ISSUE 98
March 2015

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 2015. Since returning from the summer break we have attended the Auckland/Waitemata DHB maternity services collaboration workshop in late January, continued working towards a purpose-built maternity unit in West Auckland, followed up on the use of the HbA1c blood test during early pregnancy, and attended DHBs meetings. We continue to track 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.

Judi Strid

This issue of the MSCC's newsletter begins with a tribute to Judi Strid who died on 26 February 2015. Judi's contribution to women's health and her involvement in key health groups, especially maternity groups, in the 1980s and 1990s cannot be overestimated. She was passionate about evidence-based information for consumers, was involved in many initiatives such as the NZ Guidelines Group and the Cochrane Collaboration, and spent the last 10 years of her life as the Directory of Advocacy at the office of the Health and Disability Commission. As the tribute on page 2 reveals Judi worked tirelessly for the changes to the maternity system that came into effect in the late 1980s and early 1990s. The MSCC is just one of many the organisations that owes a great deal to Judi and it is important to take this opportunity to acknowledge her many achievements and honour her now she is not around to disapprove of such behaviour.

What's in this issue of the newsletter

The March issue of the newsletter features a tribute to Judi Strid, a summary of some of the information in the National Maternity Monitoring Group's second Annual Report which the MSCC received last month, an article on how the media reports deal with maternal deaths, a report on the Auckland/Waitemata DHB maternity services collaboration workshop, a brief comment on the clinical practice guideline on "*Screening, Diagnosis and Management of Gestational Diabetes in New Zealand*" which has recently been placed on the MOH website, and information on two exciting workshops.

Happy reading!

Lynda + Lettica

CELEBRATING THE LIFE OF JUDI STRID

On Thursday 26 February 2015 Judi Strid died at home following a four-year battle with cancer. She was 59 years old, the mother of five children and three grandchildren.

Judi was a truly remarkable woman, a leader and one of the most effective change agents in the maternity sector in New Zealand during the 1980's and 1990's. I met Judi in the mid-1980s and we soon became friends and colleagues as we joined and/or established consumer groups and worked on numerous issues of concern in the maternity sector. Judi was an inspiring and hard-working member of the Home Birth movement (three of her children were born at home), Save the Midwives, Maternity Action, as well as many other groups.

In 1986 she helped form and then led the Direct-Entry Midwifery Task Force whose aim was to see the establishment of a direct-entry midwifery programme in New Zealand. Over the next four years Judi led this hugely successful campaign. On 29 November 1987 taskforce members met with Marilyn Waring to discuss strategies for achieving the goal of getting a specialist midwifery training course of a high standard that would be both appropriate to New Zealand and which would also be recognised internationally. As co-ordinator of the Task Force Judi inspired and motivated the rest of us with her passion and enthusiasm for the cause, and over the next few years we vigorously lobbied MPs, wrote letters, applied for funding, produced submissions, networked with other women, researched overseas midwifery training programmes and attended conferences both in New Zealand and overseas. Without Judi's commitment and countless hours of unpaid work we would not have achieved as much as we did. The passing of the Nurses Amendment Act in August 1990 was an overwhelming victory for all those involved in this campaign.

Few midwives today, and probably not one pregnant woman choosing a midwife to care for her, know just how much they owe to Judi Strid.

The Auckland Women's Health Council was formed in July 1988 following a number of informal meetings about women's health issues held in the early months of that year. Judi was a founding member of the AWHC which became an incorporated society in September 1989. She was the first paid co-ordinator of the AWHC, taking on the job after funding had been obtained when the demands of the AWHC's work became more than could be done by Sue Neal, our volunteer secretary. Judi worked tirelessly for the Council, organising fundraising book fairs, writing grant applications, attending hundreds of meetings including those of the newly formed Auckland Area Health Board. She also played a major role in the formation of the Federation of Women's Health Councils in 1990 and subsequently worked in a volunteer role as the first convenor of the Federation for several years.

Judi was also involved in the hui on maternity services consumer representation held at the Manukau Institute of Technology in Otara on Saturday 25 November 1989. The meeting was attended by around 50 women and Task Force members, Ray Naden, Anne Nightingale, Sam Denny and Yvonne Underhill-Sem. The result of this meeting was the formation of the Auckland Maternity Services Consumer Council in 1990.

Debbie Payne, the first convenor of the Maternity Services Consumer Council, said that the MSCC was Judi's brain child in that it was her idea to set it up as an umbrella group similar to the Federation of Women's Health Councils. Judi helped Debbie set up the first meeting of the MSCC Steering Group in 1991 and for the first year MSCC meetings took place in Debbie's home as Debbie was on a year's maternity leave at the time.

At the beginning of 1995 Judi resigned from both the AWHC and the Federation of Women's Health Councils.

She then went on to set up the Women's Health Information Unit at National Women's Hospital in Epsom where she became renowned for her commitment to ensuring women (and health professionals) had access to the latest evidence-based information on a wide range of women's health issues.

Judi was appointed Director of Advocacy at the office of the Health and Disability Commissioner in 2004, a position she held until November 2014. She was a tireless champion of health and disability consumer advocacy and of the Code of Rights in her role as Director. Judi also served as the HDC representative on the National Quality Improvement Committee, where she championed the consumer voice, alongside Jean Hera, the consumer representative from the Palmerston North Women's Health Collective. Jean said Judi was a great support to her in this role.

In 2005 Judi was made a Member of the New Zealand Order of Merit (MNZM) for her services to women's health.

Judi was a very private person, and always refused any attention or acknowledgement of her many achievements. She would definitely not have approved of this article. However, as others have observed "a great kauri has fallen" and those left behind want to celebrate the life and untimely death of this unique, determined and very humble woman.

Lynda Williams

NATIONAL MATERNITY MONITORING GROUP ANNUAL REPORT 2014

The National Maternity Monitoring Group (NMMG) was established in 2012 by the Ministry of Health. Its purpose is to oversee the maternity system in general and, more specifically, the implementation of the NZ National Maternity Standards. It has one consumer on it, eight "clinical sector experts" and Bronwen Pelvin, the Ministry of Health's Principal Advisor on Maternity.

In February 2015, the MSCC received a copy of the NMMG's Second Annual Report. The report outlines the group's work over the 2013/2014 year, discusses its findings and lists its recommendations. It also provides examples of good practice and some useful statistics.

The Recommendations
The recommendations outline the areas where the NMMG expects action from key maternity stakeholders to ensure improvements are made in the provision of maternity services in New Zealand.

- **Registration with an LMC** – the NMMG wants a continued focus on first trimester registration.

- **Variation in gestation at birth** – the NMMG wants rates of induction of labour and caesarean sections to be monitored carefully by DHBs and progress fed through to the group.

- **National consistency in provision of co-ordinated maternal mental health services** – each DHB must include a formal maternal mental health referral pathway in its next Maternity Quality and Safety Programme (MQSP) annual report.

- **Maternity ultrasounds** – professionals, the MOH and DHBs must make understanding and acting on the rising number of primary ultrasound scans a priority.

- **Connecting and supporting maternity consumer representatives** – support for consumer representatives is lacking and both the MOH and DHBs must address this by providing role clarification, financial reimbursement, access to their community, proper mechanisms to report into the MQSP, and opportunities to connect at the national level.

- **The NZ Maternity Clinical Indicators** – the MOH and the DHBs must address the lack of support for clinical maternity coders because it is hampering national consistency.

- **The MOH Annual Report on Maternity** – this report is valuable and must be presented annually.

- **DHB Maternity Quality and Safety Programme Annual** Reports – work to improve the quality of maternity services needs to be aligned with wider quality initiatives at the DHB level.

The report then details the NMMG's work under each of these recommendations under the headings: *Our focus*, *What we've done this year, What we found, In 2013 we recommended,* and *What has changed since then?* There is also a brief outline of the changes the NMMG expects to see next. At the end of each section a good example is featured.

Some of the findings

The NMMG were surprised at the high numbers of non-LMC first trimester claims that they found. In 2012 there were 49,015 non-LMC claims nationwide which equates to 79% of the total births in that year. There was little change in the statistics for LMC registration between 2011 and 2012.

The NMMG noted there was significant variation in both the rates of elective caesarean sections and the rates of induction of labour in DHBs in 2012 at 37, 38 and 39 weeks' gestation.

The NMMG found that current funding for primary mental health services is not ring-fenced. It is part of DHB baseline funding which is then transferred to PHOs. A recent increase in this funding is mostly targeted at youth mental health, low income groups, Maori and Pasifika groups.

In 2011/12 the average number of primary maternity scans claimed under the Section 88 Maternity Notice for women who had a live birth or stillbirth was 3.4. The most common number of scans received was three.

Consumers need to be involved in discussions and decision-making at every level of the maternity sector, but the NMMG found that a number of DHB MQSPs had either not engaged with, or utilised or supported consumer representatives over the previous year.

The NMMG found there is significant variation in the quality of maternity coding within, and between, DHBs. Some DHBs have only one person doing all the maternity coding (which helps with consistency), whilst others consider it a general item. At present there are no national training programmes available for maternity coders.

The next Ministry of Health Report on Maternity is due to be published in early 2015. It will be a full report for the 2012 period.

The NMMG found that much of the wider quality improvement work occurring in DHBs is guided by the Health Quality and Safety Commission (HQSC). DHBs are informed on Ministry expectations as part of DHBs annual planning processes, and these expectations are discussed in DHB quality accounts. These expectations do not specifically mention the MQSP or maternity. The NMMG was to see maternity aligned and incorporated as a distinct workstream within the DHB quality accounts.

The report ends with an update on previous NMMG work and the key areas of focus for the 2013/2014 year.

A copy of the 2014 NMMG's 50-page report for the 2012 year is available at: http://www.health.govt.nz/publication/national-maternity-monitoring-group-annual-report-2014

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 next six months of 2015 are**:**

7 April, 5 May, 2 June, 7 July, 4 August, and 1 September

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.

MATERNITY IN THE MEDIA

The year has not got off to a good start as far as positive maternity stories in the media are concerned. As recent events have shown, one maternity tragedy can be replayed over and over in newspaper headlines and articles over a period of years, especially when it involves midwives and primary birthing units, and the desire to find someone to blame for what may be an unavoidable tragedy.

At the beginning of March 2015 a Tauranga mother died giving birth to her third baby. Her death did not make the front page of the *NZ Herald* or the 6pm news on *TVOne* or *TV3*. She, too, died as a result of an amniotic fluid embolism. She died in hospital in the presence of medical specialists who were unable to save her. Her baby survived "with seconds to spare." (1)

The fact is that an amniotic fluid embolism (AFE) is a rare and usually fatal condition that occurs when amniotic fluid enters the mother's bloodstream. The first stage of AFE usually involves cardiac arrest and rapid respiratory failure. It is a leading cause of death during labour or shortly after the birth. It can be difficult to diagnose, and the underlying causes of AFE are still not fully understood. According to the 2014 report of the Perinatal and Maternal Mortality Review Committee (PMMRC), 10 of the 25 direct maternal deaths that occurred in New Zealand between 2006 – 2012 were due to AFE. (2) In several of its previous reports the PMMRC has referred to the link between induction of labour and AFE as a result of the number of inductions that were followed by the death of the mother from an AFE.

Unfortunately the media does not report the tragic death of a mother during childbirth as a result of an amniotic fluid embolism in the same way each time. If she dies in hospital surrounded by doctors her death is seemingly unremarkable and not out of the ordinary. It may be reported but does not make the front page nor does it result in an ongoing series of articles and a witch hunt to find someone to blame.

When the death occurs at a birthing unit in the presence of midwives the media spotlight is relentless, unforgiving and never-ending. It becomes a very one-sided and ongoing drama that serves to stoke the fires of ignorance, fear and intolerance. The whole story in all its complexity is never told. In such situations women are always the losers, whether they are the mothers who die or those who were caring for them. The concept of childbirth as a normal life process is sacrificed on the altar of a fantasy – the belief that giving birth in hospital in the presence of obstetricians is always safe, and that birthing mothers only die at home or in primary birthing units in the presence of "inexperienced" midwives.

References

1. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11412770
2. PMMRC "Eighth Annual Report of the Perinatal and Maternal Mortality Review Committee. June 2014.

Waitemata/Auckland DHB Maternity Services Collaboration Project workshop

Several MSCC members attended the Maternity Services Collaboration stakeholder workshop on Wednesday 21 January 2015.

Jay O'Brian, Waitemata DHB's "patient experience manager" was the facilitator for the workshop. Linda Harun, general manager of Child, Women and Family, began with a brief over of the collaboration project. Chris Mules from the Health Partners Consulting Group presented some graphs on birth projections and capacity requirements, and the expected increase in the caesarean section rates and the capacity requirements needed.

Emma Farmer, head of midwifery at Waitemata DHB, spoke about the issues – antenatal, labour and birth, postnatal – which she said were "informed" by the stakeholder feedback the DHBs had received so far.

A culture of fear of giving birth has been fuelled by one-sided media articles on instances in which there was a tragic outcome. LMC midwives have taken the brunt of the bad publicity which is resulting in women choosing obstetricians as their LMC, and undergoing a lot of unnecessary interventions. UK and Australian research shows giving birth in secondary obstetric maternity hospitals leads to increased intervention rates. Home birth is invisible in the DHB environment and women have difficulty accessing homebirth midwives. Homebirth is not adequately supported by the DHBs.

Women on the North Shore and in West Auckland do not have a real choice when it comes to primary birthing, as there are no accessible primary units in either region.

There was some discussion on the rising caesarean section rates and whether a 40% caesarean section is appropriate or acceptable. Unsurprisingly, most of the obstetricians present considered the projected rate of 38 – 40% to be reasonable based on current trends. And most of the consumer representatives did not.

Sue Fleming then outlined the "proposed enhancements" to antenatal, labour and birth, and postnatal care which would take the form of "a co-design approach." She also said:

- There would be a focus on increasing the availability and attractiveness of primary birthing facilities
- The closure of any secondary unit has been ruled out
- West Auckland would get a modern "fit for purpose" maternity unit
- There is a proposal to separate out the low risk planned caesarean sections either in a separate facility or a functional separation within an existing facility

The discussion that followed each presentation was lively and the issues that arose are not new. However, there was one option that nobody mentioned, although the MSCC had become aware prior to the workshop that it is being seriously considered. Maternity managers at the Auckland DHB are planning to set up a primary birthing unit on the Auckland City Hospital site. It wouldn't be the first time this idea has been floated. The MSCC wrote to Kay Hyman who at the time was Auckland DHB's women's health manager in 2007, opposing such a move. The MSCC pointed out that it is extremely unlikely that an on-site primary birthing unit would achieve anything in terms of protecting women from unnecessary intervention and lowering intervention rates. Stand-alone primary birthing units work best when they are well away from the interventionist culture of secondary and tertiary maternity hospitals.

In the afternoon attendees had to choose a maternity scenario from one of those pinned on a wall and then join the table discussing the chosen scenario. The table that two of the MSCC members chose to join was the nearest to a normal birthing scenario there was. However, we had considerable difficulty getting the options we came up with recorded. It felt very controlled and stifled by the facilitator.

After the report back, Linda Harun described the next steps in the collaboration project. Feedback will be further analysed over the next few months, and favoured options will be put in a public consultation document which would be released in May. There would be public consultations in June and the two DHB boards would discuss the outcome in October.

This project is going to be one the MSCC will be focussing on this year as it has been very dominated by the DHB and Health Partners Consulting. Given the token consumer consultation thus far we need to try and get some action on issues like the rising caesarean section rate. Not once during the presentations did anyone discuss the evidence for reducing the caesarean section rate. While Emma Farmer stated she would resign if the caesarean section rate rose to as much as 40% (some months North Shore Hospital's caesarean section rate is as high as 40%), the DHBs were firmly focused on the need to have enough operating theatres to cope with a projected caesarean section rate of 38% - 40% by 2025.

SCREENING, DIAGNOSIS AND MANAGEMENT OF GESTATIONAL DIABETES IN NZ

The Ministry of Health recently put its 2014 Clinical Practice Guideline on the *Screening, Diagnosis and Management of Gestational Diabetes in New Zealand* on its website. (1) The 267-page document has 16 appendices which provide the supporting evidence for the document's 11 chapters. This fact in itself is a good indicator of the complexity, the differing opinions, lack of strong evidence, the controversy, and the vested interests surrounding both diabetes and gestational diabetes.

This is acknowledged in the document – "There are national and international differences of opinion especially on diagnosis and screening of women for hyperglycaemia in pregnancy which includes gestational diabetes. In New Zealand, opinions differ on where it is best to treat women and what is the best way of following up both the women and their infants after delivery due to the increased risk of developing type 2 diabetes."

One of the many contentious issues is the use of the HbA1c blood test for diabetes during pregnancy. The haemoglobin A1c test (HbA1c) is a test that measures the average blood sugar levels over the previous 6 – 8 weeks. It is used to diagnose diabetes and pre-diabetes in the non-pregnant population.

The Guideline Development Team looked at the evidence for screening with HbA1c in the first 19 weeks of pregnancy – the sensitivity of HbA1c to detect pre-existing type 2 diabetes declines during pregnancy. They found there was no published randomised controlled trial evidence. The report states: "There is minimal evidence to determine if all pregnant women at less than 20 weeks' gestation should be offered an HbA1c to detect previously undiagnosed type 2 diabetes. Recommendations from guidelines and position statements for HbA1c testing of all women or women with risk factors prior to 20 weeks appear to have been mostly derived from consensus. No evidence was identified to link screening using HbA1c early in pregnancy with later maternal or fetal outcomes."

This is not evidence-based medicine, and books have been written on the dangers of producing practice guidelines and making screening and treatment decisions on recommendations which are not based on evidence and were developed using a process of reaching a consensus. The need for randomised controlled trials is absolutely essential in order to prevent the overdiagnosis and overtreatment of gestational diabetes.

The full report is available at:
http://www.health.govt.nz/publication/screening-diagnosis-and-management-gestational-diabetes-new-zealand-clinical-practice-guideline

CONFERENCES/WORKSHOPS 2015

Sarah Buckley April 2015 in Auckland

Dr Sarah Buckley presents her ground-breaking material on the hormonal physiology of childbearing, including new material from her report, *Hormonal Physiology of Childbearing.*

Learn about four important hormone systems active in labour and birth -- oxytocin, beta-endorphins, adrenaline/noradrenaline and prolactin-- and how they act to enhance ease, pleasure and safety for mother and baby.

Investigate the impact of interventions on these systems, and how induction, caesareans and epidurals can disrupt this delicate hormonal orchestration, and the possible side-effects for mothers and babies. Discover and discuss how to optimise hormonal physiology, even when interventions are required.

Enjoy the magic of the Hour After Birth, and discover how Mother Nature's superb design continues after birth, optimising life-long health and wellbeing for mother and baby by optimising breastfeeding and attachment. **To Register**- Undisturbing Birth

Michel Odent May 2015 in Auckland and Wellington

Michel Odent will present a one-day seminar ***"Childbirth and the Evolution of Homo Sapiens"*** in Wellington and Auckland. The program brochure is available here.

In this seminar, he will discuss the future of birth: the long-term impact of modes of birth both on an individual level and on humankind and its evolution.

The period surrounding birth has been dramatically altered in recent decades, and emerging scientific disciplines have shown that this short period is critical in the formation of human beings. Michel Odent, former obstetrician and revolutionary childbirth pioneer, believes that these are two good reasons to raise questions about the way babies are born, and the consequences this may have for the evolution of Homo sapiens.

Recent scientific advances have been so spectacular that Michel Odent has just released a new edition of ***Childbirth and the Future of Homo Sapiens*** (first published in 2013). **To Register** - Michel Odent Workshop