**Issue 105**

**May 2017**

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

Welcome to our May Newsletter.

In this newsletter

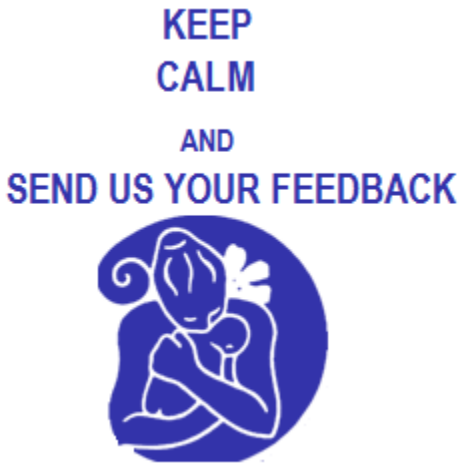
We have an updated timetable for our newsletter; a call for feedback from you, our consumers; an article on informed consent in childbirth; a write up on Birthcare Auckland ; a wonderful birth story shared with us by Sarah Sutton. Settle in with your beverage of choice and enjoy!

New Dates For Newsletters

After publishing our quarterly newsletter in March, June, September and December for a number of years, the MSCC has decided to change to our newsletter timetable. We know how busy December is for everyone, so with this in mind, we will be now producing our newsletter in February, May, August and November instead.

Call for Feedback

The Maternity Services Consumer Council is requesting help from the community we serve. Our organisation is grant funded and as many of you know gaining funding is becoming increasingly difficult. To ensure that our funding applications are successful we need to be able to provide evidence of "outcomes" in terms of contacts with maternity consumers. As our resources are mainly distributed via LMC's, CBE's and other organisations, we have little direct contact with the end user. We need you and your clients to contact us with stories about and feedback from women/families who have been supported or encouraged to make choices relating to their care, after reading our resources. Your support in providing us with some stories would be very much appreciated. Please email any feedback to mscc@maternity.org.nz



Birthcare Auckland by Holly Neilson

Right next to the beautiful Auckland Domain sits Birthcare Auckland, the only primary birthing unit available to women in the Central Auckland area. I recently went for a tour around Birthcare, and I am impressed.

A little bit of background, I have never used a primary birthing unit, I live on the North Shore of Auckland, so I birthed my babies at North Shore Hospital where I had two amazing natural births with my eyes closed trying to ignore the hospital-ness of it all. Living on the Shore I had assumed that I would not be eligible for funding and would have to pay to birth at Birthcare so didn't pursue this option. This is not the case, *if you are eligible for subsidized maternity care in NZ, birthing at Birthcare is free.* Since learning this I have spoken to a number of women, who, like me, had assumed that it costs to birth at Birthcare. It is *free*! However the post natal care, if you haven't birthed at birth care, and are outside of the ADHB region, does come with a cost.

The birthing rooms just took my breath away, four beautiful rooms designed with physiological labour in mind, three of these rooms come with a specially designed labour and birthing pools . For me, having only experienced a sterile hospital environment which was designed with high risk pregnancies in mind, Birthcare was an amazing change. A big bit of the difference between the two locations for me was a that the birth rooms at Birthcare had working curtains!- Such a simple thing but if you are labouring in the daylight hours, it matters. Each room is equipped with a number of other features that support physiological labour and birth. (A growing body of evidence shows that birthing in a primary setting, i.e. either a home birth or a birth in a primary birthing unit like Birthcare is the most important choice women wanting to avoid unnecessary interventions during labour and birth can make.) Another important feature is the on site kitchen, access to freshly prepared food sounded like heaven to me after hospital meals and no availability of anything except toast for hungry post labour mums if your baby doesn't happen to be born just before a scheduled mealtime.

There are three different options for postnatal care, however all the postnatal rooms are designed with mums and babies in mind. Post birth, women can stay at Birthcare for up to three days free of charge. The free postnatal rooms are twin shared so you may end up sharing with another mother and baby. If you birth at Birthcare you will have priority on a single room for your postnatal stay which allows the possibility of your partner/spouse staying in the room too. Women can pre-book and pay to use these single rooms without birthing at Birthcare. Birthcare also offers a premium postnatal room which is like a small hotel room and comes with a queen sized bed and other hotel-like facilities, at a cost of... All postnatal rooms have a direct dial phone so that women can contact the staff midwife providing their care, when they need support or assistance.

Having toured Birthcare, I came home with the urge to have a third child so I could experience it for myself! (Those pools just look so perfect for birthing, deep and relaxing.) In the event of a third pregnancy I may find it hard to choose between Birthcare and home! Or, I might just need to have a third and a fourth so I can experience both options...

Rebekah's Birth Story by Sarah Sutton

It was my due date with my second baby and late at night when contractions became regular but not strong. Then late the next afternoon I felt it was time to head into Birthcare. My independent midwife rang ahead to let them know we were on our way in. Upon arriving a lovely Birthcare midwife met us on the birthing level as my midwife hadn't yet arrived. She settled us into a room and my midwife joined us not long after. After a quick check and finding out I was sitting at 6cm, my waters were broken and things slowly progressed. Over the next few hours of walking the hallways around the birthing rooms and resting in our room, the contractions became stronger and closer. I felt walking was no longer helpful and was ready to hop into the birthing pool which had been prepared for me. I spent the final stages of labour in the birthing pool with gas for relief when the warmth of the water no longer was enough as the contractions intensified.

It was nearing 11.30pm when I felt like the contractions were unbearable and realized we must be nearly there. As it became time to push a Birthcare midwife came in and helped both my husband (replacing cool cloths) and my LMC midwife. It felt very calming and empowering having both midwives there and I felt a real sense of being able to have the birth I was hoping for, a birth where I could follow the leads my body was giving me without interference. At 11.57pm my little 7lb14oz girl, Rebekah, made her way into the world and was brought up to my chest ready to have her first feed. We cuddled and kept skin to skin throughout the third stage of labour, Rebekah suckling away to encourage the contractions. After the placenta was birthed and we'd had a few more cuddles I was shown to the connected bathroom to shower while the midwife checked Rebekah over and dressed her in her first outfit. After leaving the shower I was greeted by another friendly Birthcare staff member waiting with a wheelchair to whisk Rebekah and I off to our postnatal room and check whether there was anything I needed. I was given exactly what was needed after a long labour and a late night, a nice hot toasted sandwich, a cup of tea and lovely one on one personal care which continued throughout the rest of my 3 nights at Birthcare.

Correspondence with Dr Jonathon Coleman

In February this year, MSCC decided to write to all the parties ahead of the upcoming election to bring to their attention areas we felt needed addressing. The following is our correspondence with Doctor Jonathon Coleman, the current Minister of Health:

7th February 2017

Doctor Jonathon Coleman MP

Minister of Health

Parliament Buildings
Wellington

Dear Doctor Coleman,

The Maternity Services Consumer Council (MSCC) is writing to you to enquire about your parties goals with the incoming election year regarding maternity outcomes here in New Zealand.

**Maternal Mental Health**

Postnatal and perinatal depression here in New Zealand is our biggest cause of Maternal death. This is of great concern to us here at MSCC. According to the ninth annual report of the perinatal and maternal mortality review committee they found that suicide was the most common cause of maternal death from 2006-2013. The cause-specific maternal mortality ratio for deaths from suicide from 2006 to 2013 was seven times higher in New Zealand than in the UK 2006–2011, which present a serious concern for us here at MSCC.
We also noted that in the same report an outcome was found that the risk of maternal mortality increased significantly with increasing deprivation quintile in 2006–2013. The risk for women living in the most deprived 20 percent of residential areas from 2006 to 2013 was 2.4 times that of those in the least deprived 20 percent. With house prices rising and rental prices also rising we are concerned that the rising cost of basic amenities may cause our social deprivation numbers to increase and the effects of that flow on to the postnatal and perinatal depression rates.

**High Intervention rates**

The National Maternity Monitoring Group's (NMMG) Annual Report from 2016 notes that once again there has been a decrease in the standard women having a spontaneous vaginal birth. With intervention rates (induction of labour, instrumental birth and caesarean section) continuing to rise. This needs to be looked at, it may be worth looking at what has changed from 2002 where the numbers were lower for these. As answer to why this has changed may be found there. We here at MSCC want all mothers to have a positive birth experience with the lowest possible intervention rates as these may effect both Mum and baby long term in ways we don't yet understand. I have included an article from the New Zealand Herald about the unknowns of the long term effects of caesarean sections on the babies and evolution.

**26 For babies**

We have seen time and time again the importance of spending those early days with your babies. The health, social and economic benefits that stem from ensuring that each and every child has the best possible start to life in his/her first 1000 days of life are unarguable. Stable and secure attachment to an emotionally available care-giver is a foundation stone for physical, emotional and mental health lasting well into adult life. The Every Child Counts-Infometrics report in 2009 showed that poor outcomes for children cost the nation in the order of 3 percent of GDP or approximately $6 billion per annum. Early bonding and breastfeeding are important protective factors for good health outcomes. The current government says it is committed to improving the lives of children. Ensuring that parents can provide optimal care to their newborns in the earliest weeks and months is fundamental to achieving this. Parents who are adopting or those with primary care responsibilities for young children are entitled to adequate support to ensure the best start for children. We have obligations as a signatory to the United Nations Convention on the Rights of the Child (UNCROC) for policy and legislation that is in the best interests of the child. It is a discomforting fact that we are so ungenerous in our support of parents with babies and young children. Our policies lag well behind other OECD countries. This does not augur well for our future social, health or economic outcomes. The current provision of 16 weeks paid parental leave – increased to 18 weeks in 2016 - is very low when compared with other OECD countries. Sitting almost at the bottom of the OECD table for paid parental leave provision is unacceptable, unsustainable and unnecessary

New Zealand's paid parental leave provisions are among the least generous and least comprehensive in the industrialised world. The leave period of 14 weeks remained static from 2004 to 2015. Despite an increase of four weeks in Budget 2014, New Zealand still remains near the bottom of the OECD table on paid parental leave. The OECD average in 2014 stood at one year's paid leave. The United Kingdom provides Statutory Maternity Pay of 39 weeks at 90 percent of earnings. Canada offers 52 weeks of paid maternity leave.

All new mothers need an adequate level of care and support in the early weeks following the birth of their baby. Not having to stress about their job and money for the first twenty six weeks will aid this as will address the issues surrounding maternal mental Health and the high intervention rates we are seeing in birthing units around New Zealand.

We look forward to your response,

Yours faithfully,

Holly Neilson

**CO-ORDINATOR**

# Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation

**Member of Parliament for Northcote**


16 MAR 2017

Ms Holly Neilson
Co-ordinator
Maternity Service Consumer Council
mscc@maternity.org.nz

Ref. 1700192

Dear Ms Neilson

Thank you for your letter of 7 February 2017 about maternity outcomes in New Zealand.

I note your concerns about maternal mental health. The Ministry of Health recognises that the childbirth experience is a significant event of great psychological importance in a woman's life. During the perinatal period, women are at higher risk for the onset or recurrence of mental illnesses than at other times in their lives. Maternal mental illness can affect mother-infant bonding, which can lead to delayed social, emotional and cognitive development in the growing child.

For these reasons among others, the Government has an ongoing commitment to maternal mental wellbeing. In 2012, the Ministry published *Healthy Beginnings* to provide guidance to district health boards (DHBs), other health care planners and funders, as well as providers of health care services, on ways to address the mental health needs of mothers, caregivers, infants and their families. Budget 2013 allocated $18.2 million over four years to expand the range of options for acute maternal mental health care for people living in the North Island. Progress towards the full range of services outlined in *Healthy Beginnings* has led to an increased range of services being available, including inpatient services, individualised care packages, respite care as well as increased clinical responsiveness. A new dedicated inpatient unit is now available for mothers and babies in Auckland and there are a range of new and enhanced community-based options available across the North Island.

A further focus for the Government is to continue directing programmes to improve outcomes for children and youth. In September 2016, the Ministry published *Supporting Parents, Healthy Children*, which provides guidelines for mental health and addiction services to work in a family-focused way to ensure the wellbeing of children is everyone's responsibility. These guidelines also support the children of parents with mental health and addiction issues as

part of the direction set in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017.*

Investment has also been made in workforce development to ensure that the mental health and addiction workforce, in particular those working with mothers and babies have the necessary skills and competencies and are supported in their work. This is reflected in the *Mental and Addiction Workforce Action Plan 2017–2021.*

The *Service Coverage Schedule 2016/17* sets the minimum national service requirements for DHB services and specifies that:

> 'It is known that women with mental health problems – particularly women with a history of bipolar disorder, psychosis or postnatal/severe depression – are at risk of an escalation of symptoms during the pregnancy and postnatal period. Women who are identified as needing mental health services when pregnant or in the period after birth will be able to access appropriate services to meet their needs and keep themselves and their babies safe. It is expected that all women will have access to perinatal and maternal mental health services, DHBs can either directly provide specialist services, through trained staff in generic adult mental health services or provide access to specialist services.'

This schedule is publicly available on the Nationwide Service Framework Library website (www.nsfl.health.govt.nz) by searching for the title.

I appreciate your concerns about maternal suicide rates. The next suicide prevention strategy is being developed. It acknowledges the range of population groups at risk of suicide. Should the Maternity Service Consumer Council wish to provide input to this document, or be notified of the consultation draft release, the suicide prevention strategy team at the Ministry can be contacted by email (suicideprevention@moh.govt.nz).

The Ministry is approaching the issue of high intervention rates from both a national and a local level. At the national level, the Ministry is committed to upholding the *New Zealand Maternity Standards*, which recognise labour and birth as a normal life stage. Supporting normal birth has been identified as a priority within the Maternity Quality Initiative (2015–2018) under initiative one 'Strengthening Maternity Services'. The Ministry is planning to scope a project to support normal birth this year and intends to consult the Maternity Services Consumer Council as part of the planning stages of this project.

At the local level, every year the Ministry releases a New Zealand Maternity Clinical Indicators report that presents comparative maternity interventions and outcomes data for pregnant women and their babies. Data is presented by maternity facility and DHB region. Indicators include registration with a Lead Maternity Carer, type of birth, and rates of intervention among low-risk women. The Maternity Quality and Safety Programmes (MQSPs) in each

DHB, with support from the National Maternity Monitoring Group, use the clinical indicators to identify required areas of improvement within their region.

The MQSPs develop local initiatives and processes to improve their performance against identified areas. Initiatives to improve normal birth and reduce interventions, as outlined in the MQSP annual reports 2015/16, include:

- promotion of normal birth campaigns
- review of Induction of Labour Guidelines
- monitoring utilisation of, and undertaking community consultation on, primary birthing units
- holding antenatal appointments in primary birthing units
- investigating alternative therapies and education to support normal birth.

I also note your suggestion about extending paid parental leave in New Zealand to 26 weeks. While the Ministry of Health provides advice in this area when requested, paid parental leave policy decisions are the responsibility of the Ministry of Business, Innovation and Employment. I have forwarded your correspondence to Hon Paul Goldsmith, Minister for Tertiary Education, Skills and Employment, for his consideration.

Thank you for raising your concerns with me.

Yours sincerely

Coleman.

Hon Dr Jonathan Coleman
**Minister of Health**

cc Hon Paul Goldsmith
Minister for Tertiary Education, Skills and Employment
Parliament Buildings
Wellington

Enc

16th May 2017

Hon. Dr Jonathon Coleman,

Minister of Health,

Parliament Buildings,

Wellington, 1031

Dear Hon. Dr Coleman,

Thank you for your letter dated the 16th of March 2017 in which you describe the services etc that your Ministry has put in place with the aim of improving maternity outcomes in NZ/Aotearoa. While MSCC is pleased to see that the Ministry of Health (MoH) recognizes the significance of the long term effects that pregnancy and childbirth can have on women the programmes that have been put in place are simply not showing the results we would like to see.

Maternal Mental Health

New Zealand does have the 5th highest rate of female suicide in the world. The exact numbers of maternal suicides are hard to establish because the Ministry of Social Development's report, *The Social Report 2016,* does not record occupation so it is hard to get an accurate number of mothers committing suicide. It does however, show that this is a massive problem for New Zealand. MSCC also notes that the 2013 budget increases for acute maternal mental health care only covered the North Island, we must enquire about services available to mothers in the South Island?

MSCC was pleased to see you referenced the National Maternity Monitoring Group's (NMMG) Report in your reply. While we were pleased to see that this group has a focus on the promotion of normal birth in New Zealand, we are alarmed that the Maternity Clinical Indicators Report for 2015 states:-

**"**From 2009 to 2015, there was a statistically significant increase in the proportion of standard primiparae who had:

- an instrumental vaginal birth (indicator 3)
- a caesarean section (indicator 4)
- an induction of labour (indicator 5)
- an episiotomy without third- or fourth-degree perineal tear (indicator 7)
- a third- or fourth-degree tear and no episiotomy (indicator 8)
- an episiotomy and a third- or fourth-degree tear (indicator 9)

Conversely, there was a significant decrease in the proportion of standard primipare who had:

- a spontaneous vaginal birth (indicator 2)
- an intact lower genital tract (indicator 6)

And further that, “The proportion of term babies requiring respiratory support increased significantly from 2009 to 2015.”
It is obvious that the policies and resources allocated to Maternity Services during this time have failed miserably in reducing interventions in pregnancy, labour and birth, interventions that cost the country dearly in both monetary terms and in terms of short and long term health and wellbeing for both mothers and babies. The breastfeeding rate amongst women who have had a caesarean section is lower. Babies born by c-section miss out on exposure to vaginal maternal microbes, microbes that help kick start a baby’s immune system and that a growing body of research shows assist in disease prevention for life.

We appreciate that the National Government has set up the Maternity Quality Initiative, defined National Maternity Standards, gathered comparative data through the Maternity Clinical Indicators process, required the DHBs to set up Maternity Quality and Safety Programmes, continued publishing annual Reports on Maternity (although we are disappointed that the most recent of these available on the MOH website is 2014!). However none of these things have stemmed the rising tide of interventions into what is a normal physiological process for most women or the rising costs of these interventions.

You say that the Ministry is planning to scope a project to support normal birth this year. There is already ample evidence to show that one simple and cost effective way to reduce costly intervention into the birthing process is to have more women birthing in Primary Birthing environments like primary birthing units or at home. The MSCC has been lobbying for the establishment of more primary birthing units for decades and even on our own patch in Auckland, despite extensive “consultation” over the last 20 years, there is still no accessible primary birthing option for women in the urban North Shore or in West Auckland.

We do not need more consultation, more data gathering, more reports – statistics available to your Ministry already show that establishing (and upgrading existing) free standing primary birthing units in every DHB and a national campaign led by the Ministry to promote this birthing option would dramatically improve outcomes, decrease costs and probably lead to greater retention in our primary maternity workforce, midwives (another maternity issue that is fast approaching crisis point).

We look forward to hearing that your government has allocated and ring-fenced funding for the establishment and upgrading of primary birthing units, starting with the major urban centres where the intervention statistics are generally the most alarming and damaging to health of the current generation of mothers and the generation being born, prior to this year’s election.

If New Zealand can encourage healthy mothers to birth in primary settings leading to a reversal in the upward trend of intervention rates, we as a country could set a precedent for the rest of the world as we did in the 1990s when we introduced the LMC system that gave NZ women continuity of care throughout their maternity experiences.

Yours sincerely,

Holly Neilson

Co-ordinator

**MSCC Meeting Dates for 2017**

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 days in your diary and come along to our monthly meetings. You can be assured of a warm welcome.

We meet at 9.45am on the first Tuesday of the month, our meeting venue is either out West or in Central Auckland (Birthcare Auckland), so please contact the office to find out the venue. mscc@maternity.org.nz or Adith on 022 421 6008.

The meeting dates for the next six months are:

**6th of June, 4th of July, 1st of August, 5th of September, 3rd of October, 7th of November.**

Events MSCC is attending

Holly will be attending the 8th Biennial Joan Donley Midwifrey research Forum in Chirstchurch during October**.** The purpose of the forum is to provide an opportunity for midwives and others to share ideas, experiences and knowledge through research, audits and postgraduate studies relating to midwifery and maternity care. Tickets to this event can be found here: https://www.eiseverywhere.com/ereg/index.php?eventid=230313&

It is sure to be an amazing event