MATERNITY SERVICES CONSUMER COUNCIL

Issue 106 August 2017

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

In this newsletter

Welcome to the third newsletter of 2017, it's been a busy time at MSCC, we have a lot to share with you. Firstly our memorial of Lynda Williams who passed away on the 6th of July 2017 at her home in West Auckland surrounded by her children. An update on the Primary Birthing Unit for Waitemata District, followed by a petition submitted to the NZ Government by Australian midwife, Denise Hynd. Followed by our concerns at the lack of access holders meetings for midwives working out of the ADHB. A summary of the Annual Perinatal and Maternal Mortality Report for 2015, and finally a commentary on ALRANZ's July screening of *Trapped!.*

Lynda Williams 11 March 1950 - 6 June 2017

Lynda was appointed as the first coordinator of the Auckland Maternity Services Consumer Council in 1992 and continued to hold the position until her health demanded that she resign in March 2016. Lynda will remain synonymous with the organisation.

After the birth of her second child, Lynda and family moved to Canada where Lynda trained as a Lamaze method childbirth educator. Following her return to NZ, Lynda started teaching childbirth education classes from her home, encouraging women and their partners to be active participants in their labours and providing them with the skills she hoped would see them avoid unnecessary medical interventions. By the mid 1980s however, Lynda noticed that women were feeling disempowered within the hospital system and that the c-section rate amongst her clients was climbing. By this time Lynda had experienced a healing homebirth of her third son and was highly motivated to change the system and facilitate empowering births for women. Over the next 15 years Lynda attended the births of a number of the couples who attended her antenatal classes and had asked her to be a support person and advocate for them. Lynda instigated the formation of the Auckland Caesarean Support Group in 1984 and from this time onwards became an active member of a bunch of new maternity and women's health advocacy organisations such as Save the Midwives, Maternity Action, Obstetric Watch, the Direct Entry Midwifery Taskforce, Fertility Action, NZ College of Midwives and the Auckland Women's Health Council. At this time, Lynda started attending the Hospital Board meetings, something she continued to do until late 2016.

Her work with all these organisations made it obvious how the health system disempowered women and, when the Patient Advocacy positions were set up in the wake of the Cartwright Inquiry, Lynda was determined to become the first patient advocate at National Women's Hospital. She took up this position in 1989 but resigned in September 1991. She said that in this role she felt constantly undermined, sometimes in subtle ways and other times much more blatantly. She felt she could be a more effective advocate from outside the system.

However, this experience did not dim her enthusiasm for helping women to actively participate in their health care and the following year, she took on the coordinator's role of the newly established Auckland Maternity Services Consumer Council. She also worked first for Fertility Action and had another stint with this organisation when it became Women's Health Action. When Judi Strid resigned

as coordinator of the Auckland Women's Council to work in the office of the Health and Disability Commissioner, Lynda took over as coordinator of this organisation and remained in this position till the beginning of 2017.

During her time at MSCC, Lynda consistently offered a consumer viewpoint and lobbied for consumer rights on every change that was made in maternity and neonatal care. She helped ensure that hospital systems facilitated continuity of maternity care following the passing of the Nurses Amendment Act of 1990. She represented consumers nationally on numerous Ministry of Health working parties, committees of enquiry and statutory bodies. She also lobbied tirelessly for a new primary maternity unit in West Auckland. She strenuously opposed the upgrade of Waitakere Maternity Hospital to a level two unit saying that it would only result in mothers and babies being exposed to more medical interventions. When this "battle" was lost, she led an ongoing campaign with the MSCC for the establishment of primary birthing unit in West Auckland. Despite all the evidence supporting the need for primary birthing options for all mothers, this was one battle that Lynda was not able to win before she died. Lynda was a fluent and passionate speaker and an excellent writer. She made numerous submissions, wrote consumer information resources and regular informative newsletters as well as an avalanche of letters that provided a consumer viewpoint and that required health decision makers to acknowledge the needs and rights of the consumers they served and represented. She was also a prodigious minute-taker (as her articles below show). She had the ability to listen, participate and write every relevant thing down and also to remember it all, skills which made her a formidable advocate for women and a formidable opponent for anyone who tried to sidestep their obligations to health care consumers.

As well as her tireless work for women, Lynda was an active environmentalist and an involved and loving mother and grandmother. Lynda's passion and energy is sorely missed.

To celebrate her life we have included some of our favourite bits of Lynda's writing from our archives.

DRUG COMPANY FREEBIES *June 2008*

On a wild wet windy evening in late June that made crossing the Auckland harbour bridge no mean feat, an event took place in the Spencer on Byron hotel in Takapuna that made even the most hardened cynics amongst us turn ashen-faced. As the storm raged outside complete with thunder and lightning and a tornado or two waiting in the wings, inside it was all cosy and warm, with immaculately-clad waiters handing out free drinks and delectable nibbles as the guests drifted in and mingled with their colleagues. The guests were nearly all GPs who at the end of May had received a letter from the drug company Bayer, inviting them to a presentation by a senior paediatrician and a drug company representative, after which dinner would be served. The invitation was attractive enough to bring over 100 GPs out on such an inclement night. The topic of what the letter described as "a dinner presentation" was "Feeding Options for Women Not Fully Breast Feeding".

After half an hour or so of "arrival drinks and canapé" we were ushered into a room and seated at tables set for dinner. Paediatrician Peter Nobbs was introduced and began his presentation on the history and politics of breastfeeding. He began setting the scene for the message he was there to give by focusing on an aspect of the environment that some new mothers in New Zealand 100 years ago were subjected to. The Plunket Society was put under the spotlight as Peter Nobbs described their staunch support for breastfeeding, their object-ions to an advertisement for an early version of what was then known as "humanised milk mixture" that appeared in the Otago Witness in the first decade of last century, and the two-faced behaviour of Plunket Nurses who, according to a letter that appeared in the Otago Daily Times in 1915, were telling mothers to breastfeed while they themselves were bringing up their babies on Glaxo. We were told Plunket Society's founder, Sir Truby King's Melrose property in Wellington is listed as a category 1 Heritage Building, and that it was here that the earliest attempts to make "humanised milk mixture" or infant formula in New Zealand began.

Vegetable oil, cod liver oil and dextrose were added to cows milk and this humanised milk mixture was marketed by the Plunket Society under the name of Karilac along with "Plunket cream" known as Kariol. Following a bit more history Peter Nobbs showed a slide documenting the falling breastfeeding rates in the middle of last century – it was recorded as being 91.5% in 1939, 82.1% in 1945, and 74.4% in 1952. By now it was clear that the message we were being given was that not fully breastfeeding was normal and natural, that health authorities were often hypocritical about the advice they were required to give to new mothers about breastfeeding and what they actually said and did, and that the pro- breastfeeding stance was just a lot of politically-correct behaviour. Along with this were some subtle and not so subtle messages about the problems and risks of breastfeeding.

Turning his attention to the politics of breastfeeding Peter Nobbs went on to talk about the WHO Code on the International Marketing of Breast-Milk Substitutes, the advice given to new mothers in hospital, and the argument around whether complementary feeding with a bottle does have any effect on breastfeeding. He referred to the erroneous perceptions of groups like La Leche League and quoted from one of the group's 2007 newsletters in which the sentence "Formula companies' only aim is to make money" appeared. He assured the audience that formula companies in NZ do comply with the WHO Code and therefore see themselves as providing a complementary service.

NZ Breastfeeding Authority

The next organisation to come under attack was the NZ Breastfeeding Authority. He described their website, their current proposals around the Baby Friendly Hospital Initiative, and the accreditation of the hospitals in the Auckland region in critical terms. The NZBA website refers to the benefits of breastfeeding but not the risks, and risks of infant formulas but not the benefits. He cited as an example the fact that the website mentioned bacterial contamination of infant formulas. He was very critical of how ridiculous this was when the incidence is less than one in a million.

Bottles and pacifiers

The issues surrounding the use of pacifiers and bottles featured next with Peter Nobbs referring to some of the evidence about their supposed effects on breastfeeding. Studies on the use of pacifiers show no consistent results, he said. The effects of supplementary bottle-feeding had been studied in two studies from the USA and one from Switzerland. One showed an effect on breastfeeding and one did not. The duration of breastfeeding in both groups was the same.

No RCTs

The lack of randomised controlled trials was something Peter referred to several times during his presentation. Peter ended his presentation with a list of the five most common conditions that mothers and babies present with at the doctor's office. They included reflux, colic, poor weight gain, allergies, and diarrhoea. As he talked about each condition he showed a slide with the image of the appropriate Bayer Infant Formula (brand name is Novalac) product – Novalac Reflux, Novalac Colic, Novalac Hypoallergenic, Novalac Diarrhoea. There was even a Novalac Sweet Dreams! With the exception of Novalac Diarrhoea, all products are suitable for use from birth onwards and are described as a "nutritionally complete formula suitable for long-term everyday use." Given that each of these special formulas costs around $30 a tin (almost double that of ordinary infant formula), the statement that the aim of the drug company is to make money does not seem at all unreasonable.

Bayer Consumer Care

The presentation by Ayumi Uyeda, the young female drug company rep was unremarkable in that it was clearly her job to promote the wonders of the Novalac range of specialised infant formulas. She consistently described them as "premium products', and the higher cost was simply "a price differential." Ayumi Uyeda referred to the EDEN study of 3,500 babies, "an observational study of what happens in private practice" that was firstly an epidemiological study on presenting problems, and secondly the effects of Novalac on the problem. However, there was no mention of RCTs. Her slides showed the "scientifically developed" range of specialised infant formulas and how they differed from each other. The slick marketing of solutions to "problems" such as reflux, colic and constipation, the expansion of the diagnostic criteria used to identify such commonplace events as spilling or spitting up, periods of prolonged crying and distress, and constipation and diarrhoea, along with the supply of free drinks and good food, was both impressive and incredibly dishonest. Needless to say, I left after the presentations – before dinner was served – because I suddenly found I had completely lost my appetite. I went instead to the bar and bought a spiced tomato juice and sat mulling over what I had just witnessed with a health professional friend.

This article was originally published in the Auckland Women's Health Council Newsletter June 2008 and amended for the MSCC website

AUCKLAND DHB and WAITEMATA DHB COLLABORATION MATERNITY PLAN *May 2014*

At the end of November the MSCC received a copy of the "Auckland DHB and Waitemata DHB ***Collaboration Maternity Plan***: Working together to plan future maternity services to 2025" along with notification of a 2-hour meeting scheduled for 10am on 25 November 2015. It was not clear whether the document was the consultation document we had been promised in January, and had been waiting months for, or something prepared for the meeting. Given the document did not contain options for the community to consider or call for submissions by a due date, the MSCC decided it was a document prepared for the meeting. The document stated that the Collaboration Steering Group had identified five broad issues they wished to address:

- Inequalities in health outcomes
- Fragmented care
- Inconsistency in the models of care
- Quality and safety issues
- Facility issues

"In order to address these issues we have developed 22 strategies to build a high quality sustainable maternity service across our two DHBs, through changes to maternity facilities, and current care delivery models." The strategies were grouped into six themes:

- Achieve equity
- Enhance maternity quality and safety
- Enhance continuity of care
- Strengthen confidence in normal birth
- Support transition to parenthood and infant attachment
- Ensure facilities meet population needs, including capacity for future growth.

The document regurgitated a lot of "information" on issues that maternity community groups were discussing decades ago and referred to the stakeholder engagement in the plan development. Among the consumer organisations listed on page 43 is Playcentre, but there is no mention of Parents Centre, the oldest childbirth and parenting organisation in NZ. Those who turned up at the meeting found themselves having to choose one of the themes and go to the table assigned to that theme. This was a repeat of what occurred at the January meeting. It is a great way to control and direct the "consultation" process and limit the input of those who come to these meetings. Some of those who turned up had done so in order to discuss the issue of primary birthing units as outlined in Strategy 22 – "Increase the number of primary birthing beds across the region. Engage in broad public and stakeholder consultation to ensure the type and location of primary birthing unit that best meets the needs of the communities served by the DHBs," but it was made clear during the initial DHB presentations that this was not on the agenda for this meeting. Once the DHB talk fest was completed each table was charged with choosing the make-up of the multi-disciplinary working or stakeholder groups that the Collaboration Steering Group had decided upon. The meeting was told that each group must contain at least one of four "voices" – the voices of intent, design, experience, and expertise – that the DHBs decided were needed.

Then each person was given 5 purple dots to stick on one of two charts on the wall, and sticky notes with our comments written on them to stick on other sheets of paper also stuck to the wall. This "consultation" meeting was extremely frustrating and an utter waste of time for those who attended the meeting to discuss other issues about the future of maternity services in the two DHBs. It limited

input to only those topics that the DHBs were prepared to seek suggestions on and ensured that nobody got to discuss the issues of importance to them. When "consultation" meetings are organised in a way that is so tightly controlled and limits discussion to only those subjects that the DHBs are prepared to put on the agenda, then questions need to be asked about the integrity, transparency and accountability of the DHBs to the communities they purport to serve. The day after the meeting the MSCC received a follow-up email from the DHBs. The email stated that: "we would like to ensure that maternity and community stakeholders in the Auckland DHB and Waitemata DHB are included in the conversations around these strategies. We invite you to participate in this Collaboration Maternity Plan by:

- Providing feedback
- Expressing interest, if you wish to be involved in the working or stakeholder groups,
- Providing a view on relative priority for the pieces of work that we have outlined, as not all of the work will be possible to progress immediately."

So there is little hope of there being any change in this incredibly controlled "consultation" process in the foreseeable future.

This article was originally published in MSCC's December 2015 Newsletter. Yes, it is talking about the same primary birthing unit.

ADHB acknowledges Lynda

Holly Neilson and Sue Claridge (coordinator for Auckland Women's Health council) attended the ADHB Board meeting on the 9th of August. It was great to see that not only did they acknowledge Lynda in the printed papers (see text below) but specifically acknowledged her and her contribution very near the beginning of the meeting.

4.1 Acknowledging Lynda Williams

New Zealand's health sector lost a champion of the patient experience with the recent passing of Lynda Williams, MNZM. Mother of five and grandmother of six, she will be greatly missed.

Lynda dedicated more than 35 years to health activism. An early highlight was her appointment as patient advocate at National Women's Hospital in 1989. After two and a half years, Lynda returned to work at Women's Health Action and in 1994 she took up the position of co-ordinator of the Auckland Women's Health Council. She also worked for the Maternity Services Consumer Council from 1992 and as a member of the Postnatal Distress Support Network board from 2004. From 2008-2010 Lynda was an elected member of Auckland DHB, serving as a member of the Community and Public Health Committee. Lynda received her 2017 Order of Merit for services to women's health.

We offer our heartfelt sympathies to Lynda's family while giving thanks for a singular contribution and a lasting legacy.

Lynda's death and her work over the years was officially and formally noted by the DHB and it was our impression that those who spoke (albeit briefly) remembered her fondly. Lester Levy (Chairman) and one or two other people made note of her contribution and her long-term commitment to attending DHB meetings and said that the DHB would be sending their condolences to her family. They also acknowledged both Holly and Sue as following in Lynda's footsteps.

Primary Birthing Unit update, well, sort of!

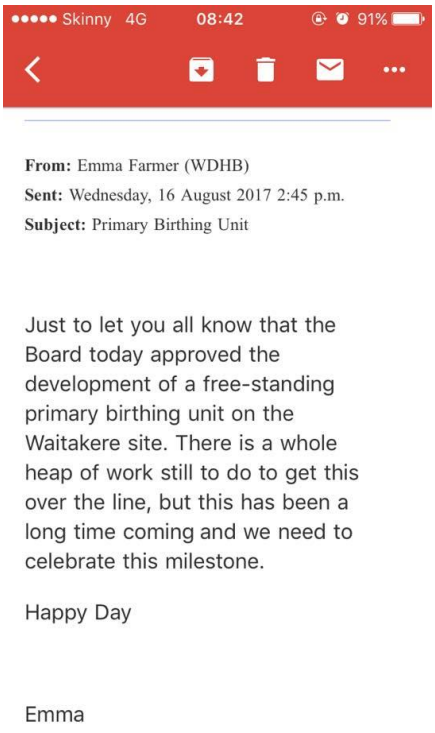
On August 21st we posted the following on our Facebook page:

MSCC attended the WDHB Board meeting on the 16th of August 2017 having previously been advised that the Primary Birthing Unit business plan was due to be presented. MSCC had let other interested parties know, so on the day, a dozen women and two children were waiting with bated breath to hear the plan presented. After exceptionally short board meeting, the public session closed and we shuffled out, disappointed. No plan. No explanation. Nothing.

Dr Dale Bramley, CEO of WDHB came out to tell us that the business plan would be addressed in the confidential part of the meeting. He was soon followed by Dr Lester Levy, Chair of the WDHB, ADHB and CMDHB, who told us rather ominously " We know what you like, or what you would like." This comment left us all in doubt that we would hear a positive response to the business plan. Currently, I can only confirm that the business plan was presented in the confidential meeting and that the outcome was still confidential. A memo will be sent out to MSCC shortly. MSCC will keep you posted.

Imagine our surprise then, when a comment was shared by a follower on our Facebook page, that she (and other access holding LMCs) had received an email from a senior maternity staff member, announcing that development of a primary birth unit on the Waitakere Hospital site had been given the go-ahead! We immediately sent a letter of inquiry to Dr. Dale Bramley CEO WDHB, asking about the validity of this. Within two hours we received a reply! Dr Dale Bramley advised, there was no official word, the email in question should never been sent and that he would let us know the outcome when he could.

This post originally appeared on MSCC's facebook page



Why is a retired Australian midwife petitioning NZ parliament?

By Denise Hynd:

When in Australia, I like many midwives believed that continuity of care by a known midwife would redress the escalating rates of childbirth intervention occurring there, and elsewhere. Meanwhile here in Aotearoa, the majority of women have for several decades, been able to contract with a midwife Lead Maternity Carer (LMC)[i] to co-ordinate all their government-funded maternity care. Yet in 2014[ii], the NZ rates of intervention continued to rise as they have in previous years, for example 25.9% of all births ended in a caesarean section up from 23.3% in 2003. Though healthy NZ women can labour and birth with their midwife in either a primary (birth) unit, at home or in hospital, 87% chose a hospital that year. Less than 10% of women birthed in a Primary Birth unit and the NZ homebirth rate remained around 3%, where it has been for the last decade.

Overall, only one-third of women had a normal birth, defined as "*a spontaneous vaginal birth without an induction, augmentation, epidural or episiotomy*". As in Australia, women in more affluent locations had fewer 'normal' births than their more deprived kiwi sisters.

All NZ health consumers have a legislated right to informed consent. However as elsewhere, the media is often sensationalist and biased[iii] in reporting maternity issues, whilst hospital dramas dominate national television. This is one reason why many healthy women leave home, sometimes by-passing birth centres to deliver in hospitals, believing this is their 'safest' option, unaware of international and NZ research that shows otherwise. Thus some under-utilised community-based primary units have been closed or are under threat of closure, sometimes despite public campaigns to keep them open, or to gain others. One hospital based and a privately operated alternative has opened over the same period.

Meanwhile, most doctors and other health professionals including administrators and many midwives, have only known managed and often fraught hospital deliveries and so, like most of the population have no confidence in, and possibly, concerns about, out of hospital, natural birth. Studies have found that birth trauma, as well as fear of birth are both a consequence of and contributor to a medicalised birth culture, which need to be addressed by policies and campaigns. The New Zealand College of Midwives (NZCOM) has recently made some headway in their efforts to increase the national value[iv] and recognition of midwifery issues[v] .

The basic information and actions presented in my petition[vi] were part of the 2012 Maternity Manifesto[vii] which gained the endorsement of national organisations including NZCOM, HomeBirth Aotearoa, Maternity Services Consumers Council (MSCC) and others. "*More support for evidence-based birth options and information*" from the NZ Ministry of Health is the aim of the five strategies sought, whilst background information and evidence is also provided in the petition.

As, UK Professor Soo Downe has said;

"Most women, in every country across the world, would prefer to give birth as physiologically as possible. For most women and babies, this is also the safest way to give birth, and to be born, wherever the birth setting. If routine interventions are eliminated for healthy women and babies, resources will be freed up for the extra staff, treatments and interventions that are needed when a labouring woman and her baby actually need help. This will ensure optimal outcomes for all women and babies, and sustainable maternity care provision overall".

Please sign and share this petition with your family and colleagues. It will go to members of parliament after the forthcoming election, meanwhile it is to be found at:

https://www.change.org/p/ministry-of-health-more-support-for-evidence-based-birth-choices-and-information-in-new-zealand .

Thank you, Denise Hynd

---

[i] https://www.midwife.org.nz/women-in-new-zealand/about-lead-maternity-carer-lmc-services
[ii] http://www.health.govt.nz/publication/report-maternity-2014
[iii] http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=11826932
[iv] http://www.stuff.co.nz/national/health/93079280/midwives-settle-pay-equity-fight-and-get-8-million-pay-rise
[v] http://www.radionz.co.nz/national/programmes/ninetonoon/audio/201837520/midwife-shortage-'heading-for-crisis-level'
[vi] https://www.change.org/p/ministry-of-health-more-support-for-evidence-based-birth-choices-and-information-in-new-zealand
[vii] http://www.maternitymanifesto.org.nz/the-maternity-manifesto-better-beginnings/

Perinatal and Maternal Mortality in 2015

He matenga ohorere, he wairua uiui, wairua mutunga-kore.

The grief of a sudden, untimely death will never be forgotten.

The Perinatal and Maternal Mortality review committee (PMMRC) recently released its report on Perinatal and Maternal Mortality in NZ for the year 2015. This is the eleventh report by the committee and shows comparative data from the years 2006-2015. The PMMRC investigates and reports on:-

- deaths of babies born from 20 weeks gestation through to 28 days after their births
- deaths of women who die at any stage of pregnancy or within six weeks of giving birth

Warning some of the content in this report may be disturbing to read

Maternal Mortality in 2015.

In 2015 there were 11 maternal deaths reported. There were three direct maternal deaths, and eight indirect maternal deaths. A direct maternal death is as a result of obstetric complications, e.g. infection, eclampsia thrombo-embolism, during pregnancy, birth and up to 42 days postpartum. An indirect maternal death is the result of a pre-existing disease or a disease that developed during pregnancy that was not due to obstetric causes, but was aggravated by the physiologic effects of pregnancy. The causes of the three direct maternal deaths were due to amniotic fluid embolism and venous thromboembolism. Of the eight indirect maternal deaths, five were suicides, one neurological causes and two were due to a pre-existing medical condition.

A Decade of Data

From 2006 to 2015 the PMMRC has reported 105 deaths; 35 direct maternal deaths, 64 indirect maternal deaths, and 6 unclassifiable deaths.

The three leading causes of maternal mortality were suicide (27), amniotic fluid embolism (13) and pre-existing medical conditions (29).

- 41 deaths occurred antepartum and 64 postpartum.
- 65 deaths occurred in a hospital, 40 within the community.
- 65 included births and 40 were undelivered.
- 10 perimortem caesarean sections occurred resulting in seven babies born alive (of which one died as an early neonate) and three stillborn.

Potentially Avoidable Deaths

39% of these maternal deaths were labelled as potentially avoidable and 62% were found to have contributory factors

- 42 due to poor organisational/management factors e.g. lack of access to suitably skilled care providers, inadequate staff numbers, delay in response/procedure.
- 42 due to personnel factors e.g. lack of care provider skill or knowledge.
- 44 due to barriers to access and/or engagement with care.
  The barriers to access to care included, 11 deaths due to substance abuse, 13 due to maternal mental health problems and 18 due to lack of recognition of the complexity or seriousness by the woman/or family. Family violence was responsible for 9 deaths.

Maaori Perinatal and Maternal death

A specific chapter has been added to the 2015 report to focus on Maaori maternal and perinatal mortality. Maaori mothers have an almost double maternal mortality rate when compared to NZ European mothers when the data from 2006 – 2015 is combined.

Maori have a higher rate of maternal suicides and neonatal deaths of babies born <28 weeks gestation (but not maternal deaths unless the data is aggregated from 2006). After excluding babies dying as a result of congenital defects, babies of Maaori mothers are significantly more likely to die as neonates at all gestational ages, except between 28 to 31 weeks of pregnancy.

Maaori Maternal Death by Suicide.

Between 2006 and 2015 there was a total of 27 perinatal maternal suicides, 15 of these women were Maaori, 7 of whom, were under 25 years of age.
Eight suicides occurred during the pregnancy, (six during the first 20 weeks of pregnancy).
Four followed a termination and three followed a miscarriage or a live birth.
Eight women died within six weeks of a live birth or termination of pregnancy.
Associated factors in the period between onset of pregnancy and death by suicide:

- Relationship issues with partner/ex partner
- Family violence
- Financial concerns
- Housing difficulties
- Transport difficulties
- Limited phone availability
- Drug and Alcohol issues
- Fetal abnormality
- Past history of mental health issues.

The report emphasised**:** ***Most of the women who died from suicide experienced multiple risk factors. Early recognition of these risk factors, particularly where there are multiple factors, will assist health services and professionals to provide better services for these women.***

Perinatal Mortality

The perinatal mortality rate includes late terminations of pregnancy (>20weeks gestation), stillbirths and neonatal deaths from 20 weeks gestation through to 28 days after births. There has been a significant reduction in stillbirths, fetal deaths and the lowest perinatal related mortality rate (9.7/1000 births) since 2007. Congenital abnormality was the leading cause of perinatal mortality accounting for 27.3% of babies who died or 2.64/1000 births.

There was a significant reduction in stillbirths at 37–40 weeks. However, the rate of stillbirth at 41 weeks was higher than in any year from 2007 to 2014. “Review of the 17 stillbirths from 41 weeks without congenital abnormality, against the Auckland Consensus Guideline on Induction of Labour (Wise et al 2014) and against best practice for antenatal assessment in women with risk factors, found the care provided did not follow the guideline and/or best practice in six of the 17 stillbirths.”

The report states that 25% of perinatal related deaths had contributory factors and 14% potentially avoidable.

PMMRC reports from 2011 – 2015, show a significantly higher perinatal mortality rate for babies whose mothers were Pasifika or Indian compared with those mothers of all other ethnicities in NZ. Babies born to Pasifika, Indian and Maaori mothers have the highest stillbirth and neonatal mortality rates. Unsurprisingly, there is an association between increased socioeconomic deprivation and perinatal mortality. For both Maaori and NZ European mothers the rate of spontaneous pre- term birth increases with deprivation.

Multiples (twins etc) has 4.5 times the risk of perinatal mortality compared with singleton babies.

Seven neonatal deaths in 2015 were attributed to SUDI. Six of these babies had mothers who were smokers and were associated with unsafe sleeping arrangements. Two babies were small for gestational age (SGA).

Recommendations

• The Mortality Review Committees' Maaori Caucus reiterate*, **"As a matter of urgency, the Ministry of Health update the National Maternity Collection (MAT), including the ethnicity data as identified by the parents in the birth registration process."*** (PMMRC 2015; p16).

• The PMMRC investigate why there has been no reduction in neonatal mortality in NZ.

• The PMMRC supports the development of a national interdisciplinary clinical practice guideline on the indications and timing for induction of labour, to guide clinicians to offer induction when appropriate (that is, where evidence shows that benefit to mother and/or baby outweighs risk) and to avoid induction when not appropriate.

• That DHBs with rates of perinatal related mortality and neonatal encephalopathy significantly higher than the national rate review, or continue to review, the higher rate of mortality or morbidity in their area and identify areas for improvement.

• The PMMRC recommend the HQSC (Health Quality Safety Commission) establish a permanent Suicide Mortality Review Committee.

The Mortality Review Committees' Maaori Caucus made extensive recommendations to help reduce Maaori Maternal Suicides including:-

• Improved awareness and responsiveness to the increased risk for Maaori women.

• Primary care (GPs, FPA), LMCs, termination of pregnancy services (TOP), alcohol and drug services, and secondary and tertiary providers of maternity, obstetric, mental health, and maternal mental health services should improve their systems, guidelines and professional development to ensure that they are responsive to the identified increased risk for Maaori women.

• Comprehensive assessment of risk factors for Maaori women should be undertaken at diagnosis of pregnancy and/or on first presentation for antenatal care. This should be undertaken for all Maaori women, regardless of age, including those who are seeking termination of pregnancy.

•Communication and coordination between primary care (GPs, FPA), LMCs, TOP services, alcohol and drug services, and secondary providers of maternity, obstetric, mental health, and maternal mental health services should be improved and enhanced.

• Child and Youth Mortality Review Committee (CYMRC) consider including information about whether female suicide cases were pregnant in the 12 months prior to their deaths in addition to the pregnancy status information currently collected.

• Where Maaori women exhibit symptoms suggesting serious mental illness or distress, an urgent mental health assessment, including consultant psychiatrist review and consultation with perinatal mental health services, on the same day these symptoms are first noted should be undertaken.

For full report:
https://www.hqsc.govt.nz/assets/PMMRC/Publications/2017_PMMRC_Eleventh_Annual_Report.pdf

Trapped Screening

On Wednesday the 5th of July, I attended a screening of "Trapped!" a documentary by Dawn Porter, which was hosted by ALRANZ (Abortion Law Reform Association of New Zealand) at the Auckland University. I went in with the impression that it would be a documentary about abortion rights here in NZ. However it was about the increasingly hostile legislation being passed state by state in America, thereby greatly restricting the ability of a consumer to access an abortion.

I was initially concerned about how relevant this would be to NZ but realised that the situation in the US and NZ is in fact comparable. Certainly at the time of filming (filmed in 2015) our laws were very much the same.

After the showing of the documentary, a panel discussion was held with ALRANZ current president Terry Bellamark and executive member Ellie Stewart. Terry outlined what happened in the USA since the making of the documentary and what new challenges are facing women and abortion providers in the US. She stated that these challenges are relevant to NZ and that our 40-year-old laws are unfit for purpose. The panellists then discussed the ways in which, in ALRANZ's view, pregnant women are being discriminated against in NZ, due to the onerous process imposed on those seeking an abortion.

Many attendees, including myself, were already aware that abortion is in the Crimes Act, and that two certifying consultants are required to approve abortions. Some were surprised to learn that a medical professional has the ability to declare "conscientious objection" with regard to both abortion and contraception. It is shocking to know that up to 200 women each year are denied an abortion in NZ.

Members of the audience wanted to know what action can best be taken to bring about a change to the law. The panel suggested finding out which political parties have progressive policies, lobbying MPs and challenging politicians like Prime Minister Bill English on their anti-choice or apathetic views. Keeping the issue in the public discourse was vital to bringing about change.

So how accessible is abortion in NZ for the average consumer?

The Contraception, Sterilisation, and Abortion Act 1977 sets out the parameters for access to abortion services in NZ. It established the Abortion Supervisory Committee which maintains a list of certifying consultants and doctors who are capable of approving abortions (or not). It is difficult to avoid the conclusion that abortion regulations are more about controlling women's fertility than about providing safe abortions. The 2016 Report of the Royal Commission on Contraception, Sterilisation, and Abortion calls for a review of the legislation enacted by 1970s politicians, predominantly men, who created a system that reduces the number of women dying of sepsis in unsafe, illegal abortions but potentially forces most women to give birth whether they like it or not.

The Commission reports that a legally acceptable reason for termination of pregnancy was the woman being assessed as "severely sub-normal" whereas being the victim of rape was not. Rape was not considered a good reason because the Commission feared/fears women wanting an abortion would lie saying they were raped in order to obtain one. The legislation supports the abortion of fetuses diagnosed with congenital abnormalities and the wording presumes that aborting an "imperfect" baby is desirable, potentially adding to the difficulties experienced by some women who choose to continue their pregnancies following such a diagnosis.

The majority of terminations are agreed to on the basis of *Danger to Mental Health.* In 2015, 12,810 women were forced to say that continuing the pregnancy would endanger their mental health, when in fact, they may just have being looking at their lives and thinking, *I cannot possibly bring a child/another child into this*.

Despite the fact that 177 consumers were denied an abortion in 2015, some NZers believe that the way the law is being applied, amounts to abortion on request.

Women in many parts of NZ have difficulty getting access to a termination services and in many places are not able to choose between a medical or surgical termination. A medical abortion involves taking two pills of mifegyne**.** Women under seven weeks pregnant can take both pills at once, however women between seven and nine weeks pregnant need to take them on two separate days. A surgical abortion, is an outpatient surgical procedure and is the method preferred by women. This option is far more invasive than a medical abortion and it is concerning that consumer's feel that a day stay and a surgical abortion is the easier route.
The requirement that women must get the approval of two certified consultants increases the time between their decisions to end their pregnancies and their ability to legally book the procedure. This delay often means it is too late to access a medical termination of pregnancy.
Consumers, within the SDHB can only access abortion services in Invercargill and Dunedin. Women from outside these cities have to arrange travel, accommodation and time off work and, of course are burden with cost. Furthermore, Invercargill only offers a medical abortion up to nine weeks, after which time women are referred to Dunedin which can perform surgical abortions up to 14 weeks.
As there are no termination services on the West Coast at all, women are referred to Christchurch Hospital or sometimes Nelson. Women from Wanganui need to make a trip to Wellington to access a surgical abortion, (Wellington has no medical abortion option) Rotorua and Taupo women are referred to Waikato Hospital. Auckland women have access to the ADHB's Epsom Day Unit or an independent not for profit service for medical termination at the Auckland Medical Aid Centre in Mt Eden. In the Far North consumers have the option of a surgical abortion at Whangarei Hospital or travelling to Auckland, For more details see abortion.org.nz

Where do our politicians stand?

The National Party thinks the law should remain as it currently stands. Labour, New Zealand First and Act supports a review of the law, as does New Zealand First. The Green Party also supports a review of the law, wanting to decriminalize abortion, meaning that the revised laws would sit under Health legislation.

All in all, it was a very informative evening, it was wonderful to meet such dedicated women as Terry and Ellie.

Holly Neilson

Access Holders Meeting

During the AGM for the Auckland Regional NZCOM, the LMC representative for ADHB presented her report on the current state of the midwifery LMC workforce at ADHB. During the reporting the representative shared that the ADHB had held only had one Access Holder meeting in 2017. These meetings provide a way for LMC midwives to communicate with the hospital about issues that may be concerning to them and provide their feedback to changes occurring within the hospital. Without these meetings, their only communication with the Hospital is a weekly email called *Friday Catch Up*. Concerns were shared that LMC's voices are going unheard without regular Access Holder meetings. At the same AGM we heard that CMDHB holds these meetings monthly, and WDHB also hold them regularly.

LMC's at the ADHB are working under the added burden of extreme midwifery staffing shortages, which are continuing to force LMCs to work outside the scope of their Access Agreement and to continue to provide midwifery care at times when they should have been able to hand over to the secondary service. There has been no negotiation with LMCs about their willingness to do this and no talk of compensating for them for propping up the hospital service, as well as no recognition that these midwives may be working prolonged hours, putting themselves and potentially, mothers and babies at risk.

ADHB must offer more Access Holders meeting so midwives have a platform to voice their concerns and to negotiate safe boundaries for the care they provide when in the hospital.

A general midwifery shortage in NZ means that midwives all over the country are working under similar conditions and we have to wonder if this midwifery shortage is one of the causes of the rising intervention rates.

You are hereby invited to attend the:

Annual General Meeting for MSCC

When: Tuesday the 3rd of October at 9.45am

Where: at Earthsong's common house, 457 Swanson Road

There is NO parking on site, so please park on the road.

Further meeting dates for the year:

- November 7th, steering meeting at Birthcare Auckland
- December 5th, end of year lunch, venue to be advised

For further information us on 027 417 3528 or mscc@maternity.org.nz

Events coming up:

2017 Home Birth Conference & Hui

October 7 @ 9:00 AM - October 8 @ 5:00 PM
Jetpark Hotel & Conference Centre

8th Biennial Joan Donley Midwifery Research Forum

JOAN DONLEY
MIDWIFERY RESEARCH COLLABORATION

"Supporting and strengthening midwifery practice through research"
To be held at The Piano – Centre for Music and the Arts, Christchurch on the 19 & 20 October 2017