Issue 107 November 2017

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

In this newsletter

Welcome to our final newsletter of 2017, it's been business as usual here at MSCC, so as always we have a lot to share with you. First up we have a piece on Helensville Birth Centre and their 100% breastfeeding rate, then a comparison of women and newborn health reports from two DHBs, then a review of some of the studies presented at the 8th Joan Donley Midwifery Research Forum followed by a quick review of the recent Homebirth Aotearoa conference and hui. So grab your drink of choice, settle in and enjoy!

Helensville Birthing Unit one of the best in the country for breastfeeding rates.

100% of the babies born at this West Auckland birth centre are exclusively breastfed on discharge, meaning the unit has now received its fourth consecutive accreditation under the Baby Friendly Hospital Initiative, the programme designed to promote breastfeeding worldwide, having become originally accredited in 2008.

Helensville Birthing Centre (HBC) is a four bedroom unit in, funnily enough, Helensville, West Auckland. Overseen by Helensville District Health Trust, this centre strives to give babies the best start in life. With breastfeeding rates at a national average of 83%, HBC is exceeding expectations. I would prefer this to read, is well ahead of the national average, or something like that. BFHI would like to see all babies breastfed, ultimately that is the expectation, so they are not exceeding expectation they are exceeding BFHI accreditation rules. When asked about why they think the unit is doing so well HBC shared with us that it comes down to support. Support for staff means that HBC has a low staff turnover. They support their staff with ongoing breastfeeding training and have three lactation consultants on staff. HBC is run by a very supportive trust who continually invest into education for both mothers and staff, to help achieve the best health outcomes they can.

The Trust helps funds ongoing support for women after they've been discharged from HBC, including a free clinic with a lactation consultant for women in the region, referral to a local GP provides a free frenotomy (tongue tie etc release) service and a coffee group every second week at the centre, which peer counsellors (supported by La Leche League) attend.

To help celebrate this achievement, we have included a story written by a mother who experienced Helensville Birthing Centre first hand, Christina feels the staff at Helensville made all the difference to those early days of her breastfeeding journey.

Breastfeeding Journey by Christina Hira

I feel that while there are quite a few birth stories being written, there are not enough breastfeeding stories. And honestly, breastfeeding can be really difficult sometimes. It is just as foreign as giving birth and often we don't have a lot of preparation for it. So here is our journey.

After Kaylee was born I stayed in the pool with her for quite a while. At some point during that time she managed to find my nipple and latch on herself. I was really quite chuffed and thought awesome, she knows what she is doing. After I got out of the pool and got cleaned up, (Kaylee had some skin-to-skin with dad), Kaylee was placed back on me for a feed. We placed her in the middle of my chest and watched as slowly she found her own way to my nipple. This breast crawl is just amazing to watch. Slowly lifting and moving herself closer with loads of breaks in between. The breast crawl takes usually at least an hour. In the end though, Kaylee couldn't quite figure out how to latch on, so we helped her and she had her first feed.

We then moved to the room we would be staying in at the birthing centre. We had a lactation consultant come in later that afternoon and check how Kaylee was going with the feeding. I remember her saying things like, “oh see now, you can see Kaylee has a good latch” and “can you hear that?. That noise is her swallowing, so you know she is getting something”. As lovely as she was, after having no sleep in the last few days of pregnancy and then experiencing the most exhausting thing I have ever done, I just didn’t get it. I nodded and said, “yup, I see that” and “yes, I can hear her swallowing”, when honestly, I had no clue. It was all a bit overwhelming.

The staff at the Helensville Birthing Centre were amazing though. They kept just giving me loads of encouragement and support. The next couple of days passed with me spending 90% of my time skin-to-skin feeding with Kaylee.

Then we found out that Kaylee had a tongue tie. This meant that her tongue could not come out far enough to breastfeed correctly and was basically rubbing up against my nipple kind of like sandpaper whenever she was feeding. I felt so relieved. My nipples were sore from breastfeeding, but I thought this was normal. Part of the adjustment period. It was such a relief to find out that something was actually wrong and the pain I was feeling wasn’t normal.

We had the lactation consultant come in and do an assessment. She had a whole list of reflexes to check to see how efficient Kaylee was at getting food out. Turns out the tongue tie was reducing her ability to get food by about 50%. We were able to make a booking at a doctor’s for the next morning to get it sorted but that meant we had a night of expressing ahead of us. I would express the milk and then feed it to Kaylee via a syringe with a small tube attached that I would put in her mouth with my finger so she was still encouraged to suck a bit.

That night was so hard. They brought in an electric pump and showed me how to use it. The nurse looking after us then went away and came back after I had expressed some. I was on the verge of tears at the look of how little I had managed to get out, but the nurse was so unbelievably encouraging, telling me that it was a great amount to pump and how I was doing a great job. I needed that. So for the rest of that night my husband and I were up every hour with me trying to pump as much as possible to keep up with the appetite of my hungry little girl. The staff kept coming in throughout the night to check on me. In the morning I felt exhausted but really glad we were going straight to the doctors to get the tongue tie fixed.

Then began the process of having my nipples recover while continuing breastfeeding. I applied loads of lanolin and just pushed through knowing it would all improve soon. It was difficult, but it felt like things were improving, but a week later I developed mastitis, (a breast infection that often starts from a blocked milk duct and bacteria getting in through damaged nipples). I had a fever and was prescribed antibiotics. This meant once again having to pump milk - the only way to clear the blocked duct is to drain the breast of milk. I struggled a lot over the next few days, having to express milk as well as feeding Kaylee. This left hardly any time for sleeping, let alone anything else! Especially because early on newborns will feed approximately 8-12 times in a 24hr period and often

feeding will take 40mins to an hour! Add to this pumping milk, trying to remember to put cold cloths on my breast to cool it down, taking the antibiotics regularly, as well as eating! The antibiotics had gotten rid of my fever but I wasn't really noticing much improvement in anything else. It then got to the point a couple of days later where the midwife said, that if it didn't improve by tomorrow I would have to go to the hospital to get IV antibiotics. However, the next day things started to slowly improve, the redness decreased and the blocked duct started to clear. Slowly but surely things started to get better. It wasn't until about week 4-5 that I felt like, "ok, I think I have this breastfeeding thing down". It was a tough few weeks, but we got there. I am so unbelievably grateful for our wonderful friends and family who brought us meals and always checked before they came over whether we needed anything, often picking up groceries or nappies too!

Comment from Adith Stoneman, I.B.C.L.C.

Many mothers are misguided in the belief that breastfeeding hurts and often persevere with breastfeeding whilst enduring terrible pain. The issue that causes the pain needs to be addressed as it potentially leads to a cascade of issues which all too often results in the mother giving up breastfeeding (understandably), because it has become, "all too hard".

In the early days and weeks it is normal for women to experience a strong sensation, (which may be described as pain), when the baby first latches and shapes the breast into its mouth. This strong sensation should not last more than 30 or so seconds. If after that time, there still is pain we need to determine what the issue is, starting with the most obvious, the latch.

The baby gains energy from breastmilk for growth and development. Whilst feeding, a baby uses up valuable energy and it is important that the balance of energy tips very much in favour of an energy gain at the end of each feed. A baby that has challenges with breastfeeding may not have the right energy balance leading to a whole array of issues for baby, the most obvious being "failure to thrive".

It is important that mothers take the lead from their babies. It is not at all abnormal (although it is hard work) for a baby to feed many more times than the generally believed guideline of 8 to 12 times a day. In the early days and weeks baby may well come to the breast 18 plus times in a 24 hour period. Baby may not always have a "good" feed, that is okay, just suckling is important for stimulating milk production. In the early weeks of breastfeeding mothers lay down the foundation for their long-term milk supply so engorgement and restricted feeding times can have negative effect on their milk supply in the long-term.

When mothers have nipple trauma a great remedy is their own breastmilk which is full of antibacterial components. Lanolin should always be used sparingly as it makes the breast slippery, making it hard for the baby to latch onto the breast.

Christina's story is not unusual. It takes most new mothers up to 6 weeks before they feel totally "comfortable" with breastfeeding. For some mother and baby teams the journey may be smoother but each and every mother baby team needs time to adjust from internal care (pregnancy) to external care (breastfeeding).

What mothers need to successfully breastfeed their babies is:

Encouragement, Support, and Correct Information.

We are delighted to read that Christina received plenty of support and encouragement from her community.

A comparison: Two DHBS, two Annual Reports, one year, 2016.

In August, Auckland District Health presented the "National Women's Annual Clinical Report (for women and newborn health)" and in September Counties Manukau Health published and presented their "Women's Health and Newborn Annual Report 2016 – 2017. The reports are presented very differently with National Women's Health providing a quantitive statistical report with brief comments and Counties Manukau using a framework of maternity quality and safety referencing the recommendations of the National Maternity Monitoring Group and the report of the Perinatal and Maternal Mortality Review Committee. These differences in presentation make a comparison difficult but some of the similarities and differences raise interesting questions.

Is a comparison fair?

The two DHBs share a geographical boundary and each provided maternity care for over 7,000 birthing women in 2016. The majority of births in both DHBs occurred in the tertiary level hospital. However, Counties Manukau DHB (CMDHB) owns and operates three primary level birthing units while Auckland DHB (ADHB) subcontracts to the privately owned Birthcare for a small number of births and most of their primary level inpatient postnatal care.

Number of women birthing in 2016.			
Auckland Hospital	7241	Middlemore Hospital	6997
Birthcare	314	Botany Downs BU	328
		Papakura BU	268
		Pukekohe BU	283
TOTAL	**7555**		**7276**

The intervention rates in both DHBs are increasing while the numbers of women birthing in a primary birthing unit decreases. The numbers of women giving birth in the tertiary hospitals in both DHBs who have an unassisted vaginal birth is decreasing year by year.

	ADHB					**CMDHB**				
	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016
Total induction of labour	32.3%	33.8%	31.3%	33.0%	33.5%	20.7%	22.0%	22.5%	25.3%	24.8%
Total forceps/ventouse	11.8%	11.5%	11.5%	12.6%	12.8%	6.3%	6.2%	6.9%	6.8%	7.0%
Total caesarean section	33.4%	34.7%	34.6%	35.6%	36.0%	21.1%	22.9%	23.2%	22.8%	24.4%
…And when intervention rates rise the number of vaginal births decreases										
Total vaginal births	54.8%	53.8%	54.0%	51.8%	51.2%	72.6%	70.9%	70.0%	70.4%	68.6%

Induction of Labour

Both DHBS have instituted programmes to try to reduce the numbers of induced labours (IOL). Unfortunately, it looks as though induction numbers in both DHBs are slowly creeping up. It does

seem a little absurd that somewhere between 1:3 and 1:4 Auckland women cannot safely await a spontaneous onset to their labours.

Counties Manukau Health

Induction for prolonged pregnancy cannot be booked before 41 weeks + 5 days with induction guaranteed to start within 48 hours. Women with diabetes can be booked at 36 weeks but are not induced before 38 weeks unless necessary. Women expecting twins can be booked 2 weeks in advance of their planned induction date but all other women requiring an elective IOL can only be booked 1 week in advance. These IOL booking guidelines resulted in 21% of women who were booked for IOL going into spontaneous labour prior to their booked IOL date in the three months between 1 January and 31 March 2016.

National Women's Health

National Women's had their lowest rate of induction in 2014, the year they adopted the Auckland consensus guideline on indications for induction. However since then the rates have crept up again making one wonder if the guideline has been dropped or is being ignored. The report states that, *"Audits around indication for induction have not so far revealed concern about the reasons for induction based on clinical conditions; however, further detailed audit is required around the timing of IOL for the condition."* Maybe NWH should adopt the CMH guideline of not allowing IOL bookings more than 2 weeks ahead? Alarmingly, just under 40% of first time mothers who had their labours induced also had a c-section and 11.45% had a c-section because the induction failed.

Caesarean section

The c-section rate continues to rise in both DHBs though CMH is more than 10% behind suggesting that the biggest risk for c-section is having access to private obstetricians (and the fact that the School of Medicine's Department of Obstetrics is based on the 12th floor of Auckland City Hospital). NWH has 104 medical officers and 133 midwives (this does not include Birthcare midwives) on staff whereas CMH has 27 medical officers and 284 midwives (across all 4 facilities). Even though not all of these medical officers and midwives would work full time, it is obvious which professional group dominates in each of the DHBs. In addition 30 private obstetricians have access at NWH whereas we could only find 1 private obstetrician with access to CMH.

CMH appears to provide care for more women who have obvious risk factors and yet more of these women give birth vaginally. Unfortunately CMH's report did not include stats for full-term admissions into neonatal care so we can't see whether there are poorer neonatal outcomes associated with their lower c-section rates.

Maternal Risk Factors	**NWH**	**CMH**
Smoking at Booking	4.7%	10.6%
BMI >25	18.7%	38.4%
Diabetes in Pregnancy	2.95%	8.9%
Pre-eclampsia & HELLP Syndrome	3.14%	7.9%

NW Health does provide us with some outcomes by both mode of onset of labour and mode of birth that show that babies who are born vaginally at term have the lowest rate of admission to NICU.

Neonatal intensive care admissions by onset of birth at NWH in babies born ≥ 37 weeks gestation				
	Spontaneous labour	Induced labour	Elective (Planned) c-section	Emergency (Pre-labour) c-section
Admitted to NICU	4.3%	7.7%	6.0%	16.2%
≥ 2days in NICU	3.5%	6.8%	4.6%	16.2%
	Spontaneous vertex birth	Forceps/vento use birth	Elective (prelabour) c-section	Emergency (in labour) c-section
Admitted to NICU	4.7%	7.31%	6.0%	9.0%
≥ 2 day NICU	4.1%	6.7%	4.6%	8.1%

Vaginal Birth After Caesarean Section (VBAC)

National Women's Health data tells us that 38% of first time mothers gave birth via c-section in 2016; 11.1% were elective (pre-labour) and 27.0% were emergency.

(Alarmingly NW Health's report also shows that the reason given for 19.3% of c-sections for first time mothers was maternal request. The report goes on to say that there is a *"large difference in spontaneous vaginal birth rate among standard primipara* by caregiver (private obstetrician 31%, NW 54%, self-employed midwife 56%) supports the belief that indications for Caesarean section among women under the care of private obstetricians are frequently non clinical*."
* Low risk first time mother)

The only comparable data reported regarding VBAC at ADHB & CMDHB was;

Mode of onset of birth following one previous c-section					
	National Women's Health			Counties Manukau Health	
	VBAC	**Elective c-section**	**Emergency prelabour c-section**	**VBAC**	**Elective & Emergency c-section**
2012	31%	64%	5.0%	48%	52%
2013	30%	64%	6.0%	36%	64%
2014	30%	66%	4.0%	32%	68%
2015	32%	64.0%	4.0%	31%	69%
2016	27%	69%	4.0%	36%	64%

Both women's health services essentially allow women who have had a previous c-section to opt either for an elective repeat c-section (ERCS) or a "trial of labour". In both DHBs the number of women electing an ERCS is increasing although the rate in CM Health was nearly 10% less than at NW Health. Of the 27% women with one previous caesarean opting for "a trial of labour" at NW Health, 62% gave birth vaginally, a rate similar to the overall rate of vaginal birth for all women of 64%. (CM Health didn't report on VBAC outcomes.) Given that women having a vaginal birth after one c-section statistically have as much chance of birthing vaginally as all birthing mothers, maybe it is time to look at changing the language around a VBAC. Offering women a "trial of labour" pre-

empts the possibility/probability of failure. Encouraging women who have had a previous c-section to have a "spontaneous labour" may increase both the confidence and the numbers of women choosing this option.

Instrumental Birth

Given that the percentage of women in both DHBs having c-sections is increasing one would have hoped that the percentage of instrumental births, severe tears and episiotomies would have decreased. Unfortunately this is not so. The way birth is managed in Auckland seems to be inflicting increasing harm on women and their babies.

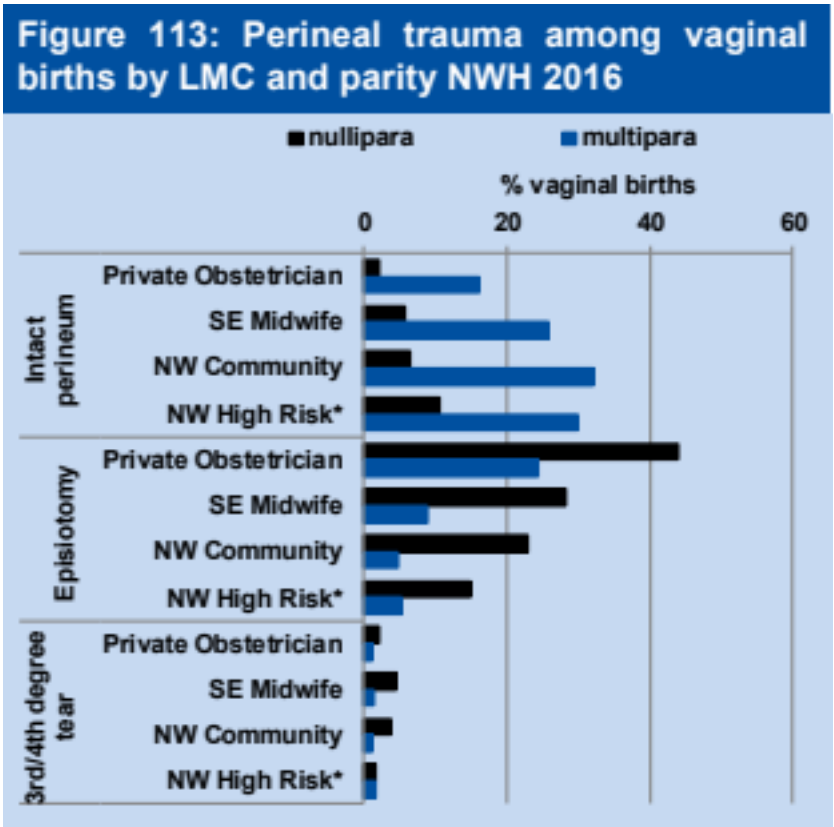
	National Women's Health					**Counties Manukau Health**				
	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016
Total forceps/ventouse	11.8%	11.5%	11.5%	12.6%	12.8%	6.3%	6.2%	6.9%	6.8%	7:0%
NZ Maternity Indicators 2015: Perineal damage in the standard primipara*										
Intact lower genital tract	16.0%	14.8%	10.1%	7.5%		16.1%	14.1	11.3	14.8	
Episiotomy without 3rd/4th degree tear	33%	36%	41%	37%		18.9%	24.8%	31.1%	28.4%	
3rd or 4th degree tear without episiotomy	3.0	2.8	3.5	5.0		4.7	5.3	4.7	4.4	

* Standard Primipara – a woman aged between 20 – 34 years at the time of birth, birthing her first baby at 37 – 41 gestation where the baby is presenting in the cephalic (head down) position and there are no recorded complications that are indications for specific intervention/s.

The NWH report states, *"There has been an increase in use of episiotomy over the past 20 years. There has also been an increase in 3rd/4th degree tears from about 2005. At 3.3% of vaginal births (1 woman in 30), this is the highest rate reported among women birthing at NWH since 1995."* …and goes on to sort of justify this by saying… *"The changes seen at NWH are reflected in the national data as seen in the New Zealand Maternity Clinical Indicators 2015 report, showing, among standard primipara birthed in secondary or tertiary facilities from 2009-2015, a statistically significant reduction in intact perineum from 26.3% to 19.9%, increase in episiotomy without 3rd/4th degree tear from 23.5% to 27.1%, increase in 3rd/4th degree tear without episiotomy from 3.7% to 4.3%, and increase in 3rd/4th degree tear with episiotomy from 1.6% to 1.8%."*

Both DHBs are now encouraging a hands on the head approach to managing the crowning fetal head although both acknowledge that the literature supporting the benefits of this is "not robust".

NWH stats show that midwives generally have a higher percentage of women birthing without perineal trauma and as most women at CM Health have a midwife as their primary caregiver during labour, this may explain their generally higher rates of intact perineums and significantly lower rates of episiotomy. Perhaps it's time to look at the pregnancy and labouring characteristics of women and midwives who have lower rates of perineal trauma and instigate changes based on these?



So far, birth in Auckland is looking pretty risky for mothers, what of our babies? Unsurprisingly more intervention in the birthing process is associated with lower breastfeeding rates.

Exclusive breastfeeding at discharge	
CM Health	84.7%
NW Health	78.0%

With the aim of improving their long-term breastfeeding rates, CMDHB has launched a service known as Te Rito Ora it was established with funding from MoH to promote the healthy feeding of infants and toddlers, with a focus on increasing breastfeeding rates and age appropriate introduction of healthy first foods. Te Rito Ora provides many different services including:
*In-home antenatal breastfeeding education- delivered by Kaitipu Ora Workers (community breastfeeding advocates) to educate and support pregnant women and their whanau to make informed choices and be confident in breastfeeding their babies. The Kaitipu Ora worker then follows and supports the mama through her breastfeeding journey.
*Intensive in-home postnatal breastfeeding support in conjunction with LMC to support initiation and maintenance of breastfeeding, these women received a minimum of two to three visits in the first week of baby being born, then one visit weekly from weeks 1-12, monthly contact after that.
*Community Lactation Support Services, all these visits take place in the home.
*Breastfeeding support groups.
*Peer Supporter Programme this programme is based on La Leche League's peer support programme, mothers with breastfeeding experience are given training to support and encourage others mothers and whanau with breastfeeding.
*Supporting implementation of Baby Friendly Community Initiative accreditation in organizations who are working to become/or maintain their accreditation.

Conclusion
From a consumer perspective these reports make depressing reading. The outcomes for women and their babies during their maternity experience are getting poorer year by year. Both DHBs have recognised that encouraging women to birth in primary settings has potential for supporting physiological birth and better outcomes for mothers and babies. The current rate of intervention in our hospitals is unsustainable both in terms of the health outcomes for mothers and babies and the costs associated with growing intervention rates. We need national public health campaigns to promote the safety and benefits of primary birthing options; we need all DHBs to invest in building and upgrading primary birthing facilities; we need to reduce antenatal screening and testing and instead put resources into ensuring that pregnant women are well and safely housed, well nourished and encouraged to believe that pregnancy and birth can be completely normal physiological processes.

Brenda Hinton & Holly Neilson

You can find these reports:
CMDHB: http://countiesmanukau.health.nz/assets/Our-services/attachments/2016-17-CM-Health-Womens-Health-and-Newborn-Annual-Report.pdf
ADHB:
https://drive.google.com/file/d/0BwvDOrdTZ9iqYTF5VTBndU9DaWZlVkxLQUlrZndTZktnSmZV/view

Joan Donley Midwifery Research Forum Christchurch 2017.

In mid October, Holly headed down to the biggest Joan Donley Forum so far, with 290 delegates registered to attend, in Christchurch, lovingly touted as the place where it all began. This was the 8th forum with the first being held in 2003, in Christchurch.

Because it was such a big forum I have chosen to report on a few presentations of particular interest to consumers. Some other presentations of interest from the forum will be published on our website due to space constraints.

Tongue Tie: A myth of Hoary Antiquity?

The first session was a presentation by Kass Jane, who is a Wellington homebirth midwife, with a masters degree (which focussed on homebirth) who is now doing her PhD study on tongue tie. Her presentation was entitled, *Tongue Tie: a myth of hoary antiquity?* Kass stated she wanted to use this presentation to delve into the history of tongue tie and started off by talking about Aristotle, saying that he described what we now know as a tongue tie in his work written in the 3rd century.

She then skipped forward to a man called Celsus who described the frenotomy process in the time of Christ. Kass revealed that there are references to tongue tie in the bible.

The earliest reference to the condition having a name, was in the 2nd century AD when a man named Galen, called it ankyloglossia.

By the 7th century we had Paul of Nagenia describing how to perform an operative frenotomy.

During the middle ages, all midwives were advised to keep a fingernail sharp to slit the frenulum of all newborns. It was well known that a tight frenulum would impede breastfeeding and the infant would die from lack of nutrition otherwise. There was rivalry between the midwives and surgeons, each feeling they were the best qualified to perform the frenotomy. (A bout of laughter went up when Kass shared this - same competition all through time evidently!)

Instruments to perform the frenotomy weren't introduced until the 16-17th century and remain remarkably similar to the tools in use today.

Throughout these early years of civilisation, there were known risks to frenotomy:

-Severe haemorrhage

-Infection (if they were using fingernails this is not surprising)

-Asphyxia from tongue swallowing.

Throughout the 19th century, frenotomy was used to ensure healthy sucking in infants and to cure established or suspected speech disorders.

Then in the 20th century, things began to get a bit murky. Up until this time, tongue tie had been seen as an impediment to feeding and speech, but that began to change.

Normalisation of failure around breastfeeding contributed to this and tongue ties began to not be treated because babies could be fed formula. During this time people falsely believed that formula was the best thing they could give their babies - "vitamins in a bottle". This led to doctors beginning to doubt the existence of tongue tie, or to simply see it as a variation of normal that did not affect the functioning of the tongue.

In the 1970's there was a resurgence of breastfeeding. This was aided by:
-Changes in birthing practices.
-Childbirth education classes
-Increased knowledge about the benefits of breastfeeding. Holly I would prefer this to read, Increased knowledge of the risk of formula feeding. Saying benefits of breastfeeding instead is not saying the same.
During the last 20 years we have also had successful breastfeeding promotions put into place. e.g. BFHI.

So what is Kass actually doing with this history? The aim of her study is to examine the complex relationship between mothers and clinicians in the tongue tie space. Despite all the history on the subject, the diagnosis and subsequent management of tongue tie remains controversial, with many health professionals involved with the care of mothers and babies, still divided about the impact of a tongue tie on breastfeeding.

All in all, it was a fascinating look into the history of something that is often thought of as a modern phenomenon.

"Feeling confident in the care and expertise of my midwife", women's views about midwifery.

This study is not new, it was conducted in 2010-2012 in Christchurch and was derailed somewhat by the quakes. The original study was an Australian funded with an aim of evaluating primary level free standing maternity units in Australia and NZ. Christchurch's Ara Institute of Canterbury, conducting the New Zealand arm. When the 2011 quake happened this study got derailed, but Rea Dallenbach used the clinical focus groups to form a study into women's views about the midwifery care they received. The focus of the talk given at Joan Donley was the Canterbury clinical focus group's responses. Consistent themes arose throughout these focus groups:

-.Women felt they had the majority voice when deciding place of birth.
- Women had more confidence around birthing when they choose to birth in a primary setting.
-.Women very much struggled to find a midwife, at this stage it was mostly word of mouth for midwife referrals.
-.Women felt that it was really important that they shared the decision making with their midwife and that they were listened too.
- Women reported very diverse experiences of postnatal care.

So instead of doing a formal write up of the presentation we have chosen to look at it more informally asking Holly, who had a baby at the same time as the consumers in the study and another baby in 2015 (and due in 2018) and Emma, who had babies in 2004, 2016 (and due in 2018) whether their experiences the first time around were similar to those presented in this study by Rea Daellenbach and whether their experiences in successive pregnancies were different.

What do you remember most clearly from your first pregnancy experience and did your experiences line up with what these women shared?

Holly: *I had my eldest in 2011, and was pregnant with him in 2010. I had no idea how to find a midwife. I can remember posting on facebook asking friends, "how do I do this?". Luckily a friend's mother was a childbirth educator in Auckland, so she gave me some recommendations. There was no "findyourmidwife" then. Unfortunately, I had waited until I was 12 weeks and the recommended midwives were already fully booked. I ended up going through the midwives at Auckland City Hospital. I had a hard pregnancy and I didn't feel like they were there for me the way I expected, Because I was with the hospital team, a hospital birth was the only option for me. I switched to North Shore Hospital Community Midwifery Team in my 3rd trimester. While I am happy overall with the in-labour care that I received, my pregnancy did not give me the feeling of shared decision making, or that I was being listened too. I was realistic enough to know that my age would play into this, I was only 20.*

Emma: *It was 2004 when I had my oldest. I was young (only 20) and winging it. Gran used to be a Plunket Nurse, so she had a very, 'this is the way we do things and there no deviation from this' attitude. I was living with her at the time, so she would have had a huge influence on me. The assumption was that I would give birth at the hospital, no other info was offered though home birth was mentioned* [there was no primary unit in Tauranga at this stage]. *First antenatal appointment was with the GP. I can't really recall how I found my midwife, but I suspect Gran found her for me. I didn't actively choose her, but ultimately was happy with her. Everyone had lots of opinions on my birth and pregnancy, but I didn't feel I made an informed choice about anything. Once again age probably played into this.*

Holly and Emma are now pregnant with their third children.
How would you say your experiences compare?

Holly: *I'm only in my second trimester, but I can confidently say I feel like I am fully in charge of my own pregnancy. Finding a midwife was easy, I knew to do it as soon as possible rather than waiting till the end of the first trimester this time. The website findyourmidwife had been launched not long after my first pregnancy with Charlie. All I had to do was find my region, select a place of birth and then I had a whole range of options. It meant I knew exactly what midwife would support my choices from the get go and I knew that my midwife would be comfortable birthing at a locale of my choice. The bio provided by the midwife also meant I could weed out any I felt wouldn't be a good fit. I certainly feel this time around I can call my midwife if I need too, I'm not scared of reaching out when I need too, and I know exactly who I can talk to about it.*

Emma: *With baby number 2 in 2016, I had been living overseas until I was out of the first trimester and then had to settle back into New Zealand, so I didn't end up looking for a midwife until 18 weeks. I found it incredibly difficult to find a midwife who would take me on "at the last minute". So I started off by looking for someone who aligned with what I wanted but quickly realized that they were fully booked and I would be stuck with whoever I could find. I found one midwife who was willing to take me. She said she was going to contact me about the 1st appointment. However, after multiple attempts to contact her with no reply an acquaintance stepped in and offered to provide care despite conflict of interest concerns, however, soon after she felt she needed to take some leave, so I was all at sea again. At 30 weeks I started phoning around again. This time I successfully found a midwife. I had my first midwife appointment at 30w2d, I liked her [midwife] but probably wouldn't have kept her if I had another choice (I knew it would be difficult with a baby due at end of September), she was awesome but I would have preferred someone…softer. Overall, my care was good. My midwife pushed for Warkworth, but I felt it was too far from where was I was living and in the end I had baby in 2 hours, so this was probably a good instinct.*

This pregnancy [due 2018] I knew I wanted to get onto it a lot earlier, so I actively used findyourmidwife, really paying attention to bios to make sure I found someone who aligned with me really well, but I still had to call around. I did find someone who was much more in tune with what I wanted. Felt like I had a choice on birth location and I chose a primary unit, as it is closer to home, but ultimately, I am confident in my birthing abilities so I'm not really too fussed on birth location.

Anything that really stands out that changed in between these pregnancies?

Emma: *I'm much more interested now than I was then. So, I've changed. I haven't noticed a lot of change in the system but that's because I wasn't paying attention in the same way the first time around.*

Holly: *It feels much easier now, to find a midwife and to make choices about my birth. I can go online and find a comprehensive list of midwives, rather than word of mouth. So much easier.*

Our experiences lined up with the experiences shared by the focus groups, but introduction of the New Zealand College of Midwives' website, findyourmidwife.co.nz, has since alleviated some of the problems around finding a midwife who shared our beliefs around birth and whose practice aligned with what we wanted from our births.

Early Pregnancy probiotic supplementation with Lactobacillus rhamnosus HN001 may reduce the prevalence of gestational diabetes mellitus: a randomized controlled trial

First thing to know about this is that one of the sponsors was Fonterra, that said it was a double blind, randomized, placebo controlled parallel trial conducted in Wellington and Auckland.

The women in the trial were between 14-16 weeks pregnant and selected randomly from a pool of women with a personal or partner history of atopic disease.

While Robyn Maude only presented on the effects of the probiotic on gestational diabetes, it is worth noting that the evening before the forum, another result from the same study about the effect of probiotics on post-natal and antenatal depression, was reported in the 6 o'clock news on TV3.

However, as regards gestational diabetes, let's look at what they found. The results differed according to what measuring standard for gestational diabetes was used.

The standards are as follows: The two hour level for diagnosing gestational diabetes is significantly lower In Europe(7.8mmol/litre) than in NZ (9.0mmol/litre).

When measured against international guidelines for diagnosing gestational diabetes the results were not statistically significant. However, when they used the New Zealand guidelines of 9.0mmol/litre they showed a 68% reduction in the diagnosis of gestational diabetes. Results for the probiotic supplemented group were stratified by maternal age and positive outcomes were found to be more significant in women aged 35 and over. When women were categorised according to history of gestational diabetes, none of the women in the probiotic supplemented group who had a history of GDM experienced GDM in their current pregnancy.

It looks promising, but it will be interesting to read the complete study when it is published before drawing conclusions.

<u>Smart Start- a new government initiative that's making waves.</u>

https://smartstart.services.govt.nz/

Four government agencies have pulled together to create a one stop website for mothers expecting a baby. As a pregnant woman you enter your baby's due date and the website then provides you with information about what you can expect, should be doing each trimester of your pregnancy with the months listed for easy information. In the first trimester, it tells you if you're entitled to free care in New Zealand and what care your LMC should provide for you in pregnancy. Including the link to the Find Your Midwife website. It also has information for partners on becoming a dad, complete with links for every situation.

It has information on screening, though both the links in this section talk about the choice around screening the actual title page does not. The site also provides information on healthy eating, advice on quitting smoking, alcohol and the supplements you need to take to ensure a healthy pregnancy.

Furthermore, they mention antenatal depression, a huge step forwards for the New Zealand health sector.

The second trimester provides information on antenatal classes, and why they're important, it only links to antenatal classes offered by the district health boards. We feel there should at least be a sentence acknowledging that classes outside of those provided by the DHBs exist.

Information on taking maternity leave that helps you work out if you qualify for paid leave and how much is provided. Because the Ministry of Social Development and the Inland Revenue worked on this project you can trust the advice to be accurate.

The site comes with a to-do list and an option to sign into the government's Real Me account, so you can do an online application for government support such as a community services card or the accommodation supplement.

The information for the third trimester provides solid information about infant car seats including the what to look out for when buying a second-hand seat and finding a car seat technician to help you install it correctly.

Following the due date, there is information on how to register your baby's birth and if you have your Real Me identity logged in, you can apply for working for families, a birth certificate and add your baby to your benefit if you receive one.

All in all, it's a solid site, with all the information a family needs to handle the bureaucratic side of pregnancy and having a new baby, making it much easier for families to get their full entitlements when adding to their family.

SmartStart took away an award for Public Sector Excellence from the Institute of Public administration for excellence in achieving collective impact this year. It has helped adapt accessing the bureaucratic aspects surrounding pregnancy and having a baby to the 21st century improving accessibility for expectant parents who have grown up using technology. Well done to the team behind Smart Start!

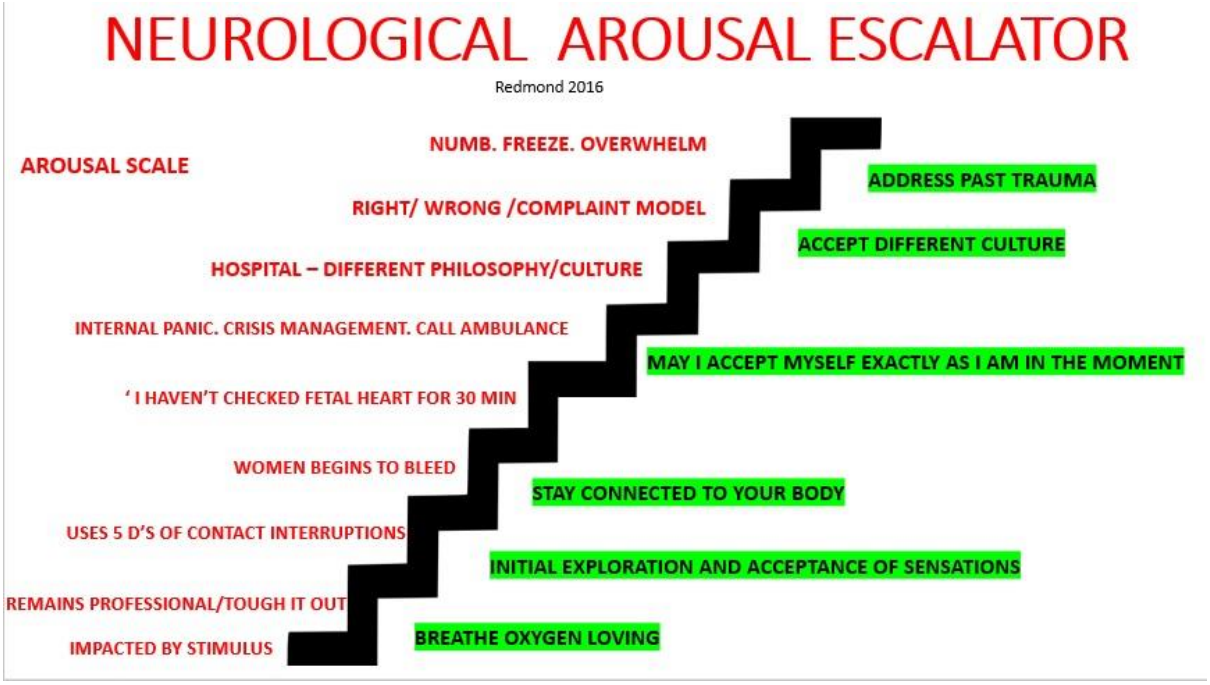
MSCC are very interested to hear Consumer feedback on this initiative, so if you, or your clients are using it please get in touch with us at: mscc@maternity.org.nz

Homebirth Aotearoa Biennial Conference and Hui 7th to 8th of October

This was a wonderful event organised by the Auckland Homebirth Community. It spanned two days, the first day being the conference and the second being the hui. The conference was held at the Jet Park Hotel in Manukau and was addressed by a great range of fantastic speakers. The presentations by the speakers were each followed by members of Home Birth Aotearoa telling their birth stories keeping the day firmly focused on what homebirth is and means for individual families.

One presentation that I found particularly interesting was Janet Redmond's talk about, Long term Effects of Birth Trauma on Midwives. The long-term effect of birth trauma on a midwife is not something consumers automatically consider when thinking about birth trauma. Janet talked about how witnessing traumatic births can cause midwives to suffer from *vicarious trauma.* Vicarious trauma is the emotional residue of exposure to traumatic incidents that health workers including midwives, experience. Midwives witness the pain, fear and terror that women/couples suffer during

traumatic birthing experiences and hear trauma stories from their colleagues as well. Case loading midwives are at risk of vicarious trauma because of the long-term, close partnerships they form with their clients. The effects of a traumatic birth can impact a midwife's psychological, physical, and spiritual well-being leading to stress and anxiety in and out of the birth room. Janet also spoke about how midwives can experience the same flight or fight reflex that their birthing mums do when faced with a stressful situation. This trauma can affect the way they respond to similar situations in the future. Janet spoke about how vicarious stress leads to an emotional reaction similar to an escalator, where when a birth starts to deviate from normal, minute by minute the midwife's stress goes further up the scale. Janet then discussed healthy ways to cope with stress in traumatic situations. A summary of which is shown in the following diagram.



The following day was a hui, held at AUT Manukau. The day started with a beautiful Kei a Wai Ceremony, in which women shared stories and poured water from their home into a beautiful common vessel. This was followed by a regional round up where the different regional homebirth groups present reported on their activities and situations. It was interesting to note all the groups are experiencing the same issues; people not coming to meetings, members being more willing to interact online than in the face-to-face groups of the past. Women came forward and shared their birth stories from Auckland and around the country.

All in all, it was a beautiful weekend and we highly encourage you to attend a Homebirth Conference and/or hui if you ever get the chance.

Maternity Services Consumer Council wish you a very Happy Holiday season. Our office will be closed from the 22nd of December till the 8th of January. Please have a happy and safe Christmas and New year!

<u>2018 Steering Group Dates:</u>

<u>January- None</u>

February- 13th at Mama Maternity

March- 6th at Birthcare Parnell

April- 3rd at Mama Maternity

Meet at 9.45am for a 10am start.