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Maternity Services Consumer Council

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

Welcome to the final issue of the MSCC's Newsletter for 2014. Over the past three months we have continued to lobby for a purpose-built maternity unit in West Auckland, attended the screening of the new documentary *Microbirth*, begun work on another leaflet in our *The Facts* series, attended the La Leche League 50th anniversary conference, followed up on the use of the HbA1c blood test during early pregnancy, and attended DHBs meetings. We have also begun tracking where all our pamphlets are going with a view to submitting a few grant applications outside of the Auckland region. Meanwhile, we continue to respond to requests for information, and mail out thousands of our leaflets.

Funding applications

Following an anxious few weeks in September which saw the MSCC's bank account dip down to a few hundred dollars we were very relieved to receive a letter from Lottery Community advising us that the MSCC had been awarded a grant of $39,500. We were also very appreciative of the $1,500 we received from the Waitakere COGS committee, $2,548 from the Auckland COGS committee, $2,000 from the Manukau COGS committee, $1,216 from the Rodney/North Shore COGS committee, and the $500 from Papakura/Franklin COGS committee.

What's in this issue of the newsletter

The December issue of the newsletter contains a summary of the statistics in National Women's Health Annual Report for the 2013 year, an article about researchers access to women's maternity information, a Cochrane review which found that the routine use of antibiotics following premature rupture of membranes at the end of pregnancy offers no benefit for either mother or baby, a report on the seminar for physicians held prior to the La Leche League 50th anniversary conference, and an article on the latest NICE guidelines on the care of mothers during labour.

And don't forget to check the dates for the MSCC's Steering Group meetings for the first half of 2015.

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

Lynda + Lettiica

2013 ANNUAL REPORT FROM NATIONAL WOMEN'S

National Women's released its Annual Clinical Report for 2013 in August 2014. The report is the 21st in the current series.

The 286-page report contains a wealth of statistical information on the 7188 women who gave birth at NWH in 2013 and the 7377 babies they gave birth to, plus the 35 women who gave birth before they actually got to the delivery unit. In 2013 there were 147 sets of twins (156 in 2012) and 4 sets of triplets (2 sets in 2012).

Normal births decrease

The intervention rates have risen slightly over the past year, continuing an ongoing trend. In 2013 53.8% (3884 out of 7223 birthing mothers) had a spontaneous vaginal birth, and 0.8% (56 birthing mothers) had a vaginal breech birth.

Only 43.6% of first-time mothers had a spontaneous vaginal birth, compared to 46.2% in 2012. The report notes that "the spontaneous vaginal birth rate has remained consistently low since 2004."

Induction of labour

In 2013 33.8% of mothers had an induction of labour. More than one in three first time mothers – 40.4% (up from 37.5% in 2012) – had an induction of labour. The rate for multiparous mothers was 30.3% (up from 28.1% in 2012).

The report states "the induction rate has increased markedly from 2007 (24.8%) to 2013 (33.8%). There has been an increase in the induction rate at term, and specifically at each of 37-41 weeks gestation." Such significant increases in the induction rates were concerning and resulted in a detailed audit of inductions being made a priority. The report notes that the review of induction of labour processes and methods which commenced in 2013 will continue in 2014.

Premature rupture of membranes, post-dates, diabetes, and suspected small for gestational age were the most frequent reasons for induction of labour in 2013. In 2012 prolonged latent phase of labour was the most frequent reason for induction. Improved data checking processes were responsible for the reduction in inductions for prolonged latent phase of labour in 2013. When post-dates was the primary indication for induction, 11.8% occurred prior to 41 weeks (down from 15% in 2012) and 12.5% occurred at or beyond 42 weeks (down from 16% in 2012 and 22% in 2011).

34.7% caesarean section rate

In 2013 the caesarean section rate was 34.7%, compared to 33.4% in 2012, 32.5% in 2011, and 20.8% in 1995 and 1996. This year there was an increase in

the difference between the caesarean section rate for first-time mothers (36.8% in 2013 compared to 34.1% in 2012, and 34.5% in 2011) and for mothers having subsequent births (32.8% compared to 32.7% in 2012, and 30.8% in 2011).

The report points out that the caesarean section rate at National Women's is the highest it has ever been, with the most common reason for a caesarean section being a repeat caesarean. This is followed closely by a first-time mother having a caesarean before labour or following induction of labour.

The report notes that "research evidence is clear that repeated caesareans are strongly associated with adverse maternal outcomes, such as abnormal placentation, postpartum haemorrhage and peripartum hysterectomy.

Forceps and Ventouse

In 2011 the rate of forceps and ventouse deliveries (combined under the term "instrumental vaginal birth") dropped below 12% for the first time since 1997, with a rate of 11.1%. In 2012 and 2013 it has remained stable at around 12% – 20.8% of first-time mothers, and 4.2% of multiparous mothers.

Some mothers are subjected to more than one instrument – forceps and ventouse, or different types of forceps, and to the birth of a baby by caesarean section after an attempted vaginal instrumental birth. In 2013 41 mothers had a double instrumental birth, and 48 mothers had an attempted vaginal instrumental birth prior to emergency caesarean section. The report notes that these are rare events but are associated with more severe outcomes for both mother and baby.

Epidurals

Epidurals continue to be the most common form of analgesia for the management of labour pain (52% of women in labour), with women having an induced labour being the most frequent users (69.7% compared with spontaneous labour 39.2%). For first-time mothers it was 82% if labour was induced and 67.7% if labouring spontaneously. For multipara it was 55.6% if labour was induced and 36.9% if labouring spontaneously.

The highest use of epidurals is in first-time mothers who are over the age of 40 (83.7%), with a private obstetrician (81.5%).

Breech birth

Breech births made up 5.4% of all births in 2013. Of the 319 singleton babies presenting as a breech, 281 (88%) were delivered by caesarean section. Among the 46 breech births at 32-36 weeks the percentage of caesarean deliveries was 98%, despite there being no evidence to support such a practice. For the 219 breech births at 37 weeks and over the percentage of caesarean sections was 97%.

The report notes that the NWH guideline on Breech Birth was updated in May 2012 to reflect changes in guidelines internationally.
"Considerable effort is made in counselling and advising women who wish to attempt vaginal breech birth. Although only a small number of obstetricians will consider conducting vaginal breech births, the desire to accommodate this option is such that these obstetricians make themselves available sometimes out of roster in order to accommodate the wishes of women who make this choice."

Waterbirth
There were 32 babies born in water in 2013 - four mothers were cared for by NW LMC midwives, and 28 were cared for by independent midwives.

Postpartum Haemorrhage
The postpartum haemorrhage (PPH) rate continues to rise and it remains a cause for considerable concern. It is associated with the increasing caesarean section rate. The overall primary PPH rate (500mls and over) was 35.5% (up from 33.6% in 2012). "With an overall PPH rate of 35.5% the challenge for NW is not to remain stable but to decrease the rate," the report states.

It was 18% following a spontaneous vaginal birth compared to 71.9% following an emergency caesarean section and 53.3% following an elective caesarean section. It also varied by onset of birth, from 25.8% in spontaneous onset of labour to 35.9% in induced labour.

Peripartum Hysterectomy
In 2013 five women had an emergency postpartum hysterectomy. Hysterectomies following birth are usually associated with caesarean sections.

Maternal Mortality
There were two maternal deaths at National Women's in 2013.

Breastfeeding
In 2013 79% of mothers were discharged from National Women's exclusively breastfeeding their babies.

- A copy of the 2013 Annual Clinical Report is available at:
http://nationalwomenshealth.adhb.govt.nz/health-professionals/annual-clinical-report

Researcher access to women's maternity information

Women are not being informed when registering with a Lead Maternity Carer that when they sign the registration form they are in fact signing a waiver and agreeing to their maternity information being able to be accessed by researchers.

The Ministry of Health's (MOH) website states under the "Privacy Issues" heading of the National Maternity Collection page:

"When a woman registers with a lead maternity carer she signs a waiver that allows health data to be used for research under the Health Information Privacy Code 1994.

The Ministry of Health is required to ensure that the release of information meets the conditions of any legislation related to the privacy of health information, in particular the Official Information Act, the Privacy Act 1993, the Health Information Privacy Code 1994 and the Adult Adoption Information Act 1985." (1)

However, there is nothing on the Ministry's *Registration with Lead Maternity Carer* form or the Midwifery and Maternity Providers Organisation (MMPO) *Registration with Lead Maternity Carer* form stating that in signing the form the woman is signing a waiver allowing her health data to be used for research.

What the MOH form lists in dot points above the woman's signature is that she understands that the Ministry of Health will use the information in this registration form in a manner consistent with the Health Information Privacy Code 1994 to make payments to her LMC for the services provided, and to monitor the health status of women and their babies, and to produce the annual report on Maternity. There is no mention of the use of her information for research purposes.

Likewise the MMPO's registration form refers to the fact that in signing the form the woman understands that MMPO, the Ministry of Health and related health providers will be using their personal information to monitor quality of care, treatment and health statistics and accuracy of claiming in a manner consistent with relevant privacy legislation. There is no mention of researchers accessing their information.

But there is the somewhat threatening statement:

"I understand that if I do not agree to this information being forwarded by my Lead Maternity Carer, I will not be eligible for publicly funded maternity services."

This raises the question how are women supposed to know that they are actually signing what the MOH refers to as "a waiver" when there is nothing in the registration forms that refers to research or that clearly states what the woman is actually agreeing to?

This situation is unacceptable and if the LMC registration form is indeed "a waiver" that enables researchers to access a woman's maternity information then this must be spelled out very clearly in these forms.

References

1. http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/national-maternity-collection

MSCC Meeting Dates for 2015

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 2015 are**:**

3 February, 3 March, 7 April, 5 May, 2 June and 7 July

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.

ANTIBIOTICS FOR PREMATURE RUPTURE OF MEMBRANES NEAR TERM HAVE NO BENEFIT

The pre-labour rupture of the membranes (PROM) at or near term increases the risk of infection for the mother and her baby. The routine use of antibiotics for mothers when their membranes break at the end of their pregnancy may reduce this risk. However, due to increasing problems with bacterial resistance and the risk of maternal anaphylaxis (allergic reaction) with antibiotic use, it is important to assess the evidence addressing risks and benefits in order to ensure judicious use of antibiotics. It is also important to note that most women spontaneously start labour within 24 hours, so delaying induction of labour and waiting for the spontaneous onset of labour is a possibility.

A new Cochrane review was undertaken to assess the balance of risks and benefits to the mother and baby of the use of antibiotics to prevent infection following the premature rupture of membranes at or near term.

The latest Cochrane review of the evidence for using antibiotics for PROM at the end of pregnancy follows a previous analysis in 2002 that gave no clear clinical practice guidelines because of a lack of reliable data. Despite the quality of evidence being low, the researchers stated in 2002 that they found no convincing evidence of any benefit to mother or baby.

The 2014 review includes an additional two studies involving 1801 women, giving a total of four included studies of 2639 women. The recommendations in the latest review continue to bemoan the quality of the scientific evidence, which is low, but this time the authors go a step further and suggest that antibiotics should not be used because of the lack of evidence of any benefit to mother or baby. (1)

The reviewers concluded:
“The conclusions from this review are limited by the low number of women who developed an infection across the studies overall. There is not enough information in this review to assess the possible side-effects from the use of antibiotics for women or their infants, particularly for any possible long-term harms. Because we do not know enough about side-effects and because we did not find strong evidence of benefit from antibiotics, they should not be routinely used for pregnant women with ruptured membranes prior to labour at term, unless a woman shows signs of infection.”

As we now know how important it is for newborn babies to receive the founding populations of microbes from their mother during the birth process, it is essential that we take good care not to interfere with this microbial handoff unnecessarily.

References

1. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001807.pub2/pdf

La Leche League NZ's 50th Anniversary Conference

La Leche League recently held a conference to mark their 50th anniversary in NZ. Debra Graham attended the pre-conference seminar for physicians and produced the following report on the seminar for the MSCC newsletter:

La Leche League New Zealand's 50th Anniversary conference was held at the Waipuna Hotel and Conference Centre in in early October. On Friday 3rd October, a pre-conference seminar "*Breastfeeding Essentials for Physicians: What every doctor needs to know*" gathered twenty-nine doctors and allied health professionals to hear six captivating experts on breastfeeding. It was a wonderful atmosphere of networking and an opportunity to hear about the history of La Leche League New Zealand and the role of mother-to-mother breastfeeding support.

Dr Alison Barrett BSc, IBCLC, MD, FRCS, FRANZOG started the day with 'Heirlooms and Souvenirs: How our Microbiome influences Health.' Alison is an Obstetrician and Gynaecologist consultant at Waikato Hospital in Hamilton where she is a FRANZCOG training supervisor for junior doctors. Prior to entering medical school, Dr Barrett studied ecology and biological sciences, and these two fields continue to inform her clinical work. She is very passionate about how birth and breastfeeding affects our future health.

Dr Leila Masson, M.D., MPH, FRACP, DTMH, IBCLC. Leila is an integrative paediatrician who combines allopathic medicine with a nutritional and biomedical approach to help her patients attain optimal health. Her session titled 'Allergies and Reflux in Infants' shared her approach to children's immune disorders and the research behind it, in order to give doctors simple yet effective strategies to help young patients get healthier. Breastfeeding is an important aspect of her work.

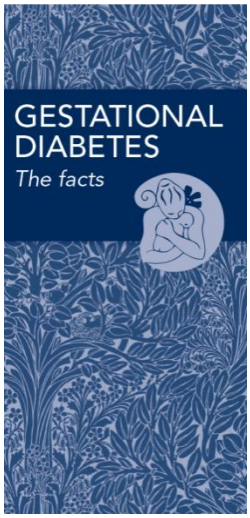
Carol Bartle RN, RM, PGDipChild Advocacy, MHealSc IBCLC. Carol, with her nursing, midwifery and lactation consultant background, works as the Canterbury Breastfeeding Advocacy Service Coordinator in Christchurch and as a policy analyst with the New Zealand College of Midwives. Carol has recently appointed on to the ILCA International Code Expert Panel. Her informative, evidence-based session 'Breastfeeding Research: A taste of what's fresh and new' brought us all up to date.

Dr Yvonne LeFort MD FRNZCGP FCFP (Canada) FAB, IBCLC presented the evolving topic 'Clinical Impact of Tongue tie - when to snip?' Yvonne is a family physician based in Milford Family Medical Centre on Auckland's North Shore has been involved in helping breastfeeding mothers and babies for over 15 years. Yvonne believes that general practitioners need to be aware of what assistance they can provide and how to support these valued members of our practice and

our society as a whole. Yvonne discussed the latest research relating to tongue tie management.

Diana West BA, IBCLC, LLL Leader & best-selling author was the first of two key note speakers from the conference. Diana made a great impression with her 'Helping Millennial Mums to Breastfeed'
Then Pinky McKay IBCLC, LLL Leader & best-selling author rounded off a special day with 'It Takes a Village: Mothering the Modern'

This seminar proved to be an ideal context for physicians to continue their professional education in a highly respected, stimulating environment and be up to date with current issues in breastfeeding medicine. They took away how to support breastfeeding mothers and babies to achieve their breastfeeding goals and to facilitate their future health right from the start.



The MSCC has produced a sixth leaflet in its "*The Facts*" series.

The Gestational Diabetes leaflet describes what GDM is, the process of screening for GDM, the disadvantages of having a single test, treating GDM, and outlines the differing opinions on gestational diabetes, the risk of overdiagnosis, and how to minimise the risks.

There is a charge for all the leaflets in "*The Facts*" series, but one free copy of each leaflet is available upon request.

There are also more articles and information about gestational diabetes on the MSCC's website: www.maternity.org.nz

MIDWIFE-LED CARE SAFER THAN HOSPITAL CARE

In December 2014 the UK National Institute for Health and Care Excellence (NICE) released its revised guideline on "*Intrapartum Care: Care of healthy women and their babies during childbirth."* (1) The evidence now shows that midwife-led care is safer than hospital care for women having a straightforward, low risk pregnancy. This is because the rate of interventions, such as the use of forceps or an epidural is lower and the outcome for the baby is no different compared with an obstetric hospital.

The NICE guidelines reverse a generation of misinformation about birth, especially birth in secondary and tertiary hospitals. There was never any evidence that hospital births were safer. As one mother who had had a caesarean birth wrote, we have known for quite some time that "treating all women as though they were a hair's breadth from disaster raised stress levels among women in labour exponentially, and caused the need for interventions."

"Suddenly women who had shown no signs of problems were being given drugs to induce their labours, were being hooked up to machines that restricted their movement during labour (and movement is extremely helpful in a normal labour) and were being plied with painkillers which had a knock-on effect on the straightforward progress of the birth. The result, we now know, was that the number of "complicated" deliveries – caesareans, forceps, ventouse – rose dramatically, and many mothers who could have had a straightforward birth ended up having a dramatic, emergency intervention to get their now distressed unborn child safely delivered," she wrote. (2)

The guidelines begin by stating that giving birth is a life-changing event and "the care that a woman receives during labour has the potential to affect her – both physically and emotionally, in the short and longer term – and the health of her baby. Good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s)."

Home births are equally as safe as midwife-led units (birthing centres) and all healthcare professionals should inform women of all the options available to them and advise them that they have the freedom to choose where they give birth. Professor Mark Baker, NICE's clinical practice director, said: "Where and how a woman gives birth to her baby can be hugely important to her. Although women with complicated pregnancies will still need a doctor, there is no reason why women at low risk of complications during labour should not have their baby in an environment in which they feel most comfortable. Our updated guideline will encourage greater choice in these decisions and ensure the best outcomes for both mother and baby."

A summary of the guidelines also featured in a recent issue of the *British Medical Journal* which appeared at the beginning of December. (3)

The *BMJ* paper listed four points as being what the authors described as the bottom line:

The bottom line

- The care that a woman receives during labour can affect the woman herself (physically and emotionally) and the health of her baby in the short and longer term
- Maternity services should provide a model of care that supports one-to-one care in labour
- Low risk mothers and babies do not benefit from birth in hospital obstetric units or from many previously "routine" but unindicated labour interventions
- Clinicians need to be familiar with the evidence and able to talk non-judgmentally to women about their choices

Hopefully, this will be repeated in numerous journals throughout the world, especially those read by obstetricians, GPs and midwives. The increasing amount and rate of interventions in the birth process have never been based on good evidence, and it is going to take lots of journal articles to get the message through to the healthcare professionals involved that unnecessary interventions have the potential to cause short term and long term harms to both mothers and babies.

NICE has also updated their guidelines on cord-clamping (avoid clamping the cord immediately after the birth), and the association between co-sleeping and SIDS (Sudden Infant Death Syndrome).

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2. http://www.theguardian.com/society/2014/dec/03/hospital-childbirth-misconception-home-reversing-nice-guidelines
3. http://www.bmj.com/content/349/bmj.g6886