reports due to the on-going lack of resourcing. It draws a comparison between Waitemata DHB which had 6660 women giving birth in 2009, and Auckland DHB/National Women's Health which had 7735 women giving birth in 2009 and points out that Auckland DHB was far better resourced with a Steering committee and a Project team which enabled it to publish its very comprehensive annual report.

As Lester Levy is now Chairperson of both Waitemata and Auckland DHBs, he will hopefully get the message and see to it that Waitemata DHB is adequately resourced to produce a more informative report than it has been able to provide over the past few years.

A major problem with Waitemata DHB's annual reports is the lack of separate data on maternity services for North Shore and Waitakere hospitals. All the tables and figures are a combination of the statistics for both hospitals. This obscures the picture of what is really going on at each hospital, and hides the hugely significant differences in the rate of interventions between the two hospitals. Women living on the North Shore and women living in the West are entitled to the relevant statistical information about the maternity services provided in their area.

Waitemata DHB demands $1178 for further information

At the beginning of 2010 the Maternity Services Consumer Council wrote a letter to the CEO of Waitemata DHB requesting additional information on its maternity services under the Official Information Act. We were shocked to get a letter in response demanding $1,178 before the DHB agreed to begin work on providing the information requested, especially since much of it was contained in monthly reports that both Waitakere Hospital and North Shore Hospital had up till August 2009 provided for Waitemata DHB board members. Not only was the information important for women living in Waitakere City and for women on the North Shore it was also needed for the renewed interest in setting up a birthing centre in each area.

Lack of statistical data and another demand for money

The 2009 report is similar to the 2008 report in that it is focused on figures with percentages indicating "trends," but very few of the figures and tables are accompanied by the actual numbers of women.

So the MSCC wrote another letter in May 2011 requesting statistical information on the numbers of women giving birth in each hospital in 2009 and 2010, the caesarean section rates at each hospital, and the number of West Auckland women who had a caesarean section at North Shore hospital for each of these two years. Once again a letter was sent demanding an unspecified amount of money. This was received at a time when the

MSCC had completely run out of money and had had to borrow money while waiting for the grant from Lottery Community to arrive. The MSCC decided to take the matter to the ombudsman and phoned the acting general manager of child, women and family services to enquire exactly how much money the DHB was going to demand so it could quote the figure in the letter of complaint to the ombudsman. Three weeks later the information was received – at no charge.

The separate statistics obtained

In 2009 a total of 6660 women gave birth at North Shore and Waitakere hospitals – 3730 at North Shore hospital (compared to 3690 in 2008) and 2930 at Waitakere hospital (compared to 2944 in 2008).

Of the 3730 births at North Shore hospital, 1204 were by caesarean section. A total of 116 women who had a caesarean section at North Shore hospital lived in West Auckland. Of the 2930 births at Waitakere hospital, 615 were by caesarean section.

Combined statistics for both hospitals

As already noted the mode of birth is only given in percentages as a combined figure for both hospitals. In 2009 the spontaneous vaginal birth rate was 63.7% (compared to 64.8% in 2008), the caesarean section rate was 27.3% (compared to 26.4% in 2008), and the forceps/ventouse rate was 8.7% (compared to 8.5% in 2008).

Induction of labour

There are several figures comparing induction of labour by age, and comparing the rates for all women giving birth and for first-time mothers. One figure revealed that the induction rate among first-time mothers was 21.6%, and was lowest among the 20 – 24 year-olds (16.5%) and highest among 40+ year-olds (49.4%).

The overall induction rate for all women was 18.3%.

In contrast to the 2008 report there was no information in the 2009 report on the mode of birth for those women who were not induced, or for those who were.

Epidurals

There was only one figure on epidural use in this year's report. The figure shows the epidural use by age among first-time mothers but does not provide an overall percentage. The figure reveals that epidural use increased with age from 42% for women under 20 years to 65.9% for women over 40 years of age.

The lack of further information on epidural use such as epidural use and mode of birth for first time mothers, and multiparous mothers, etc is regrettable.

Caesarean section rates

The only figure on caesarean section rates in the report was a figure on page 28 showing the increasing rates of caesarean sections by age groups between 2000 and 2009.

In 2009 the caesarean section rate for women between 20-24 years of age was 15.4% and for women aged 40 years of age and over the caesarean section rate was 39.1%.

Out of a total of 2133 first-time mothers who were over 37 weeks pregnant with one baby and were not induced, 23.9% had a caesarean section, compared to 38.3% who were induced.

Out of a total of 2200 multiparous mothers who were over 37 weeks pregnant with one baby and were not induced, 12.3% had a caesarean section, compared to 7.1% who were induced. Of the 596 women who had had a previous caesarean section 72.7% had a repeat caesarean section.

Lead Maternity Carers (LMCs) in 2009

The table on page 23 shows that 144 mothers (2.2%) had an GP as their LMC in 2009 (compared to 2.8% in 2008); 678 mothers (10.2%) had a hospital midwife as their LMC (compared to 10.7% in 2008); 4832 mothers (72.6%) had a self-employed midwife as their LMC (compared to 67% in 2008); 608 mothers (9.1%) had a Know Your Midwife as their LMC (compared to 12.3% in 2008); 356 mothers (5.3%) had an obstetrician as their LMC (compared to 6.2% in 2008); and 37 mothers (0.6%) had the Maori midwife team as their LMC (compared to 0.7% in 2008).

If the numbers and percentages were available separately it would reveal the difference in percentages between the types of LMCs attending women at North Shore hospital as compared to those at Waitakere hospital.

Ethnicity (WDHB)

The ethnicity figures on page 13 show that of the mothers giving birth at North Shore and Waitakere hospitals in 2009, 56.2% were European, 16.7% were Asian, 11.4% were Maori, and 12% were Pacific.

In the 2008 report these figures were provided separately for each hospital and revealed significant differences between the two.

Helensville, Warkworth and home births

The statistical information in these reports only covers births at Waitakere and North Shore Hospitals despite the fact that a maternity report from Waitemata DHB should also include information on the women giving birth at Helensville and Warkworth maternity units as well as the numbers of women living in the Waitemata DHB region who give birth at home. These figures are readily available.

- For a copy of 2009 Annual Report on Maternity Services contact Sarah Watson, Child, Women and Family Services, Waitemata DHB, Private Bag 93-503, Takapuna, email: Sarah.Watson@waitematadhb.govt.nz

THE RISKS OF IV FLUIDS DURING LABOUR

A Canadian study published in *International Breastfeeding Journal* in August 2011 revealed that weight loss in newborn babies is associated with their mothers being given IV fluids during labour or before a caesarean section. Canadian researchers found that newborn babies whose mothers were given IV fluids during labour may be losing weight in an attempt to regulate their hydration rather than not getting enough breast milk.

From January 2008 to June 2010, data were collected from five sites in Ontario, Canada. Infants had to be born full term and healthy, and mothers had to be planning on breastfeeding to participate. The study followed 109 participants from labour or before a caesarean section to 2 weeks postpartum. During labour or before a caesarean section, the amounts of oral and IV fluid were collected from admission to birth.

All babies were weighed every 12 hours for 72 hours, then daily until they were 14 days old, and neonatal output was weighed for three days starting at birth. At 60 hours after birth, when newborn weight loss is at its highest, there was a positive link between newborn weight loss and maternal IV fluids.

Senior researcher, Professor Joy Noel-Weiss from the School of Nursing at the University of Ottawa's Faculty of Health Sciences, said:

"Nurses, midwives, lactation consultants, and doctors have long wondered why some babies lose substantially more weight than others even though all babies get small amounts to eat in the beginning. It appears neonates exposed to increased fluids before birth might be born overhydrated, requiring the baby to regulate his or her fluid levels during the first 24 hours after birth.

We should reconsider the practice of using birth weight as the baseline when calculating newborn weight loss in the first few days following birth. For mothers and their breastfed babies, accurate assessment of weight loss is important."

As newborn weight loss is commonly used to gauge how well a baby is breastfeeding and whether to introduce formula milk – this finding should be taken into account the authors suggest.

Reference

Joy Noel-Weiss et al. "An observational study of associations among maternal fluids during parturition, neonatal output, and breastfed newborn weight loss." *International Breastfeeding Journal* 2011, 6:9 doi:10.1186/1746-4358-6-9. Published: 15 August 2011.

PERINATAL & MATERNAL MORTALITY IN 2009

The Perinatal and Maternal Mortality Review Committee (PMMRC) has released its report on perinatal and maternal mortality in New Zealand for the year 2009. This is the committee's fifth PMMR report. This year the report was able to analyse and report on three years of data for the period 2007 – 2009.

Maternal mortality

There were five direct maternal deaths and nine indirect maternal deaths in 2009. 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 causes of the four direct deaths were four cases of amniotic fluid embolism and one case of eclampsia.

The nine indirect deaths include four cases of H1N1 influenza infection, three suicides, one case of non-obstetric sepsis, and one pre-existing medical condition.

The 14 maternal deaths included:

- 6 antepartum and 8 postpartum
- 12 occurred in hospital and 2 in the community
- 10 births and 4 undelivered babies
- 3 with potentially avoidable factors present, 11 with none.

The factors relating to the potentially avoidable deaths involved four cases relating to organisation and/or management, three relating to personnel, one relating to the environment and four relating to barriers to access/engagement with care.

The report notes that in 2009 the MMR working group determined that there were contributory factors in five of the 14 maternal deaths and that three of these deaths were potentially avoidable. The review of maternal deaths for the years 2007–2009 found substandard care in 61% of cases overall with this contributing significantly to the death in 36% of cases.

Amniotic fluid embolism

The report states that the four cases of maternal death due to amniotic fluid embolism in 2009 brings the number of deaths from this cause to a total of eight in the four years from 2006 – 2009. While amniotic fluid embolism is an unpredictable and uncommon condition, the report notes that there was an association between induction of labour and amniotic fluid embolism.

The working group concluded that the number of maternal deaths is too small in these four years to measure time trends or for in depth analysis, but plans to provide a more comprehensive analysis on five years of maternal mortality data in 2012.

Recommendations
The report includes a number of recommendations relating to maternal mortality concerning maternal mental health, obstetric emergencies, communications between services, H1N1 influenza, and family violence.

Maternal Mental Health
Maternal mental health remains a significant issue due to the suicide statistics in these reports. Over the four years from 2006 – 2009, 20% (10 out of 49) of the maternal deaths was the result of suicide.

The 2008 report recommended the integration of maternal mental health services into maternity services, and confirmed 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 2009 the perinatal mortality rate was 10.6 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 both Australia in 2008 and the UK in 2009.

Some of the key points in the report:

- The intrapartum stillbirth rate in 2009 was 6.3 per 1000 births. One-quarter of stillbirths continue to be unexplained, and half of these occur at term.
- Maori and Pacific women are 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.
- There is an excess of perinatal death from spontaneous preterm birth among Maori and Pacific mothers.

Teenage mothers
Mothers under the age of 20 years are at higher risk of stillbirth and neonatal death compared to those aged 20–39.

Fifty percent of teenage mothers whose babies died between 2007 – 2009 were Maori.

Forty-five percent of all teenage mothers whose babies died were smokers.

Fifty percent of teenage mothers whose babies died lived in the highest deprivation quintile.

Recommendations
The report has a number of recommendations regarding perinatal related mortality, including the recommendation that all women should commence maternity care prior to 10 weeks, recommendations concerning teenage mothers, and the contributory factors and potentially avoidable perinatal related deaths.

The PMMRC report is available at:
www.pmmrc.health.govt.nz/moh.nsf/Files/pmmrcfiles2011/$file/pmmrc-5th-report-2009.pdf

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 Steering Group meetings are currently being held at Birthcare in Parnell. The meeting dates for the last few months of 2011 are**: 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 in October – the MSCC Steering Group will be meeting on Level 1 at BIRTHCARE, 20 Titoki Street, Parnell.

SCREENING FOR HIV DURING PREGNANCY

The Otago University AIDS Epidemiology Group's HIV/AIDS report for 2010 was published on their website earlier this year. Despite the fact that the offer of an HIV test is now part of the routine care provided to women during pregnancy, the report did not include any information on how many women were identified as being HIV+ as a result of the antenatal HIV screening programme.

Official Information Act request

So an Official Information Act request to the AIDS Epidemiology Group was emailed off asking for the numbers and ethnicity of women identified as being HIV+ during pregnancy in 2010. The same request last year resulted in a fairly prompt response with the requested information. This year the process proved to be extremely convoluted and lengthy. It took several weeks for the AEG to reply and state the request must be made to the National Screening Unit at the MOH. It took two letters and another month before the information was supplied.

Three women

There were three women diagnosed as HIV+ during their pregnancy in 2010. One of the women was European, one was Asian and one was "other." Two of the women lived in the North Island and one in the South Island.

In 2009 two of the three women diagnosed as a result of the screening programme were African and one was Maori.

Antenatal HIV screening has now become a routine part of the first blood tests that are taken – usually during the first trimester – throughout New Zealand.

Lack of informed consent

Reports from childbirth educators in the Auckland reveal that many pregnant women are unaware that they have been tested for HIV, something the MSCC has been concerned about since the programme was first proposed. During the roll out of the HIV screening programme there was an emphasis on the need to gain informed consent, not only for an HIV test, but for all the tests included in that first blood test. However, it now appears that the status quo has reasserted itself and in many instances women are sent off for their first blood test not knowing that the HIV test box has been ticked.

The legal requirement to gain informed consent before screening people or 'encouraging' them to take part in other public health initiatives such as vaccination programmes is a vexed issue that still needs to be addressed. To date neither the Ministry of Health nor the office of the Health and Disability Commissioner has been prepared to take any significant action about the coercive practices employed by some health professionals and PHOs who are pressured by DHBs in to meeting government targets, and who do so by ignoring rights 6 and 7 of the Code of Consumers' Rights.

THE NATIONAL CHILD PROTECTION ALERT SYSTEM WITHIN HEALTH

The issue of implementing a nationwide child protection alert system across DHBs has been in the media a great deal lately. An article in the *Sunday Star Times* on 12 December last year was the first that many of us working in women's health had heard of what was going on. (1)

The *SST* article stated that "alerts are being placed on the health files of pregnant women whose unborn children are deemed at risk of abuse" and that the alert is attached to a person's National Health Index (NHI) number, "so that if they are assessed at hospitals or medical centres throughout the country, medical staff will know their history."

The NZ College of Midwives had not been involved in any discussions on the proposed system and voiced their concerns over the fact that "the discussion had been largely hospital-focused with little input from mothers and parents, or midwives."

Subsequent enquiries have revealed that a Position Paper had been produced by the Paediatric Society of NZ and finalised in February 2011. The paper, entitled "Child Protection Alert System within Health," was developed by Dr Patrick Kelly, a paediatrician at Auckland DHB and chair of the Child Protection Special Interest Group of the Paediatric Society of NZ, Miranda Ritchie, the National Violence Intervention Programme Manager for DHBs, Dr Russell Wills, paediatrician and Clinical Director Maternal, Child and Youth at Hawke's Bay DHB, and Dr Zoe McLaren, paediatrician and member of the Child Protection Team at ADHB's Starship Children's Health.

Apparently seven DHBs have been operating Child Protection Alerts within their own patient management systems for 10 years. However, only two of these DHBs, Auckland and Hawke's Bay have progressed to placing alerts externally on the national Medical Warnings System database. So it comes as no surprise that the position paper was produced by staff from these two DHBs

The paper states that "the Privacy and Children's Commissioners, the Ministry of Health, the Ministry of Social Development and the NZ Police all support the system in principle." (2)

Medical Warnings System

The Medical Warning System (MWS) is associated with the National Health Index database which contains the unique health identifiers/NHI numbers for nearly all New Zealanders.

Under the national child protection alert system (NCPAS) when a "vulnerable" child or pregnant woman is identified, a flag on their NHI points to the child

protection alert placed in the MWS. So irrespective of which hospital that person may subsequently present for treatment, clinicians will see the child protection alert on the MWS and contact the relevant DHB for the information specific to the child protection issues.

The paper identifies some key issues for the child abuse alert system. They include the stigma attached to having a CPA on the NHI/MWS, privacy concerns, and what are referred to as "procedural issues." These include listing the siblings of an abused child on the alert, the security of the information, the removal of alerts, and evaluating the effectiveness of the alert system.

Under privacy issues the paper states that although the parents' right, as the child's representative, to know is guaranteed in the Privacy Act 1994, this right is not absolute. It is therefore "reasonable not to inform parents that an alert has been placed if there is concern that parents may not re-present for medical care of their sick or injured children." (2)

The Ministry of Health has produced a Child Protection Alert Management Policy which outlines proposed minimum criteria and processes. The Policy notes that alerts placed on a pregnant woman's NHI number will usually be removed after the baby is born, although there is provision for the alert to be transferred to the baby when its NHI number is generated if the health professionals involved consider there are ongoing risks.

CPAS until 17 years of age

Once a child has an alert placed on the NHI/MWS it remains there until the child turns 17. The information that appears in the Medical Warning System alert states: "Child protection concerns, contact XDHB" and provides the contact number of the DHB named.

Dr Russell Wills, one of the authors of the Paediatric Society's position paper said currently alerts were placed on the NHI of children who had been treated for inflicted injuries, so if they turned up at another hospital, the previous incident would come up. Alerts were put on the system only where a referral had been made to Child, Youth and Family – it is standard practice to inform the family that this has been done – and where there was considered a likelihood of further abuse. A "multi-disciplinary team" of doctors, nurses and social workers (which must include at least one member with training in child protection, made the decision on whether to lodge an alert. (1)

Only senior staff on the multi-disciplinary team had the authority to place, review and remove an alert.

But will it work?

All of this raises many questions about how such a system, developed without consultation with key stakeholders, will work in practice. Objections have already

been raised by the former Health & Disability Commissioner Robyn Stent, whose stepdaughter was wrongly suspected of abuse at Starship hospital's child protection unit. Ms Stent was reported as saying that she does not trust medical professionals to make the right calls around the alerts. (1)

Midwives in Auckland have also raised serious concerns about the impact that the reporting systems are already having on the women they provide maternity care for. Requesting midwives to fill in forms that contain additional information about both the women they are caring for and their families, and then expecting them to forward this information to the DHB is likely to result in a loss of trust between the pregnant woman and her midwife. Some women are already opting to give birth alone and without assistance rather than risk their midwife reporting the birth of their baby to Child Youth and Family or other agencies.

Increasing the likelihood of a woman receiving little or no antenatal care and/or going into hiding to give birth to her baby is not a sensible way of dealing with the issue of child abuse.

Given that the system that has been gradually put in place over the past decade and now covers half the children in New Zealand has not been evaluated to see if it has made any difference to the incidence of child abuse, it simply does not make sense to go ahead with a rollout of a new CPAS without reviewing the old one.

The whole focus of the documents produced by the authorities so far is on the placing of alerts rather than what systems must be put in place to provide the services that a family labelled as "vulnerable" needs. It is also an ambulance at the bottom of the cliff approach rather than one that involves investing in the resources that will help ensure babies are nurtured and cared for within their families.

References

1. Tony Wall. *Sunday Star Times*. 12 December 2010.
2. Patrick Kelly et al. *Child Protection Alert System Within Health.* February 2011.

HOME BIRTH AOTEAROA CONFERENCE 2011

Active Birth Taranaki is hosting this year's National Home Birth Aotearoa Conference in New Plymouth. Speakers include Maggie Banks, Penny Brownlee and Maralyn Foureur.

Date: 28 - 30th October 2011
Venue: Okurukuru Winery, Surf Highway 45, New Plymouth.

Conference will be about forging the links between the homebirth heart and the community – inspiring and invigorating those who know this secret already, and inviting and encouraging those who are yet to hear it.

Held in the stunning surroundings of Okurukuru Winery, New Plymouth the conference will provide speakers and facilitate discussion to:

- **Nurture and Inform** in Pregnancy and Birth
- **Inspire and Educate** in Parenting
- **Connect and Encourage** in the Community.

Why is the way our community views and experiences birthing so vital to a community's success?

How would our community feel if parenting was a universally honoured and valued role to be enjoyed not endured?

We aim to create a stimulating, inspiring learning and sharing environment. This weekend will be a change-maker energising parents, Lead Maternity Carers, Students, Child Birth Educators and anyone involved in the Social Service Industry. So if this is you, or you are interested in community social services benefiting women and families, plan to come NOW! (Approved by the Midwifery Council of New Zealand as a professional activity with 5 points allocated.)

Whilst the conference proceedings are not inclusive of children, and it is definitely an adult-focused educational, social forum, we welcome families to be a part of this weekend. Babes-in-arms are assumed to be an integral part of conference. An on-site crèche for older children will be provided close by if there is enough demand confirmed by September 1 2011, but you may find it works best for your family to bring a friendly adult who can share the delights of New Plymouth with your children for the day.

Taranaki will be in full bloom, with the fabulous Rhododendron Festival offering another great reason to come feel the energy and spirit of our Maunga, Moana and our Province, 'Taranaki – like no other'. This does mean that accommodation will be in hot demand and you need to ensure you book your bed now!

- Further information is available on both the Home Birth Aotearoa website: http://www.homebirth.org.nz and Active Birth Taranaki website: http://todayschoices.org/