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Maternity Services Consumer Council

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

This is the final issue of the MSCC's Newsletter for 2013. Since we sent out the September newsletter we have attended the Joan Donley Midwifery Research Forum in Queenstown, the 3-day Perinatal Mental Health symposium in Auckland, completed the revision of our *Screening during Pregnancy* pamphlet, and begun work on a major upgrade of the MSCC website. We have also written a number of grant applications, responded to requests for information, and have mailed out thousands of our pamphlets.

Funding applications

The MSCC is very appreciative of the funding we have recently received from some of the COGS committees. We received $2,742 from Auckland COGS, $3,000 from Manukau COGS, $500 from Franklin COGS, and $2,000 from Waitakere COGS for some of our administrative and operational costs. Our grant application to the North Shore COGS committee was declined, for the second year in a row.

DHB Maternity Quality & Safety reports

The MSCC has been working for some months on gaining access to the Waitemata DHB and Counties Manukau DHB maternity reports. DHBs are required to produce an annual report each year as part of the audit criteria for DHBs contained in the *New Zealand Maternity Standards*. The Ministry of Health has made it clear to DHBs that they expect these reports to be placed on their websites. We would encourage you to check the website of your DHB and if you can't find a copy of their Maternity Quality and Safety report email the DHB and ask for a copy and remind them that these reports need to be placed on their website.

What's in this issue of the newsletter

The December issue of the newsletter contains a personal story about being tested for gestational diabetes, an article about the overdiagnosis of gestational diabetes, a summary of both the Waitemata DHB and Counties Manukau DHB Maternity Quality and Safety report, and some maternity madness.

Don't forget to check the dates for the MSCC's Steering Group meetings for 2014.

We wish you all a very happy Christmas and New Year, and hope you have plenty of time to rest and relaxation over the summer break.

Lynda + Nicola

TESTING FOR GESTATIONAL DIABETES – ONE MOTHER'S STORY

There is so much research out there about testing in pregnancy but a big hole is that no one really investigates how all this testing and screening actually affects pregnant women, emotionally and physically.

This is my story and I know I am just one woman but trust me, these stories are out there and we need to listen.

My midwife discussed with me the risk factors that I had for gestational diabetes and suggested that instead of having the one-hour test that we went straight to the two-hour test and that we did this earlier than normal in my pregnancy. While I got all this I don't think she ever actually asked if I wanted to have it at all. We make assumptions all the time but during pregnancy this really needs to be avoided. However I decided that given my risk factors I would agree. Its funny how being pregnant can make you feel so vulnerable that even the strongest of people lose their voice. However I digress….

Blood tests were never fun for me anyway. I have deep thin veins and so often it's a struggle to find one to draw blood from. The record is four attempts to draw blood, numerous plasters and a number of bruisers. Well this was before my GDM test.

The day before the test I dutifully fasted even though snacking regularly was the only thing that really helped keep the morning sickness away. Needless to say by the time morning came I was ravenous, feeling a bit seedy and not at all looking forward to the test.

I managed to organise the kids and get them off to school. Often it is hard on women to juggle this hour or two of sitting at the lab with children so I was lucky that mine were both school aged.

When I arrived at the clinic they were busy and I had to wait. Never a nice time when you are already counting down the minutes to be done.

Finally my turn, yay! It didn't go too badly and after two attempts they managed to draw enough blood for the initial test. This didn't help the seedy feeling and so I was feeling a little green by the time I took my seat back in the waiting room with my drink.

I had been trying to eat quite healthy up to this point and so the sugar in the drink just added to my seedy feeling and I was feeling quite nauseous after getting it all down in the allotted time period. This was a lot more sugar then I would normally consume and I developed a headache.

A few pages of the old and tired magazines later and I was over it. Quick clock check and not even 30 minutes had past! The headache was worse, I was nauseous, bloated and was feeling quite low. Overall I wish I had declined it.

Due to a busy waiting room and how awful the drink had made me feel the lab people agreed that I could go lay down in my car. Sitting in the warm stuffy waiting room was making me worse so I squeezed myself into the back seat and lay down. This helped but not enough and I started watching the clock, waiting anxiously for the two hours to be up so I could have a small snack.

I started to feel worse after about an hour. My nauseous feeling got so bad I felt like I was going to vomit and so I got out of the car and went and sat outside in the fresh air. No one had warned me about this. They talk about what happens if you are diagnosed but ignore how the testing itself might actually make you feel and I felt even the lab test staff wasn't too worried. What's a little dizziness and headache when we want your blood?

Finally the two hours were up. I was hanging out to leave but unfortunately they struggled to find a vein. Seven attempts later it was a no go. I started crying at this point, all the dizziness, all that sugar was going to be for nothing. Thankfully they finally decided to do a finger prick to take some blood and assured me this would hopefully be enough. I have never been so relieved to see the back of a lab test.

Unfortunately due to a lab mix up my second blood test was mislabelled and couldn't be counted. I was not repeating the experience and so they just went off my results for the first fasting test which were enough to diagnose me with gestational diabetes.

Being diagnosed with gestational diabetes (GDM) changed my pregnancy but that is a whole other story!

The testing for GDM had such an impact that when I went for my post birth test I actually found myself having a small panic attack about the drink, the time and how I would feel.

We hear all the time about the benefits of testing but maybe we need to look for alternative methods and better risk assessment and maybe we need to start talking about the actual test and how you might feel.

To empower women to make an informed choice about GDM testing we need to be giving them the whole picture because in the end, informed choice is the gold standard and women shouldn't get any less.

Nicola Mapletoft

THE DIAGNOSIS OF GESTATIONAL DIABETES

As Nicola's story clearly illustrates the processes of screening for and the diagnosing of gestational diabetes is not without its problems. There are also increasing concerns about the impact that these tests are having on women, their babies, their current and future pregnancies, as well as on our health services.

The detection of glucose intolerance during pregnancy, known as gestational diabetes mellitus (GDM), was first described as an entity in the 1960s but its clinical significance, the optimal screening strategies, diagnostic criteria and the value of treatment have been the subject of intense debate. As currently defined, GDM includes a wide spectrum ranging from previously unrecognised diabetes through to relatively trivial degrees of glucose intolerance. While a pregnancy in a woman who has previously undiagnosed diabetes can be said to be genuinely high risk, the major outcome of those found to have a minor degree of glucose intolerance is an increase in the birth weight of their baby – a surrogate measure of debatable clinical relevance. (1)

In 2008, a large multicentre observational study (Hyperglycaemia and Pregnancy Outcomes study – HAPO) confirmed that there was no threshold of glycaemia that defined a high-risk group and that many of the outcomes attributed to modestly elevated blood sugars are confounded by maternal obesity.

In 2010, based on their interpretation of the HAPO results, an expert body known as the International Association of Diabetes in Pregnancy Study Groups (IADPG) suggested significant changes to the diagnostic criteria that would increase the proportion of pregnancies 2-3 fold to 18-20%. Despite there being no trial evidence that outcomes of clinical significance would be improved by this change, it was swiftly adopted as policy by the influential American Diabetes Association and has subsequently been endorsed in several other countries. (1)

The Agency for Healthcare Research and Quality of the National Institutes of Health recently commissioned a systematic review and convened an independent panel to consider the diagnosis of GDM. In its preliminary report (March 2013) the panel rejected the IADPSG proposal, expressing concern about the adoption of new criteria that would increase the prevalence and the corresponding costs and interventions, without clear demonstration of improvements in clinically important outcomes. (1)

Overdiagnosing Gestational Diabetes

New Zealand is in great danger of jumping on the international bandwagon of overscreening pregnant women, overdiagnosing gestational diabetes and overtreating women. Internationally there are huge variations in diagnostic criteria which results in the prevalence of hyperglycaemia in pregnancy ranging from 7.9% (Canadian Diabetes Association criteria) to 24.9% (Australian Diabetes in

Pregnancy Society criteria) in the same group of women using the two-hour, 75g oral glucose tolerance test. (2)

Dr Sarah Buckley describes diabetes during pregnancy as usually being a mild condition that develops only in the later months, involves glucose levels that are generally insufficient to cause major short-term effects for the pregnant woman, and usually causes no symptoms. She points out that GDM is self-limiting by definition, and that mild hyperglycaemia is a normal and important adaptation in pregnancy due to the insulin-resisting effects of pregnancy hormones. The increase in maternal glucose levels ensures that an adequate amount of this essential fuel can easily cross the placenta and supply energy to the growing baby. (3)

Dr Buckley also refers to the controversy that exists around the possible effects of GDM on the baby – including effects during pregnancy, in the newborn period, and also later in life – and also whether treating the pregnant woman for GDM will benefit her baby at any of these times. (3)

The more women who are screened for gestational diabetes the higher the number of false positives. The cost of treating women falsely diagnosed with GDM as well as the resulting unnecessary anxiety experienced by women given the gestational diabetes label makes universal screening unethical. Few women are made aware of the controversy surrounding these screening and diagnostic tests and are therefore not in a position to make an informed decision about whether to accept the offer of any of the tests. There is also the overselling of the risks for the woman and her baby in having a trivial degree of glucose intolerance which is then falsely labelled as gestational diabetes.

Over the past two decades the MSCC has heard from many women who had the tests and then found they could not remain with the LMC midwife they had chosen and were treated by a team of people who did not remember who they were from one appointment to another. They felt that everything changed once they were diagnosed with gestational diabetes, and that they were different from other pregnant women.

Being screened for gestational diabetes is not compulsory and LMCs must give women information on the controversy surrounding this questionable diagnosis.

References

1. Tim Cundy. Department of Medicine, Auckland University. “Gestational Diabetes – Expert Opinion or Independent Review?” Abstract 150 Preventing Overdiagnosis Conference. September 2013.
2. Uniservices, Auckland University. “Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: A Clinical Practice Guideline. Draft Version. 2013. Commissioned and funded by the Ministry of Health.
3. Dr Sarah Buckley. “Gentle birth, gentle mothering.” Published by Celestial Arts. 2009.

WAITEMATA DHB MATERNITY QUALITY & SAFETY PROGRAMME REPORT FOR 2012

Waitemata DHB's Maternity Quality & Safety Programme Annual Report for 2012 was placed on its website several months ago. (1) DHBs are required to produce an annual report each year as part of the audit criteria for DHBs of Standard One of the *New Zealand Maternity Standards*. (2) The Ministry of Health expects each DHB to make them publicly available by placing them on their website. However, there are no guidelines on what information should be included in these reports.

The 29-page report contains some statistical information on the 7111 women who gave birth at the two hospitals and three birthing centres in 2012. There were 3839 births at North Shore Hospital, 3034 births at Waitakere Hospital, 60 births at the Helensville Birthing Centre, 148 births at the Warkworth Birthing Centre, and 30 births at the Wellsford Birthing Centre.

The report notes that 2012 saw an increase in births at both North Shore and Waitakere Hospitals, and for the first time the Waitakere birth numbers exceeded 3000. "It is likely that the additional volumes created by the diabetes in pregnancy service contributed to this increase," the report says.

The diabetes in pregnancy service commenced in April 2012 and was fully operational by July 2012. This resulted in pregnant women being able to access this service locally instead of having to travel to Auckland DHB, something the MSCC had been lobbying for for many years. It was only when Auckland DHB decided it was no longer going to provide the service for Waitemata DHB mothers that Waitemata DHB was finally forced to do what it should have done a decade or more ago.

Percentage of normal births continues to decrease

There was a decrease in the rate of normal births and a corresponding increase in the caesarean section rate. Between 2011 and 2012 normal birth decreased from 65.4% to 62.3% and caesarean section increased from 25.3% to 28.8%.

Caesarean sections

At North Shore Hospital around 1300 of the 3839 births were by caesarean section, while at Waitakere Hospital around 700 of the 3034 births were by caesarean section. The report notes that "North Shore Hospital has one of the higher caesarean section rates in New Zealand."

For first-time mothers expecting one baby at term whose labour was not induced (referred to as standard primipara) 2216 or 21.7% had a caesarean section. For mothers who had had a previous caesarean section 586 or 76.8% had a caesarean section. These two groups contributed to 47% of all the caesarean sections performed at the two hospitals in 2012. Induction of labour in first-time mothers expecting one baby at term rose from 38.3% in 2011 to 50% in 2012.

This increase is one of the drivers of the review of induction of labour processes and policies at Waitemata DHB.

Induction of labour

The two graphs on induction of labour at each hospital by age group of the women from 2008 to 2012 which are featured on page 14 of the report show that maternal age influences the rates of induction especially in 35-39 years and over 40 years age groups.

Rates of interventions in standard primapara at each hospital

It is in the table on page 9 of the report that the difference between what happens to first-time mothers at each hospital is revealed. In 2012:

- 73.3% of first-time mothers at Waitakere Hospital had a spontaneous vaginal birth compared to 61.3% at North Shore Hospital;
- 10.8% of first-time mothers at Waitakere Hospital had an instrumental vaginal birth compared to 18.5% at North Shore Hospital;
- 15.9% of first-time mothers at Waitakere Hospital had a caesarean section compared to 20.4% at North Shore Hospital;
- 0.8% of first-time mothers at Waitakere Hospital had a blood transfusion after a caesarean compared to 2.4% at North Shore Hospital;
- 3.6% of first time mothers at Waitakere Hospital had an induction of labour compared to 5.7% at North Shore Hospital;
- 17.3% of first-time mothers at Waitakere Hospital had an episiotomy compared to 24.1% at North Shore Hospital;
- 26.3% of first-time mothers at Waitakere Hospital had an intact lower genital tract compared to 16.8% at North Shore Hospital.

There is no information in the report on epidural rates, breech births, water births, postpartum haemorrhage, postpartum hysterectomy or maternal mortality.

Regional Collaboration

The report notes that “Waitemata DHB and Auckland DHB have commenced a regional collaboration process to explore the delivery of co-ordinated Women’s Health service to the region. The project is being led by the clinical directors with support from Professor Richard Bohmer, Harvard business school expert in healthcare management. The project group includes LMC and consumer representation.”

The MSCC has been contacted numerous times during the past year with rumours about what is being proposed. As the year ends we are none the wiser.

References

1. www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=jIg6BhjVzcY%3d&tabid=65
2. www.health.govt.nz/system/files/documents/publications/nz-maternity-stds-sept2011.pdf

COUNTIES MANUKAU DHB MATERNITY QUALITY & SAFETY PROGRAMME REPORT FOR 2012

Counties Manukau DHB's Maternity Quality & Safety Programme Annual Report for 2012 was emailed to the MSCC at the end of October in response to our request for a copy of the report and is also on the CMDHB website. (1) As noted in the previous article DHBs are required to produce an annual report each year as part of the audit criteria for DHBs of Standard One of the *New Zealand Maternity Standards.*

The 71-page report contains some statistical information on the 7425 women who gave birth at Middlemore hospital and three birthing centres in 2012. There were 6341 births at Middlemore Hospital, 354 births at Botany Maternity Unit, 370 births at Papakura Hospital, and 360 births at Pukekohe Hospital.

The report notes that while the number of women living in Counties Manukau having babies increased from 6075 in 2003 to 7409 in 2007, the number of births has remained static since 2007.

The majority of women living in the CMDHB region have their babies at a CMDHB facility with most of these births occurring at Middlemore Hospital. Overall 17% of CMDHB women gave birth in 2012 at a primary birthing unit.

Spontaneous vaginal birth

The vast majority of women birthing in a Counties Manukau facility give birth vaginally. In 2011 among mothers living in Counties Manukau expecting one baby at term and whose labour was not induced (referred to as standard primipara), 70.8% had a spontaneous vaginal birth. For those mothers giving birth at Middlemore Hospital 65.6% had a spontaneous vaginal birth.

In 2012 the rate of vaginal births in Maori mothers living in Counties Manukau was 82% and 80% for Pacific mothers.

Caesarean section rate

Women living in Counties Manukau are less likely to have a caesarean section than women giving birth in either Waitemata DHB or Auckland DHB. However, the caesarean section rate has been increasing over the past three years with 21.1% of all births being by caesarean section in 2012.

Rates of interventions in standard primapara

Table 9 on page 28 of the report shows that in 2011:

- 2.7% of first-time mothers living in Counties Manukau had an induction compared to 3% of mothers giving birth at Middlemore Hospital.
- 13.4% of first-time mothers living in Counties Manukau had an instrumental vaginal birth compared to 15.2% of mothers giving birth at Middlemore Hospital.

- 13.1% of first-time mothers living in Counties Manukau had a caesarean section compared to 16.23% of mothers giving birth at Middlemore Hospital.
- 4.2% of first-time mothers living in Counties Manukau had a blood transfusion after a caesarean section compared to 4.3% of mothers giving birth at Middlemore Hospital.
- 1.8% of first-time mothers living in Counties Manukau had a blood transfusion after a vaginal birth compared to 2.1% of mothers giving birth at Middlemore Hospital.
- 12.2% of first-time mothers living in Counties Manukau had general anaesthesia for a caesarean section compared to 13.2% of mothers giving birth at Middlemore Hospital.
- 21.8% of first-time mothers living in Counties Manukau had an episiotomy compared to 21.3% at Middlemore Hospital;
- 20.3% of first-time mothers at living in Counties Manukau had an intact lower genital tract compared to 16.5% at Middlemore Hospital.

VBAC

The percentage of mothers giving birth vaginally after one previous caesarean section as fluctuated from 2003 to 2012. In 2012 21% of mothers with a previous caesarean birth went on to have a vaginal birth for their second baby.

Risk factors higher in Counties Manukau mothers

The report notes that there is a higher prevalence of obesity and being overweight, smoking, hypertension in pregnancy, diabetes in pregnancy, low socio-economic status, no antenatal care, and small for gestational age in mothers living in Counties Manukau. “The higher prevalence of these risk factors in CMDHB will contribute to the higher perinatal mortality rate noted by the PMMRC.”

Diabetes in Pregnancy

Mothers in Counties Manukau have a higher rate of both pre-existing diabetes and gestational diabetes than mothers in most other areas. The report states that the numbers of mothers identified with gestational diabetes has almost doubled over the six years from 2006/07 to 2011/12, rising from 225 to 407. The highest rates are in Indian (9.6%), Chinese (8.6%) and other Asian women (7.7%), but the largest volume of cases continues to be women of Pacific ethnicities, with 154 in 2011/12.

The CMDHB report also contains information on pre-term births, neonatal outcomes and breastfeeding at discharge from hospital. The final section is on the implementation of the Quality and Safety programme in CMDHB in 2012/13.

References

1. www.countiesmanukau.health.nz/About_CMDHB/Planning/MaternityCare/MQSP-AnnualReport-2012-2013.pdf

MSCC Meeting Dates for 2014

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 at 10am on Tuesday mornings – and the days have been fitted around school holidays.

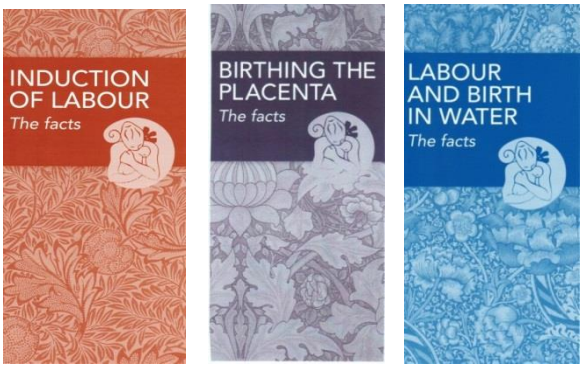
The Steering Group meetings are currently being held at Birthcare in Parnell. The meeting dates for the first half of 2014 are**:**

4 February, 4 March, 1 April, 6 May and 3 June.

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 are getting lots of orders for our three new leaflets. If your order form does not have these on please download the latest order form off our website
MSCC Order Form

Cost
There is a charge for the *Induction of Labour* and *Birthing the Placenta* pamphlets, as for the first two in the MSCC's *The Facts* series – *Caesarean Section* and *Epidurals during Labour*. One copy of each is provided free of charge, while orders for multiple copies range from $1 each for 2 – 20 copies, to 50c for orders of 100 or more.



MATERNITY MADNESS

There seems to be no end to the devices that men invent to stick into women's bodies, especially but not only contraceptive devices. However, a recent invention – for use during labour – has reached new pinnacles of grotesqueness.

Referred to simply as "The Device" (1) Materna Medical's website states that "after several years of research and development, the device is currently being evaluated in clinical trials at the Nepean Hospital branch of the University of Sydney Medical School in Australia. This device is not currently FDA or TGA approved and is not available for sale." I guess we can all be thankful it hasn't come on to the market – yet.

This obscene device is designed to be used during the first stage of labour, "under the supervision of trained clinical professionals." The language used to describe its use is very telling. It is "a mechanical dilator which penetrates the first 4cm or one-third of the vaginal canal, and gradually expands the vagina from a resting diameter of 2.6cm to the fully expanded size of the delivering fetus, roughly 8-10cm. Expansion will be precisely controlled by a very easy to use semi-automatic force-controlled actuation system, and the device can be removed at any time the mother wishes."

The trials of the device began in July 2011 and were due to conclude in early 2012. The MSCC has emailed Materna Medical and asked for information about the results of these trials and when they might be made available to the public, but we have yet to receive a response.

Reference

1. http://www.maternamedical.com/the-device.html

THE BANNED FOODS LIST IS GROWING!!

A recent visit to the Ministry of Health website to check out what foods pregnant women should be cautious about eating revealed that there is now a ridiculously long list of foods under the heading, "*do not eat any of the following foods*."

It includes processed meats and cold pre-cooked meats; raw milk; yummy cheeses like camembert, brie, feta, blue, mozzarella, ricotta; pre-prepared salads including rice, pasta, coleslaw, roasted vegetable and green salads; raw, smoked or pre-cooked fish and seafood including sushi, smoked salmon, and marinated mussels or oysters; foods containing raw eggs such as mayonnaise and hollandaise sauce or desserts such as mousse; soft-serve ice cream; cream or custard; and hummus and other dips containing tahini.

GOOD GRIEF! WHAT CAN YOU EAT?