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Maternity Services Consumer Council

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

This is the third issue of the MSCC's Newsletter for 2013. Since we sent out the June newsletter we have attended the NWH Annual Clinical Report day, held our AGM, attended Human Genome Society conference, completed the revision of our *After the Birth* pamphlet. We have written a number of grant applications for reprinting costs as well as some of our operational costs, responded to requests for information, and have been mailing out thousands of our pamphlets.

## Funding applications

The MSCC is very appreciative of the funding we have received so far this year, and we actually managed to avoid the mid-year financial crisis we have experienced during the past two years. We received a $5,403 grant from Trillian Trust and a $2,000 grant from Four Winds for reprinting of some of our leaflets. At the end of July $32,000 grant from Lottery Community was received. We have also submitted grant applications to the five regional COGS committees.

## Bed Sharing

The questioning and discussion on the controversial issue of sleeping with the baby continues in the wake of media coverage of coroner's reports and the publication of new research on old data. The March and June issues of NZCOM's *Midwifery News* feature excellent articles that explore the various arguments that have been put forward as part of the debate on bed sharing. We recommend that readers check out "Sleeping with the baby" on page 34 of the March 2013 issue and "Advocates for mother and infant health question new view on bed sharing" on page 36 of the June 2013 issue.

## What's in this issue of the newsletter

The September issue of the newsletter contains a summary of some of the birthing statistics in the NWH Annual Clinical report, an article on what really happened to the extra postnatal care the Minister of Health announced in 2009, some information on how the changes introduced in 2011 means researchers are now able to access and use the Guthrie cards without having to obtain parental consent, an article on the Perinatal and Maternal Mortality Review Committee's report, a glimpse into the nightmare world of NIPT, and much more.

Happy reading!

Lynda + Nicola

# 2012 ANNUAL REPORT FROM NATIONAL WOMEN'S

National Women's released its Annual Clinical Report for 2012 in August 2013. The report is the 20th in the current series and was made available at the NWH Annual Clinical Report day held on 2 August.

The 264-page report contains a wealth of statistical information on the 7664 women who gave birth at NWH in 2012 and the 7832 babies they gave birth to, plus the 31 women who gave birth before they actually got to the delivery unit. In 2012 there were 156 sets of twins (159 in 2011) and 2 sets of triplets (4 sets in 2011).

**Percentage of normal births continues to decrease**

The intervention rates have risen slightly over the past year or so. In 2012 54.2% (4173 out of 7695 birthing mothers) had what the report refers to as a "spontaneous vertex birth," and 0.6% (45 birthing mothers) had a vaginal breech birth. Only 45.8% of first-time mothers had a spontaneous vertex birth, compared to 46.7% in 2011. It is important to note that the definition of "normal birth" at NWH includes augmentation of labour.

The two keynote speakers giving the critique at this year's Annual Clinical Report day represented a break with tradition in that they were NWH staff rather than outsiders. Together, Maggie O'Brien, Director of Midwifery and obstetrician Sue Fleming, Medical Director of Women's Health issued a challenge for National Women's to increase its normal birth rate, referring to Peter van de Weijer's critique in 2012 in which he put the spotlight on NWH's high iatrogenic intervention in the birth process, and the high iatrogenic complication rates. "Private obstetrics causes increased interventions," he said. The two women also made in history in showing during their presentation a very moving video clip of a woman labouring and giving birth without any intervention. This so unsettled one of the private obstetricians attending this event that she felt compelled to speak out on behalf of those women who were unable to give birth like this!

**Induction of labour**

In 2012 32.3% of mothers had an induction of labour. More than one in three first time mothers – over 37.5% – had an induction of labour. The rate for multiparous mothers was 28.6%.

The report notes that prolonged latent phase of labour, premature rupture of membranes and post-dates were the most frequent reasons for induction of labour in 2012. When post-dates was the primary indication for induction, 15% occurred prior to 41 weeks (up form 10% in 2011) and 16% occurred at or beyond 42 weeks (down from 22% in 2011).

"The advent of the post-dates virtual clinic at the end of 2011 has meant that referrals for post-dates induction of labour prior to 41 weeks will not be accepted

in women meeting the criteria for a normal birth pathway." Hopefully this will help reduce the number of inductions which are often the beginning of the cascade of interventions that result in a caesarean section.

**33.4% caesarean section rate**
In 2012 the caesarean section rate was 33.4%, compared to 32.5% in 2011, and 20.8% in 1995 and 1996. There was little difference between the caesarean section rate for first-time mothers (34.1%, compared to 34.5% in 2011) and for mothers having subsequent births (32.7%, compared to 30.8% in 2011).

The most common reason given for all elective and pre-labour emergency caesareans was "repeat caesarean section." Among multiparous mothers, 61% of all caesarean sections were performed primarily for repeat caesarean. The next most common indication overall was malpresentation at 13%. "In first time mothers, concerningly, 16% of elective or pre-labour emergency caesarean section were for maternal request."

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

**Forceps and Ventouse**
In 2011 the rate of forceps and ventouse deliveries (combined under the term "instrumental vaginal birth") dropped below 12% for the first time since 1997, with a rate of 11.1%. In 2012 it was rose again to 11.8% of all births, 19.7% of first-time mothers, and 4.2% of multiparous mothers.

Some mothers are subjected to more than one instrument – forceps and ventouse, or different types of forceps, and to the birth of a baby by caesarean section after an attempted vaginal instrumental birth. In 2012 34 mothers had a double instrumental birth, and 48 mothers had an attempted vaginal instrumental birth prior to emergency caesarean section. The report notes that these are rare events but are associated with more severe outcomes for both mother and baby.

**Epidurals**
The epidural rate among labouring women was 60.3% in 2012. For first-time mothers it was 82.6% if labour was induced and 58% if labouring spontaneously. For multipara it was 57.9% if labour was induced and 27.2% if labouring spontaneously.

The use of epidurals is highest in first-time European mothers (73.7%) who are over the age of 30 (72.9%), with a private obstetrician (82.2%).

One of the disadvantages of the use of epidurals featured in the keynote presentation in which it was pointed out that 20.6% of women who had an epidural had a blood loss of 500mls compared to 10.39% of women who did not

have an epidural; and 8.3% of women who had an epidural had a blood loss of 1000mls compared to 4.6% of women who did not have an epidural.

**Breech birth**

Of the 356 singleton babies presenting as a breech, 318 were delivered by caesarean section. Among the 55 breech births at 32-36 weeks the percentage of caesarean deliveries was 89%, despite there being no evidence to support such a practice. For the 252 breech births at 37 weeks and over the percentage of caesarean sections was 97%. Caesarean section for breech presentation contributes 12% to the total caesarean section rate.

The report notes that the NWH guideline on Breech Birth was updated in May 2012 to reflect changes in guidelines internationally.

**Waterbirth**

There were 37 babies born in water in 2012 - five mothers were cared for by NW LMC midwives, and 32 were cared for by independent midwives.

**Postpartum Haemorrhage**

The postpartum haemorrhage (PPH) rate continues to rise and it remains a cause for considerable concern. It is associated with the increasing caesarean section rate. The overall primary PPH rate (500mls and over) was 33.6%. It was 16.4% following a spontaneous vaginal birth compared to 71.7% following an emergency caesarean section and 54% following an elective caesarean section. It also varied by onset of birth, from 25% in spontaneous onset of labour to 32.8% in induced labour.

**Peripartum Hysterectomy**

In 2012 11 women had an emergency postpartum hysterectomy compared to twelve in 2011. These hysterectomies are usually associated with caesarean sections and the increase in hysterectomies immediately after birth are one of the more traumatic consequences of the rising rate of caesarean section. This raises the question of whether private obstetricians clearly inform their patients of the risks of their needing a hysterectomy as a result of having a caesarean section.

**Maternal Mortality**

There were no maternal deaths in 2012.

**Breastfeeding**

In 2012 80.3% of mothers were discharged from National Women's exclusively breastfeeding their babies.

- A copy of the 2012 Annual Clinical Report is available at:
http://nationalwomenshealth.adhb.govt.nz/health-professionals/annual-clinical-report

# EXTRA POSTNATAL CARE FUNDING ENDS

In the 2009 budget Minister of Health Tony Ryall announced a maternity services package of $38.5 million to provide for longer in patient stays for new mothers. The funding was for four years and expired in June 2013. As the extra funding was not “ring fenced” for postnatal care, and monitoring of DHB spending of this money was brief and superficial, it came as no surprise when Labour’s health spokesperson, Annette King released figures obtained under the Official Information Act revealing that there was not much to show for it. When averaged out, the figures show the average stay in some hospitals and birthing units is now shorter than it was in 2009. For example, mothers in Hawke’s Bay now stay 2 hours less. Over the four years of extra funding eight DHBs actually had shorter stays by new mothers between 2009-10 and 2012-13.

At Waikato Hospital the average length of stay went up by 1.2 hours to 2.47 days in 2012-13 compared with 2.29 in 2009. The Waikato DHB says the increased funding has meant women having caesarean sections in the region have been able to stay much longer in maternity care than previously.

When the extra funding was announced in 2009 many mothers took it to mean they were now permitted to stay an extra day in hospital and began demanding an extra 24 hours. What the Minister did not make clear was that the longer stay was only for new mothers who met the clinical criteria for an extra day. Clinical reasons for a length of stay greater than 48 hours included breastfeeding problems, post-operative recovery, ongoing medical problems, psychological problems, and babies with special needs. Like Waikato, many DHBs probably used the extra funding to pay for the extra days in hospital that mothers who had had a caesarean section needed.

Exactly what the money was spent on will never be known because as already noted the funding was not tagged and after the first 18 months it became part of each DHB’s baseline funding.

When asked to respond to the lack of evidence of increased in-patient postnatal care Mr Ryall said his policy was “positively received” by health professionals and there are no longer media reports of mothers and babies being kicked out of hospital immediately after giving birth. The Minister’s response is very telling in that he refers to how health professionals felt about his announcement rather than new mothers, and his method of assessing the policy was successful is that there are no longer media reports of mothers who felt they were sent home too early.

This is of major concern as Mr Ryall recently announced there would be an extra $18.2 million of funding over four years for new dedicated acute inpatient beds for new mothers experiencing acute postnatal depression and other mental illness, and for new specialist community care and services.

# Researchers now accessing Guthrie cards

Since June 2011 researchers have been able to obtain approval from ethics committees for research that involves accessing residual blood spots on Guthrie cards without having to obtain consent from parents or the adult individual whose card it is. Prior to this, researchers had to get written consent from the individual as well as Ethics Committee approval, review by the Newborn Metabolic Screening Programme Governance Team and Ministry of Health permission before the cards could be released for population research.

It is difficult to know how many parents are aware that the protocols around accessing Guthrie cards have changed, as there is no monitoring of how many new parents are given the National Screening Unit's (NSU) booklet and have read and understood that their baby's Guthrie card will be permanently stored in what is essentially a biobank, and can be used by researchers without their knowledge or consent.

The NSU's 8-page booklet contains one brief mention of the fact that the stored blood spots can be used "for research approved by an ethics committee." (1) There is a little more information on the NSU website: "For blood spot samples collected after June 2011, any applications for population research must first be approved by an ethics committee and then is reviewed by the Newborn Metabolic Screening Programme Governance Team." (2) However, given the vested interests involved there needs to be a completely independent review.

One such research proposal was recently approved by the Northern A ethics committee during its August meeting. Given the type of research involved – a study of the natural history of around 120 children born between 2006-2012 who had elevation of a chemical suggestive of a condition known as VLCAD deficiency on the initial newborn screening test – the ethical thing to do would have been to have sought consent from the parents of these children. Unfortunately, the parents will never know their child's card was accessed and used, or what the study revealed.

**References**

1. http://www.nsu.govt.nz/files/ANNB/Your_newborn_babys_blood_test.pdf
2. http://www.nsu.govt.nz/current-nsu-programmes/2917.aspx

# PERINATAL & MATERNAL MORTALITY IN 2011

The Perinatal and Maternal Mortality Review Committee (PMMRC) recently released its report on perinatal and maternal mortality in New Zealand for the year 2011. This is the committee's seventh PMMR report. This year the report was able to analyse and report on six years of data for the period 2006 – 2011.

**Maternal mortality in 2011**

There were two direct maternal deaths, five indirect maternal deaths and one unclassifiable death in 2011. A direct maternal death is one that is the result of obstetric complications during pregnancy, birth and up to 42 days postpartum, and from interventions, omissions or incorrect treatment. An indirect maternal death is one that 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 two direct maternal deaths were sepsis and venous thrombo-embolism. The five indirect deaths included one suicide, and four mothers with pre-existing medical conditions.

**Six years of data**

The 65 direct and indirect maternal deaths from 2006-2011 included:

- 24 antepartum and 41 postpartum
- 42 occurred in hospital and 23 in the community
- 45 births and 20 undelivered babies
- 23 with potentially avoidable factors present, 39 with none and three were unknown.

**Potentially avoidable deaths**

The report notes that in the six years from 2006-2011 the MMR working group believed that 35% of maternal deaths were potentially avoidable. The factors relating to the potentially avoidable deaths involved 21 cases relating to organisational and/or management factors, 21 relating to personnel, one relating to technology and equipment, three relating to geography (long distance transfers) and 26 relating to barriers to access/ engagement with care. The barriers to access included five women with maternal mental illness, two with language barriers, one with a cultural barrier and one woman who was not eligible for publicly-funded health care. Substance abuse featured in four potentially avoidable maternal deaths, family violence in four, and a lack of recognition of the complexity or seriousness of the condition in 10 cases.

**Deprivation**

Maori and Pacific mothers had a higher maternal mortality ratio when compared to New Zealand European mothers, which mirrors the statistically significant trend of an increasing maternal mortality ratio with increasing deprivation.

The report states that “Although the absolute numbers are small, pre-existing medical conditions, suicide and amniotic fluid embolism continue to be the leading causes of maternal mortality in New Zealand.”

**Maternal morbidity**

Two years of surveillance (2010-2011) of severe maternal morbidity reveal that the rate of eclampsia is 2 per 10,000 maternities, the rate of placenta accreta is 3.9 per 10,000 maternities, and the rate of peripartum hysterectomy is 4.5 per 10,000 maternities. The latter two are a direct result of the rising rate of caesarean sections.

**Recommendations**

This year’s report includes just two recommendations relating to maternal mortality. They are:

- In maternal deaths, where a coroner declines jurisdiction, post-mortem should be offered as part of a full investigation of cause of death.
- Women with pre-existing medical conditions (such as epilepsy, hypertension or mental health) should have individualised pre-conceptual counselling about their condition and the medication they are taking. Health professionals providing care to these women need to communicate the importance of continuing their medication in pregnancy, if appropriate, and to advise women to seek early medical review.

**Maternal Mental Health**

Previous PMMRC reports have also made recommendations on maternal mental health including the integration of maternal mental health services into maternity services, and confirmed the need for mother and baby units in the North Island, two initiatives that the AWHC has supported and lobbied for since the mid 1990s.

**Perinatal mortality**

In 2011 there were 665 perinatal related deaths – perinatal mortality being foetal or early neonatal deaths after 20 weeks gestation and up to 7 days after the birth. The report notes that the total perinatal related mortality rate has not changed significantly since 2007 using the New Zealand definition.

The rates of both full term intrapartum death and hypoxic peripartum death decreased significantly from 2007 to 2011.

However, there has been a significant increase in perinatal related mortality among babies born in multiple pregnancies from 2007 to 2011.

Some other key points in the report:

- Maori and Pacific mothers were significantly more likely to have potentially avoidable perinatal related deaths than NZ European mothers.
- There is a significant increase in potentially avoidable perinatal related death with increasing socioeconomic deprivation.

- The rate of late termination of pregnancy has increased in the last two years with 35 terminations performed after 24 weeks gestation.

**Recommendations**
The report also has a number of recommendations relating to the audit of congenital abnormalities, relating to reducing perinatal related mortality associated with multiple pregnancy, as well as that associated with neonatal encephalopathy.

**The PMMRC report can be found at:**
http://www.hqsc.govt.nz/publications-and-resources/publication/958/

## MSCC Meeting Dates for 2013

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 2013 are**:**

**17 September, 15 October, 12 November and 10 December**

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.

# The brave new world of NIPT

Professor Dennis Lo was in Auckland on 26 August 2013 to give a lecture on a prenatal test that is going to become part of prenatal screening or testing. Having attended a session on NIPT (Non-invasive prenatal testing) at the Human Genetics Society conference held in Queenstown at the beginning of August Lynda decided to attend the lecture to find out more about this prenatal test that has received significant media coverage over the past year. Her report follows:

Professor Lo is the director of the Li Ka Shing Institute of Health Sciences and chair of the department of chemical pathology of the Chinese University of Hong Kong. He began his lecture with the fascinating story of how he came to work on trying to develop a blood test to detect the presence of chromosomal aneuploidies such as trisomies 13, 18, 21 (Trisomy 21 is the aneuploidy that results in Down syndrome) after working in the field of cancer research. After it was discovered that tumour DNA was present in the plasma and serum of cancer patients, Professor Lo began investigating if the same thing occurred during pregnancy - whether fetal cells could be found in maternal plasma and serum. He described how he spent 10 years trying to get fetal DNA from maternal blood plasma. The results of his research were first published in the *Lancet* in 1997. (1)

His research team found that cell-free fetal DNA is present in the plasma of pregnant women. It consists of short DNA fragments among primarily maternal DNA fragments. They also found that entire fetal and maternal genomes were represented in maternal plasma at a constant relative proportion. As a result of this discovery, Professor Lo believed that it would be possible to diagnose fetal genetic disorders prenatally in a non-invasive way by taking a blood sample from the pregnant woman. Such a test has been developed and is now being heavily marketed to pregnant women.

At the Human Genetics Society conference the NIPT was referred to as a screening test rather than a diagnostic test - it was not recommended for use if the pregnant woman had not already has a blood test and an 12-week NT scan. During his lecture Professor Lo explained that due to the cost of the test when used as a diagnostic test (around $8,000), a cheaper version is currently been marketed as a screening test for pregnant women who have already been identified as having significant risk factors for having a Down syndrome baby.

What Professor Lo didn't mention is that this NIPT may also reveal abnormalities in maternal cells. But according to the presenter at the Human Genetics conference pregnant women are not told about the possibility of this incidental finding. Welcome to the nightmare of the new world of prenatal genetic testing.

**References**

1. www.thelancet.com/journals/lancet/article/PIIS0140-6736(97)02174-0/abstract

# Thrive Teen Parent Support Trust

Thrive Teen Parent Support Trust was originally known as the Teen Parenting Project. The establishment of Thrive came about following a research project in 2009. Twenty-six young parents participated in a research programme termed 'Photo Voice' with which young parents were able to use the art of photography to convey their ideals for a teen parent service. These images identified a number of key themes for service initiatives, paving the way for establishment in 2010 of a Thrive Teen Parent Support Trust; a dedicated teen parent organisation working with young parents under 24 years.

Thrives Central Hub is located within the Mt Albert YMCA building in Central Auckland. 2013 has seen the emergence of a second hub now located at 34 Lincoln Road- West Auckland. Thrive services are often out in the community delivering programmes within both community hubs and Teen Parent units.

Thrive provides a range of services with consideration to key aspects of their service users 'wellbeing. This is reflective of a holistic approach, aiming to address the underlying factors for adverse social and health outcomes. Services of the organisation include Antenatal Education, Parenting Workshops, Young Parent Groups and one-on-one Social Work Support.

**Prep 4 Parenting- Antenatal**
This term time programme covers all components of mainstream antenatal education with a unique approach and structure. These sessions are interactive using creative methods to stimulate discussion and engagement. This programme encourages attendance from both parents and recommends early engagement. The majority of participants start this programme between 12-15 weeks and remain active until birth.

**Your New-Born Group (YNG)**
This term time group is designed to create a bonding connection between parents and their infant. With a focus on massage, participants are able to learn a new skill alongside gaining the benefits of forming a secure network of friendships amongst other new young parents.

**Young Mums Support Group (YMSG)**
This programme runs term time and is coordinated by Thrive social workers. This is a closed group for up to 12participants covering a range of topics including self-esteem, goal setting, parenting, relationships, first aid and family planning. The programme uses creative arts to stimulate conversation and ideas with the young mums. These naturally occurring discussions, help to define future session plans to ensure content is most relevant to the participants.

**Young Dads Group (YDG)**
This mentoring group exclusive to the young fathers meets weekly, to provide a place to connect and support each other through the parenting journey.

**Casework – 1:1 Social Workers**
The Thrive Social work team support young parents on a one to one basis, in the context of their family and community. The aim of this service is to provide additional support to those who most need it, in any aspect of their lives such as relationships, family, housing, safety and health. The support is designed to give longer term, more intensive support with the view to creating action plans for the future.

**For more information the team can be reached on**
**09 551 4367 or 09 2139658**

thrive.org.nz
teen parent support trust

We are getting lots of orders for our three new leaflets. If your order form does not have these on please download the latest order form off our website
MSCC Order Form

**Cost**
There is a charge for the *Induction of Labour* and *Birthing the Placenta* pamphlets, as for the first two in the MSCC's *The Facts* series – *Caesarean Section* and *Epidurals during Labour*. One copy of each is provided free of charge, while orders for multiple copies range from $1 each for 2 – 20 copies, to 50c for orders of 100 or more.

# CONFERENCES/WORKSHOPS 2013

## *The 6th Joan Donley Midwifery Research Forum*

The NZ College of Midwives is holding its 6th Biennial Joan Donley Midwifery Research Forum celebrating midwifery research and knowledge on **19 – 20 September 2013**.

The forum is being held at **Rydges Lakeland Resort in Queenstown.**

Further information is available on the NZ College of Midwives at:
http://www.midwife.org.nz/research/joan-donley-midwifery-research-collaboration/the-jdmrc-forum/

## The Legacy of Cartwright @ 25 years conference

**10.00 am – 4.30 pm on Friday 27 September 2013**
**Fickling Centre, 546 Mt Albert Road, Three Kings, Auckland**

The Auckland Women's Health Council and the Cartwright Collective is hosting an *event to mark the anniversary of the Cartwright Report of August 1988*

The programme will feature **Dame Sylvia Cartwright** and other speakers, including:

- **Prof Charlotte Paul** – Screening Programmes
- **Associate Prof Martin Tolich** – Ethics Committees post 2012
- **Dr Lester Levy** – The impact on Hospitals
- **Phillida Bunkle** – The Unfortunately Legacy of the Unfortunate Experiment.
- **Marie Bismark** – Patient complaints.

**Cost: $80** (including morning and afternoon tea and paper bag lunch)

For further information and to register contact:
Lynda Williams on email: **awhc@womenshealthcouncil.org.nz**