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Maternity Services Consumer Council

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

Welcome to the first issue of the MSCC's Newsletter for 2014. Since we returned to work after our summer break we have caught up with all the pamphlet orders that arrived while we were lazing in the sun, produced this newsletter, attended a Maternity Consumer Engagement Forum, worked on upgrading the MSCC website and attended DHB meetings. We have also written several grant applications, responded to requests for information, and have mailed out thousands of our pamphlets.

Funding applications

The MSCC is very appreciative of the $2,000 we received from The Trusts Community Foundation for the badly needed upgrade of our website. We have also submitted applications to the Lion Foundation and the ASB Community Trust.

MSCC's new website

The MSCC has been working hard over the past couple of months on updating our website. While the new website design went live just before Christmas, there was much to do as we added new pages and uploaded new information and articles, and checked and revised the information that was already there.

We encourage you to check out our new website and feel free to send us through any feedback and suggestions.

What's in this issue of the newsletter

The March issue of the newsletter contains a summary of the recently released survey of maternity services at Counties Manukau Health, Hassanah's account of her attendance at the epidural talk at National Women's, an article on recent research which revealed a link between the use of paracetamol during pregnancy and ADHD in children, and a surprise finding that shows animal mothers customise their milk depending on whether their baby is a girl or a boy. There is also information on several events, including Sarah Buckley's workshop which is being held in Auckland on Friday 11th April.

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

Happy reading!

Lynda + Nicola

HAVING A BABY AT MIDDLEMORE HOSPITAL WHEN YOU ARE YOUNG, MAORI AND/OR PACIFIC

At the beginning of the year Counties Manukau Health (CMH) released a report it had commissioned Pacific Perspectives Ltd to prepare on what is working well and where improvements can be made in the maternity care being provided at Middlemore Hospital. The project was specifically focused on the experiences of Maori and Pacific mothers, teen mothers and women of childbearing age who live in areas of high socio-economic deprivation.

The report is called "Maternity Care Experiences of Teen, Young, Maori, Pacific and Vulnerable Mothers at Counties Manukau Health" and follows the independent maternity review in 2012 which found that unborn and newborn babies were dying at higher rates in South Auckland than the national average. The 96-page document makes for grim and at times very emotional reading and it is painfully clear that Middlemore Hospital often gives their young Maori and Pacific mothers a very hard time. The mothers interviewed said they felt unwelcome and their needs and concerns were ignored by a system that is focused on trying to make them comply with their unreasonable expectations.

Five key themes

Counties Manukau Health identified five key themes that they wanted the views of mothers on. They were:

- Accessing and engaging early in pregnancy
- Using the primary birthing units – Botany Downs, Pukekohe and Papakura
- Accessing appropriate advice and affordable contraception in a timely manner
- Developing strategies to reduce smoking in pregnant women
- Developing culturally appropriate interventions to reduce pre-pregnancy obesity.

Dissatisfied mothers

A number of focus groups and face to face interviews were held in a variety of settings with young, Maori and Pacific women, as well as women living in economically deprived areas who had given birth at Middlemore hospital. All groups expressed dissatisfaction with maternal care provided by Counties Manukau Health. The report states that "the dissatisfaction relates to:

- Perceived attitudes of staff towards mothers, for example vulnerable young mothers felt interactions with staff stereotyped, judged and stigmatised them;

- Labour, delivery and the period immediately after delivery were mentioned as times when young mothers felt they needed support and care of health professionals and their families. However the predominant CMH culture was focused on timeliness and efficiency. Mothers perceived they received a service, rather than nurturing and care. The service failed to utilise family support. We were told of many cases when births occurred at night, partners and families were sent home, (or charged an unaffordable fee to stay the night). This left vulnerable young women alone in an unfamiliar environment with staff who could not or would not respond to their needs due to other work pressures. We noted that mothers who had also delivered at Auckland District Health Board (ADHB) facilities, described a marked contrast in their experience of the maternal care services provided at ADHB. In particular staff attitudes were different, including welcoming families and going the "extra mile" to

make them feel comfortable and provide care and support in the period immediately after delivery;

- Women with English as a second language and/or with low health literacy were not able to access additional resources to meet their needs;

- Interworkforce rivalry and patch protection were obvious to mothers and their families. Mothers described tensions between private LMCs and hospital staff, with LMCs acting as advocates for them against hospital staff who were perceived as focused on discharging mothers home early; and hospital staff who criticised the actions and competence of LMCs. This impacted on their confidence and trust in the services, and their willingness to engage for future needs."

Shared Care

Women have been reporting on the problems with the Shared Care service since it was first established. Shared Care is unique to CMH and was developed in response to a shortage of private LMCs. Under the Shared Care service women receive most of their antenatal care from a GP, but are also entitled to three antenatal visits with a DHB-employed community midwife. Care during labour and birth is provided by a CMH-employed midwife. GPs that provide Shared Care are not required to have specific training in antenatal care and are not required to have a postgraduate Diploma in Obstetrics and Gynaecology. This is and has always been totally unacceptable.

What is also unacceptable is that the women who go to Shared Care for their initial maternity visit are not told about their other options, ie they can choose a self-employed midwife as their LMC, "due to financial incentives" that CMH provides to the Shared Care GPs. The report states "although doctors were the first contact for young mothers to confirm their pregnancy and their main source of information regarding different antenatal care options, they provide very little information and guidance. Women were unsure about the different options of maternity care, how to make choices and how to access the different types of care."

Shared Care was therefore not an informed choice made by the women. Their experience of Shared Care was one of long waiting times, rushed appointments, and a lack of continuity of care after discharge from hospital – some mothers had no follow-up care, others were seen many weeks after discharge and/or had an insufficient number of postnatal visits. The service was perceived by women to be medically focused and inflexible.

This helps to explain why on average 190 women in CMH per year do not have any antenatal care and just over a third of women book very late in pregnancy.

It has all been said before

The authors of the report also note that their desktop review of previous reports indicated that these views were already well documented. The MSCC can confirm this as we were receiving calls about many of the issues described in the report a decade and more ago, especially those related to Shared Care.

The stories

1. Factors preventing early engagement

Many teens were scared of a positive result:

"I was three and a half months when I found out… I was in denial because I didn't want to find out I was pregnant. I had no symptoms I just missed my period hoping it would come the next month."

"I didn't want to know, I just pretended it wasn't happening, but deep down I knew."

Older mothers said:
"I usually don't. I just get me a midwife when I'm about six months."

Then there is the story of a Pacific mother who was encouraged to attend prenatal sessions with her LMC. To get to her first check up she had to catch two buses, and it took her two hours with children in tow. Once there it took 15 minutes to complete the checks. The mother was told "you're fine" and sent home. She did not attend subsequent checks.

2. Low Health Literacy

This was particularly an issue for Pacific mothers of all ages.

"She told me I had to find a midwife and I was like what is this word? I have never heard this word before."

"I was told I have to go here and here and here and I was like, why do I have to go to all these places. In Raro I saw one person; it gave me a sore head to think of all these new things."

3. Religious and cultural beliefs

Pacific women know very little about the symptoms of pregnancy even with subsequent pregnancies:

"There's no way we would talk about anything like that in our family, no-one in my culture does, you have to find out from your friends."

4. Interworkforce rivalry

Interworkforce rivalry and patch protection were obvious to mothers and families:

"I had a show and bad cramps, I waited three days and the baby still didn't come. I couldn't sleep or anything. I rang the hospital and they kept saying don't come, it's not time. I finally rang my own midwife because I was scared, I was worried I would be too tired to push this baby out. My midwife met me at the hospital and she told them off. I heard them argue up in there."

5. History of State/Government intervention

Vulnerable mothers described difficulties with any mainstream service because of historical and on-going relationships with CYF, the Police, and Work and Income.

"When I told her my age she looked at me funny and I was a bit terrified because she asked me who's my supporters and I was worried in case she was going to get CYF."

"They (Social Service provider) sent someone to help me; it took them two years to get through my door."

6. Barriers to access

Mothers highlighted significant issues with the continuity of care.

"I never had a midwife, due to when I did have a midwife she was very judgemental because of my age being pregnant young … so I felt uncomfortable so I just basically looked after myself through the whole 9 months and gave birth in my own bath tub, I didn't go to hospital … I just did it on my own."

"The day I gave birth to my daughter my midwife didn't come and didn't see me until three weeks later. They gave me someone else when I was in labour and I was like "who the hell are you?' "

7. Staff attitudes and lack of cultural competency

The lack of compassion is incredible.

"So I had my baby at midnight and she told me I could stay until I went to the toilet. At 4am I went to the toilet and she told me to leave. It was the middle of winter and I am sitting in the foyer waiting for my mum to come back and pick me up with my new baby. My mum only just left two hours before because they said she can't stay the night. I was thinking of her petrol."

"I was looking out the hospital window in my room and I could see my mum sitting in the dark at Middlemore train station and we were both crying."

The research also highlighted that the women they interviewed very rarely complain about the service they received even when it is very bad. Others issues discussed with the mothers included accessing affordable and appropriate contraception, reducing or stopping smoking during pregnancy, and developing culturally appropriate nutritional interventions to reduce pre-pregnancy obesity.

Recommendations

The report includes a number of recommendations on how to achieve quality in maternity care across culturally diverse populations, doing something urgently abut the poor service to teen, young, Maori, Pacific and other vulnerable mothers, the need to consider the whole maternity care system when making changes, and reviewing the mechanisms used by CMH for patient and consumer input.

The MSCC considers that similar problems exist with the maternity services provided to these groups of mothers in West Auckland, and recommends that Waitemata DHB undertakes a similar survey of women who have given birth at Waitakere Hospital.

The Counties Manukau Health report is available at:
www.countiesmanukau.health.nz/News_Publications/Reports/maternitycarereview/default.htm

Epidural talks at National Women's

By Hassanah Rudd

Last year I attended the antenatal epidural talk at Auckland hospital, which could be considered odd by people who know me as I had absolutely no plans to have one. I was booked for Birthcare where the ability to have an epidural is zero.

But as I was an 'elderly multigravida' – pregnant with my 3rd child and over 42 - I am also sensible and had researched enough to know that if something goes 'wrong", it's statistically more likely to happen to me. And "wrong" would probably mean a caesarean section. So for my own knowledge around spinal epidurals and to actually have the information to give "informed" consent, I went along.

On one level I can totally see why it is good to do this talk beforehand. It would be nigh on impossible for a doctor to be certain he has covered everything and obtained proper informed consent from a woman in strong labour who may be in need of an emergency procedure. So for that – a big tick.

So all of us gathered at reception, giving each other that nod pregnant women do which is always so nice. We were then taken upstairs for the presentation given by a very nice anaesthesiologist.

First we watched probably the oldest video in obstetric history - for which he did apologise. It did cover the pain relief options but must have been made in the early 80's out of the UK. (Be great to know if anyone has an updated version, but it's probably the only one around).

Before he got on to epidurals he covered the various pain relief options available, TENS, water, entonox, pethidine. He was honest about the downsides to the drugs and the risk factors. He also suggested building up on the pain relief options as required. Not reaching straight for the epidural, because you could find that as labour progresses, you cope okay.

The use of water as a means of pain relief is a problem at Auckland Hospital, because not all of the 14 delivery suites have birth pools in the room – less than half I think. So if you turn up and those rooms are occupied you are out of luck. He did suggest using water at home before coming in. But in my experience, although that helps, it's actually when you are in strong labour that water is most effective…and 9 times out of 10 you will be in hospital by then. (Particularly if it's your first, because you really have no idea how this whole labour/birth thing is going to go).

He talked about how to use entonox for the best effect, (i.e. to start breathing in at the start of the contraction to have the effect at its height), and ran over the pros & cons of pethidine. Interestingly many in the audience were turned off using pethidine when the possible side effects on the baby were discussed.

The epidural information was good and informative. He was honest about the risk factors including the main one that shows up for them – really bad headaches from the

misplacement of the epidural. They then have to bring women back to "patch" – which is basically another epidural with a blood clot placed over the leaking spinal hole. He was also honest that it doesn't always work the first time and they have had to do it twice, and rarely, three times.

What did concern me, was the nature of the questions from the audience. Fear sat in that room like a toad. I'd place bets that I was the only one who already had children. These were all first time mums, with first time mum fears.

I get that beforehand you do think about how you are going to cope in labour and how it's going to go. I've been there too & I was probably ridiculously well informed & still anxious. But over half the questions asked were around information that is covered in any good childbirth education (CBE) class. But these were (somewhat unfairly) being asked of an anaesthesiologist. And let's be honest, he isn't going to know. He isn't a trained child birth educator, he is a doctor trained in anaesthetics.

So my immediate thought was "have none of you booked CBE classes?" I then wondered how many would in fact labour and birth without an epidural. Odds are high that it won't be many of this group. One woman even asked whether she could have an epidural just in case she needed a caesarean section.

Fear is labour's worst enemy, and there is more research evidence on what fear and the associated hormones do to labour than you can shake a stick at. Yet there was no one there at this presentation to say "Its ok, even if you think you won't be able to handle, it you will. Don't let fear dictate how you think you will cope in labour."

Sometimes fear can be all pervading in the life of a pregnant woman. Think about the response when you ask a pregnant woman where she plans on giving birth. If she says the hospital, and you ask why, I guarantee the reply will be "well it's just in case something goes wrong" ….Hello, that's fear again.

This is what I felt like saying to everyone there…but I didn't:
"*Yes labour hurts - its labour. And it's physically all-encompassing and can take everything you have and will expose your to your core…but you can do it and your body is going to do it with or without your input! The pain will not kill you, honest.*

"*Yes it's painful - but it's not constant pain. After the contraction goes away THERE IS NO PAIN. Rest, relax take deep breaths. Each of the contractions is one less and one more towards you seeing your baby. You could 'lose it' at transition – personally I start weeping – but that's a very important time as the hormone cocktail in the driving seat of labour changes then so you can birth your baby.*"

I just felt so sad that there was no one to talk through these completely understandable fears that a primagravida woman has, and I wish that there had been a childbirth educator with the anaethesiologist who could have taken these particular questions. That way information can flow and fear can leave the building.

I'm glad I went for my own information. If anything had gone pear shaped and I needed to transfer to the Hospital and needed an epidural/spinal, I would have been informed

and been able to say “I understand the risks - I have attended the epidural talk.” But my recommendations are:

For pregnant mums:

- If you are going to go to this presentation, do, but don’t make the decision about an epidural ahead of time because you aren’t certain you can handle the pain. That’s the fear talking. It’s ok if you reach the end of your tether and want to ask for one, but don’t think you can’t cope before the contractions start… because you can… You are pretty bloody powerful.
- There are things that make it harder to cope, like the contractions of an induction or being on your back. But for proper information about that, and everything else that can make labour pain cope able, book and go to good childbirth education classes. They are taken by trained and qualified CBEs and they will present the information to you honestly for you to make an informed choice about.

And for the hospital:

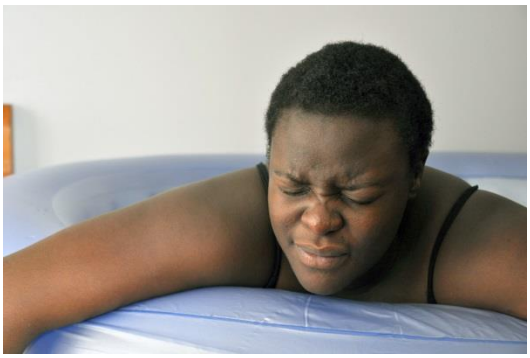
- Get a childbirth educator in for those presentations so they can answer the questions that will help allay the fears these women and their partners will have. Only then can an informed choice really be made.
- I’d also recommend that it might be best for the LMC to make the referral to these talks, that way discussion can be had around the pain relief options.

There is an African proverb that I was told when pregnant with my first child that I always remembered when labour got going.

“*Childbirth is like walking a narrow bridge. People can be with you to the bridge and meet you on the other side, but you walk that bridge alone*”

I always interpreted that as a proverb positive; it’s not that you are alone, but you need to go into yourself, to trust your body to finish the job it started nine months ago.

So I wish you a good crossing of that bridge, however you get across!



Postscript

Hassanah had a beautiful baby girl weighing 7lb 15oz who was born at Birthcare in the pool after a 40min labour. Mum and baby thriving and are very happy.

STUDY LINKS PARACETAMOL USE DURING PREGNANCY TO ADHD IN CHILDREN

Paracetamol is the most commonly used medication for pain and fever during pregnancy. But new research has revealed that it is associated with a higher risk for attention-deficit/hyperactivity disorder (ADHD) and hyperkinetic disorders (HKDs are a severe form of ADHD) in the children of mothers who used the drug when compared with children of mothers who did not use it.

A study published recently in the *Journal of the American Medical Association Pediatrics* has suggested that paracetamol has effects on sex and other hormones which can in turn affect neurodevelopment and cause behavioural dysfunction. The study's investigators noted that previous research has linked the drug to hormone disruption – a process that could impact on foetal brain development. With this in mind, the research team decided to assess whether paracetamol use during pregnancy could increase a child's risk of HDHD and HKDs – syndromes that emerge during early childhood.

The researchers studied 64,322 children and mothers in the Danish National Birth Cohort (1996-2002). More than half said they took paracetamol at least once during pregnancy. Parents reported behavioural problems on a questionnaire, and HKD diagnoses and ADHD medication prescriptions were collected from Danish registries. The risk of a child having ADHD and HKD-like behavioural problems increased when mothers used the drug in more than one trimester during pregnancy.

According to the Centers for Disease Control and Prevention (CDC), the percentage of children diagnosed with ADHD is increasing. In 2003 7.8% of children had the disorder, and this figure increased to 11% in 2011. The researchers say their findings suggest that because foetal exposure to paracetamol is frequent during pregnancy, this could explain the increasing prevalence of ADHD and other childhood behavioural disorders.

Their conclusion was that maternal paracetamol use during pregnancy is associated with higher risk for HKDs and ADHD-like behaviours in children. "Because the exposure and outcomes are frequent, these results are of public health relevance but further investigations are needed."

The results of the study also underline the importance of being very cautious when taking any drugs during pregnancy, rather than assuming they are safe.

The study was led by Zeyan Liew of the University of California, Los Angeles and was co-authored by Jorn Olsen of the University of Aarhus in Denmark.

Reference

http://archpedi.jamanetwork.com/article.aspx?articleid=1833486

Animal mothers customise milk depending on baby's sex

By Lauran Neergaard, Associated Press

17 February 2014

This photo provided by the California National Primate Research Center shows a nursing rhesus macaque monkey in 2013. In a study of hundreds of milk samples, researcher Katie Hinde of Harvard University found that nursing rhesus macaque monkeys made different milk for daughters versus sons.

A special blend of mother's milk just for girls? New research shows animal moms are customizing their milk in surprising ways depending on whether they have a boy or a girl.

The studies raise questions for human babies, too — about how to choose the donor milk that's used for hospitalized preemies, or whether we should explore gender-specific infant formula.

“There's been this myth that mother's milk is pretty standard,” said Harvard University evolutionary biologist Katie Hinde, whose research suggests that's far from true — in monkeys and cows, at least. Instead, “the biological recipes for sons and daughters may be different,” she told a meeting of the American Association for the Advancement of Science on Friday.

Pediatricians have long stressed that breast milk is best when it comes to baby's first food. Breastfed infants are healthier, suffering fewer illnesses such as diarrhea, earaches or pneumonia during the first year of life and less likely to develop asthma or obesity later on.

But beyond general nutrition, there have been few studies of the content of human breast milk, and how it might vary from one birth to the next or even over the course of one baby's growth. That research is difficult to conduct in people.

So Hinde studies the milk that rhesus monkey mothers make for their babies. The milk is richer in fat when monkeys have male babies, especially when it's mom's first birth, she found. But they made a lot more milk when they had daughters, Hinde discovered. Do daughters nurse more, spurring production? Or does something signal mom prenatally to produce more?

To tell, Hinde paired with Kansas State University researchers to examine lactation records of nearly 1.5 million Holstein cows. Unlike monkey babies, calves are separated from their mothers early on, meaning any difference should be prenatal. Sure enough, cows that bore daughters produced about 1.6 percent more milk. Since cows lactate for 305 days, that adds up. More interesting, cows often lactate while pregnant — and those

that bore a second daughter in a row produced almost 1,000 more pounds of milk over nearly two years than those that produced only sons, Hinde calculated.

Back to the monkeys — where Hinde found still more differences in the quality of the milk. Milk produced for monkey daughters contains more calcium, she found. One explanation: Female monkeys' skeletons mature faster than males' do, suggesting they need a bigger infusion of this bone-strengthening mineral. Human girls' skeletons mature faster than boys, too, but there haven't been similar studies of calcium in human breast milk, Hinde said.

Mothers' milk even affects babies' behaviour, she said. Higher levels of the natural stress hormone cortisol in milk can make infants more nervous and less confident. But boys and girls appear sensitive to the hormone's effects at different ages, her latest monkey research suggests.

One previous study of human babies has linked higher cortisol levels in breast milk to cranky daughters, not sons, but Hinde cautioned that testing cortisol reactions at only one point in time could have missed an effect on younger or older boys.

What about boy and girl twins? Hinde can't answer; the monkeys she studies seldom have twins. Nor can she explain why the animals show these gender differences.

“It's something highly personalised for that mother and that infant at that time point. That's an exquisite thing,” Hinde said, who wants to see similar study of human breast milk. Because high-quality breast milk is particularly important to the most vulnerable infants, she wonders whether premature babies in intensive care might fare better with gender-matched donor milk. Then there's the formula question.

“We think it's important — and it's not — to make different deodorants for men and women, and yet we kind of approach formula as though boys and girls have the same developmental priorities,” Hinde said with a laugh.

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 2014 are**: 1 April, 6 May, 3 June, 1 July, 5 August.**

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.

CONFERENCES/WORKSHOPS 2014

Waitakere Health Link is holding its first **NGO Health Network Forum** of the year on Wednesday 28 May 2014 at the Kelston Community Centre.

TOPIC: The history and future development of Maternity Services in West Auckland

This is a unique opportunity for NGOs and consumers to talk to the people who plan health services in the West. There will be presentations from the Waitemata DHB, independent midwives and the Maternity Services Consumer Council, followed by a discussion panel of questions and answers.

For more information phone 8390512 or email: office@waitakerehealthlink.org.nz

NZ College of Midwives 2014 National Conference

This year's NZ College of Midwives Conference will be held on 28 - 31st August 2014 in Hamilton.

This years Conference Theme is: **Midwifery relationships are the bridge to quality**

Further information is available at:
www.midwife.org.nz/resources-events/nzcom-conference/

Undisturbing Birth

THE SCIENCE AND THE WISDOM

Discover the four ecstatic hormones of undisturbed birth.

Learn how these hormones

- *Create ease, pleasure and safety for mother and baby*
- *Can be disrupted by induction, epidurals, caesareans and other interventions*
- *Optimise breastfeeding and attachment, with life-long benefits.*

Put this into practice for your clients and yourself!

Sarah's work is based on the best scientific evidence and her comprehensive report, The Hormonal Physiology of Childbearing, produced with Childbirth Connection (US) is due for release mid year.

Whole-day Workshop with
Dr Sarah Buckley

Friday 11th April (9.30am - 4.30pm)

Independent Living Service, 14 Erson Ave, Royal Oak.

$160 / $140 Earlybird (before 23rd March)

This workshop will be valuable for midwives, doulas, childbirth educators and doctors, and will also be suitable for parents and parents-to-be.

For more information and booking, see Sarah's schedule at
www.sarahbuckley.com
Book early, numbers limited.

Dr. Sarah Buckley, MB, ChB, is author of the internationally-acclaimed book

Gentle Birth, Gentle Mothering

A Doctor's Guide to Natural Childbirth and Gentle Early Parenting Choices.

BOOKS AND DVD'S OF SARAH'S TALKS WILL BE AVAILABLE.