National Women's Annual Clinical Report Presentation Day 2017

Midwifery Commentary


ENOUGH IS
ENOUGH
I
CANNOT
KEEP CALM

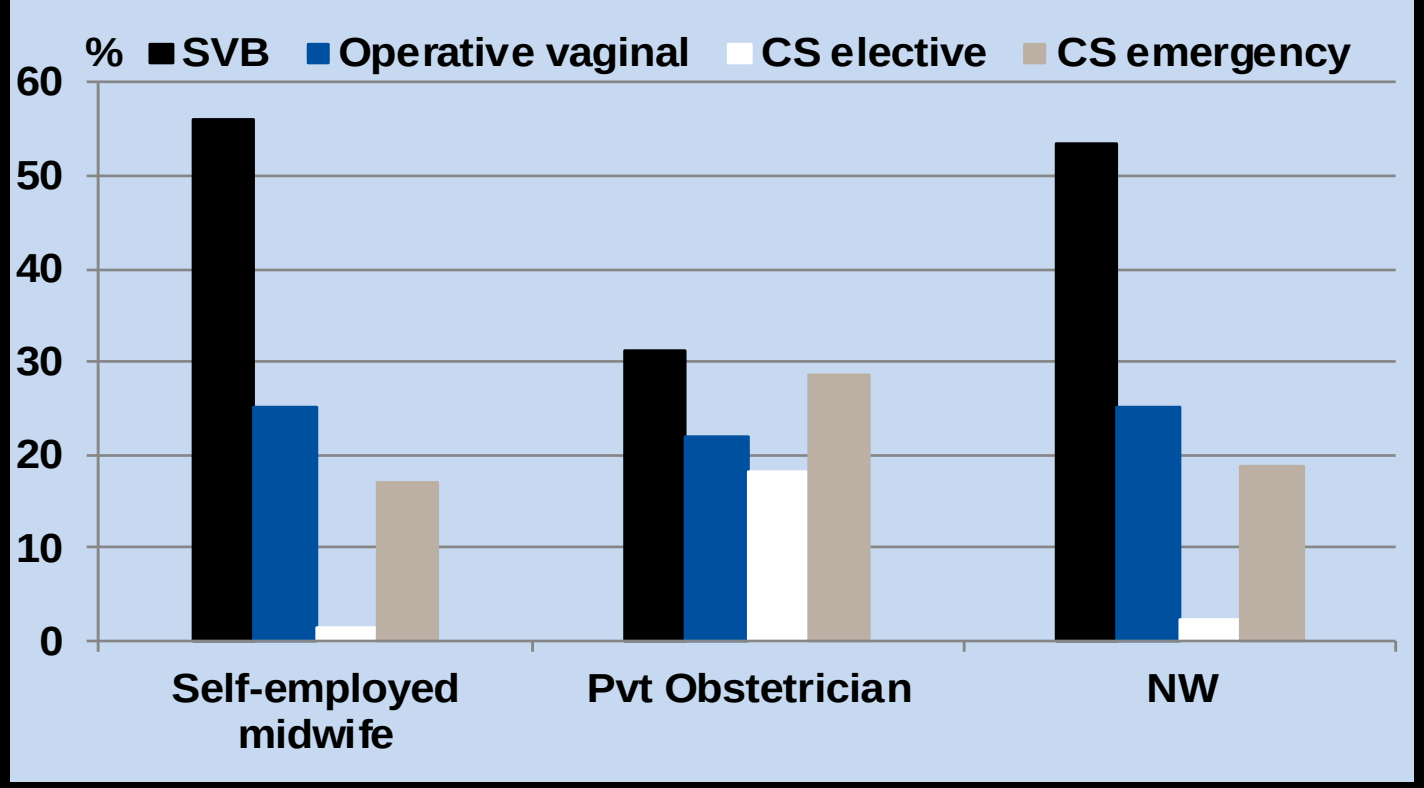
36% Caesarean section rate 2016

Standard primiparae spontaneous vaginal birth rate 55.1%

Nulliparous women 40.6% spontaneous vaginal birth in 2016

Standard primipare Caesarean section rate 19.6%

Figure 90: Mode of birth at term by LMC at birth among standard primipara NWH 2016

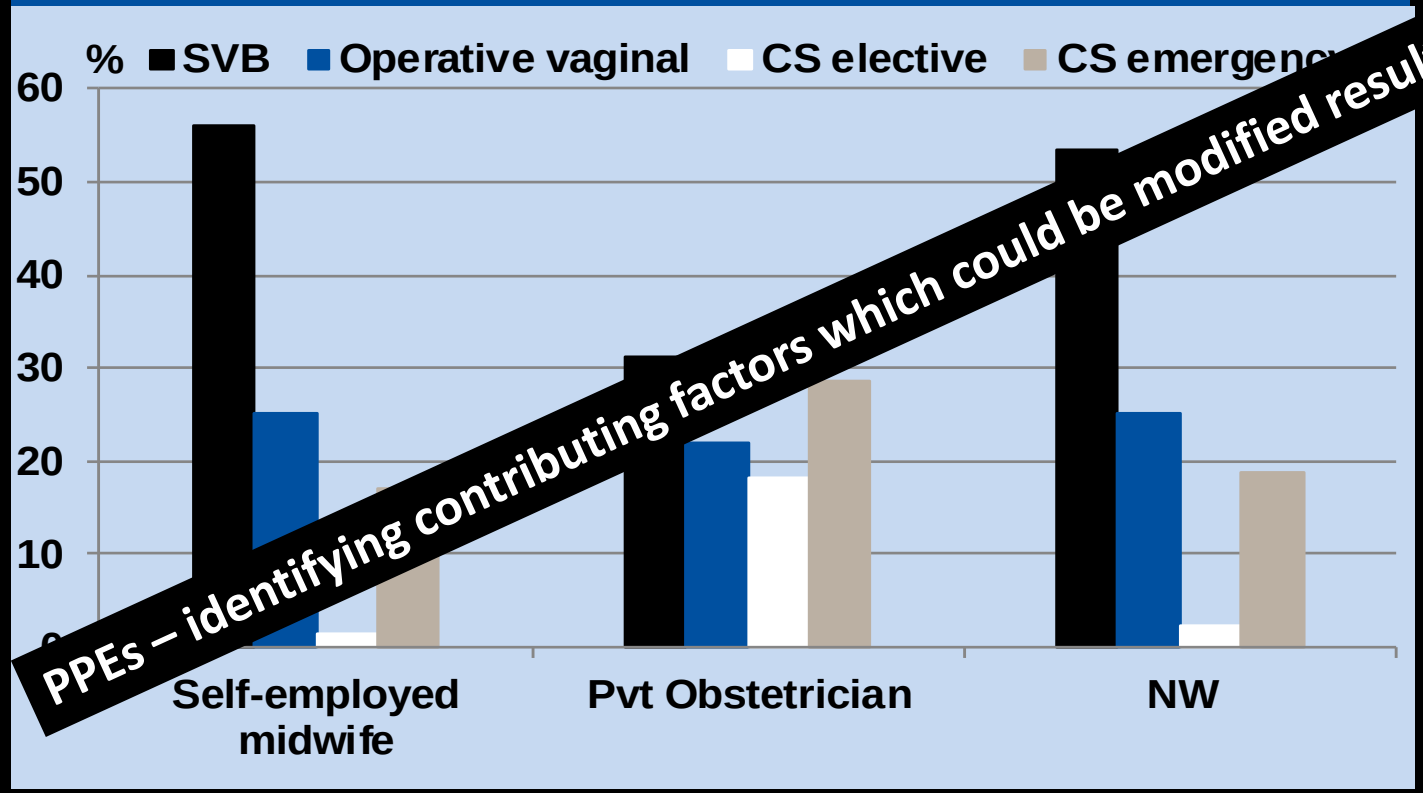


These data support the argument above that the drivers for higher Caesarean section rates among women under private obstetrician LMC care are non-clinical. Annual report 2017, pg 14.

Reframe increasing Cesarean section rates and decreasing Normal Birth rates as…

- Potentially Preventable events (PPEs) –are overtreatment, complications, unnecessary services, and harmful and inappropriate care.
- Contributory factors (modifiable components) are identified as these factors can be modified so as to led to a better or a different outcome

Figure 90: Mode of birth at term by LMC at birth among standard primipara NWH 2016



PPEs – identifying contributing factors which could be modified resulting in a different outcome

These data support the argument above that the drivers for higher Caesarean section rates among women under private obstetrician LMC care are non-clinical. Annual report 2017, pg 14.

Table 114: Primary indication for elective or pre labour emergency Caesarean section (all gestations) NWH 2016

	Total N=1739		Nullipara n=680		Multipara n=1059	
	n	%	n	%	n	%
Abruption/APH	20	1.2	7	1.0		
Diabetes	11	0.6	9	1.3	2	0.2
Disproportion	7	0.4	4		3	0.3
Failed Induction	85	4.9			22	2.1
Fetal Distress	152	8.7		15.4	47	4.4
Hypertension	38		29	4.3	9	0.8
Malpresentation			106	15.6	49	4.6
Maternal Age		1.0	15	2.2	2	0.2
Maternal Medical Condition	52	3.0	40	5.9	12	1.1
Maternal Request	181	10.4	131	19.3	50	4.7
Multiple Pregnancy	30	1.7	24	3.5	6	0.6
Obstetric History	34	2.0	9	1.3	25	2.4
Placenta Praevia ...hout bleeding	59	3.4	30	4.4	29	2.7
Repeat C... ...ection	734	42.2	0		734	69.3
Sp... ...tational Age	30	1.7	21	3.1	9	0.8
Ot... (please specify)	134	7.7	87	12.8	47	4.4

PPEs – identifying contributing factors which could be modified resulting in a different outcome

VBAC - a modifiable factor ?

Figure 93: VBAC rates among parity 1 term cephalic singleton previous Caesarean pregnancies – private obstetrician LMC 2006-2016

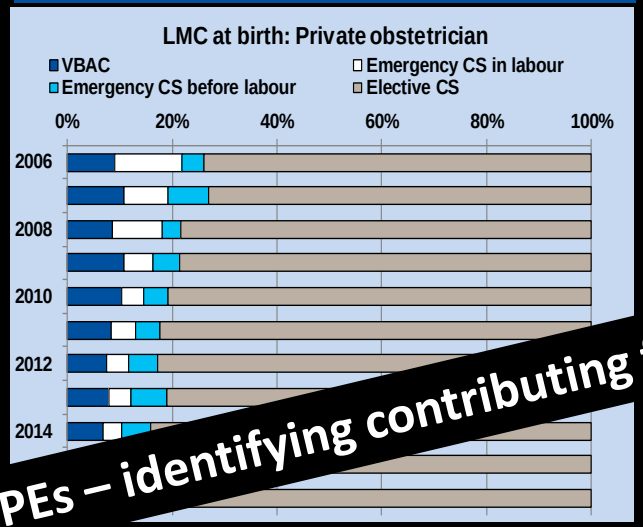


Figure 94: VBAC rates among parity 1 term cephalic singleton previous Caesarean pregnancies – Self-employed midwife LMC 2006-2016

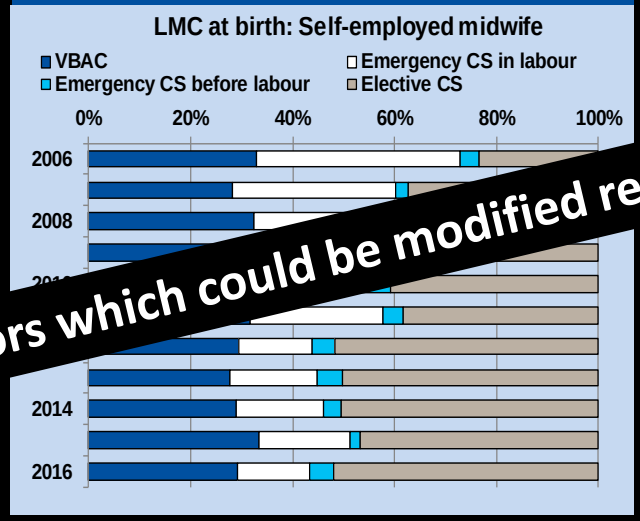
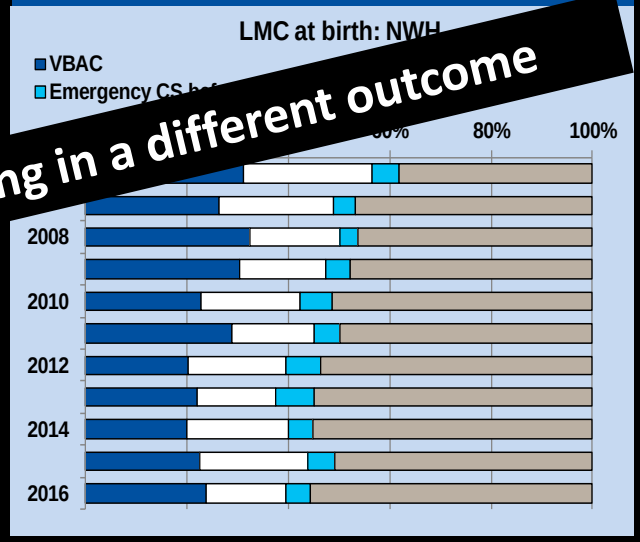


Figure 95: VBAC rates among parity 1 term cephalic singleton previous Caesarean pregnancies – NW primary maternity care 2006-2016



PPEs – identifying contributing factors which could be modified resulting in a different outcome

This comment is made in relation to Caesarean section rates.

The differences between women under private obstetrician and self-employed midwifery or NW Community service primary care are unlikely to explain the differentials in intervention rates, and these differences **are probably due to variances in the choices made by women and their LMCs** Annual report 2017 pg. 14

Maternal Request - a modifiable factor ?

Article

Feminism & Psychology

Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth

Feminism & Psychology
0(0) 1–18

DOI: 10.1177/0959353511424369
fap.sagepub.com
SAGE

A small rant…

Choice is situated in and shaped by social and cultural context and even pre-determined – by this context.

Women may be co-opted as advocates for many of the procedures of intervention that do not serve women well

This is not a reason to abandon choice, nor does it lessen the importance of choice that is informed. But, there is a need for rigorous analysis and detailed examination of the preconditions of choice in relation to childbirth.

Hypothesis: Young people growing up in countries where technology is part of their everyday life will prefer medicalised birth and associated procedures.

Prefer Vaginal Birth		
	Total	NZ
Full Sample	4083 (89.4)	**372 (90.5)**

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Opting for natural birth: A survey of birth intentions among young Icelandic women

Emma Marie Swift [a,*], Helga Gottfredsdottir [a,b], Helga Zoega [c], Mechthild M. Gross [d], Kathrin Stoll [e]

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUANTITATIVE

Home or hospital? Midwife or physician? Preferences for maternity care provider and place of birth among Western Australian students

Kathrin H. Stoll [a,*], Yvonne L. Hauck [b,c,1], Wendy A. Hall [d]

Table 106: Mode of birth by ethnicity NWH 2016

	Māori n=477		Pacific n=781		Other Asi		Indian n=735		European n=3038		Other n=304	
	n	%	n	%	n	%	n	%	n	%	n	%
Spontaneous vertex	292	61.2		57.9	1007	52.8	309	42.0	1367	45.0	151	49.7
Vaginal breech			6	0.8	14	0.7	4	0.5	15	0.5	3	1.0
Forceps	17	3.6	15	1.9	72	3.8	44	6.0	165	5.4	6	2.0
Ve	27	5.7	25	3.2	181	9.5	83	11.3	263	8.7	29	9.5
CS elective	53	11.1	70	9.0	319	16.7	103	14.0	678	22.3	59	19.4
CS emergency	80	16.8	135	17.3	313	16.4	192	26.1	550	18.1	56	18.4

PPEs – identifying contributing factors which could be modified resulting in a different outcome

Table 107: Mode of birth by ethnicity (nullipara) NWH 2016

	Māori n=172		Pacific n=270		Other Asian n=982		Indi…		European n=1536		Other n=127	
	n	%	n	%			n	%	n	%	n	%
Spontaneous vertex	79	45.9	158			43.9	144	33.5	549	35.7	48	37.8
Vaginal breech	2			1.1	5	0.5	2	0.5	6	0.4	0	0.0
Forceps			12	4.4	59	6.0	34	7.9	136	8.9	3	2.4
Ve…	22	12.8	18	6.7	152	15.5	68	15.8	214	13.9	22	17.3
CS …ective	13	7.6	8	3.0	89	9.1	34	7.9	226	14.7	20	15.7
CS emergency	44	25.6	71	26.3	246	25.1	148	34.4	405	26.4	34	26.8

PPEs – identifying contributing factors which could be modified resulting in a different outcome

Table 108: Mode of birth by ethnicity (multipara) NWH 2016

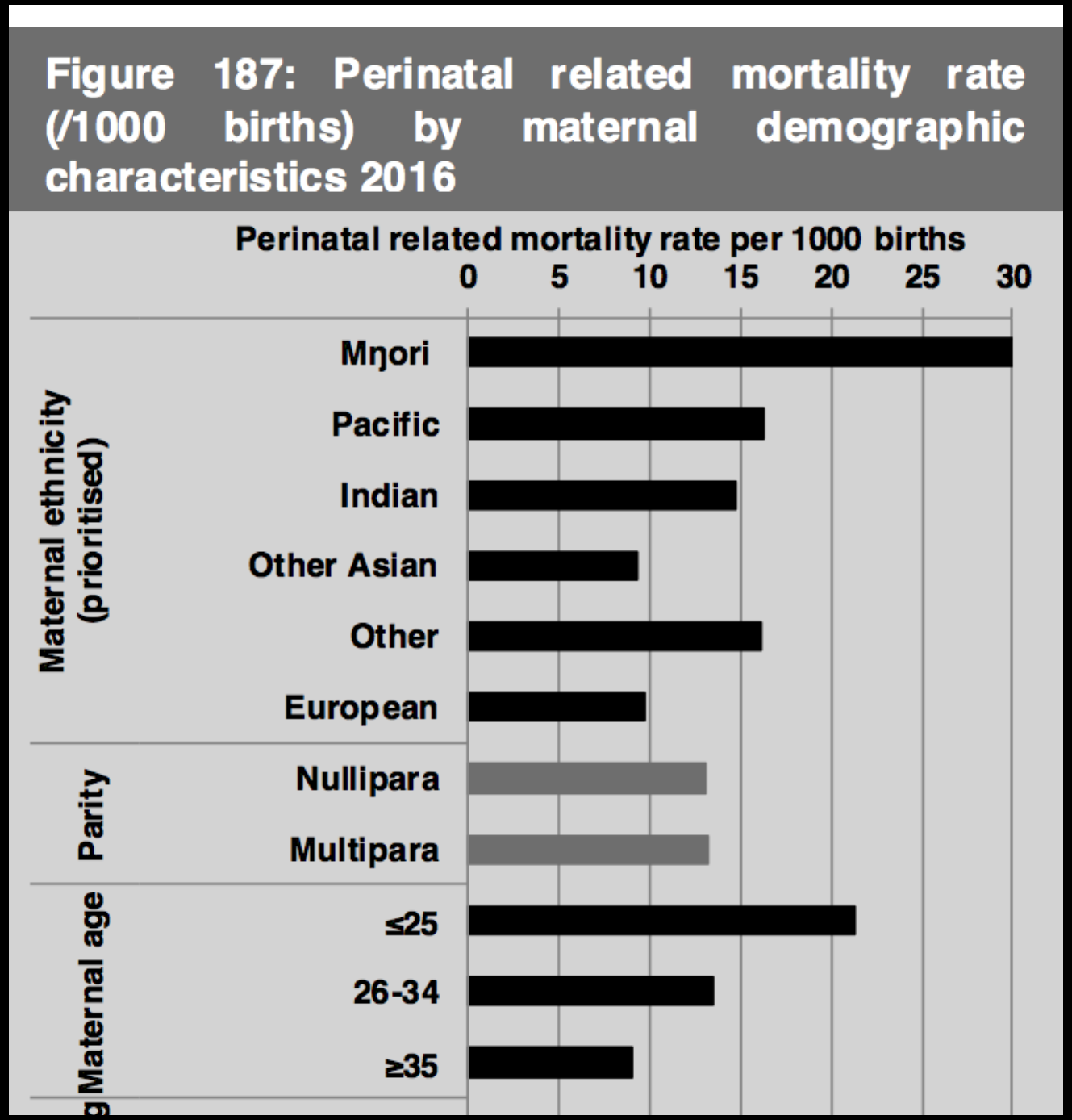
	Māori n=305		Pacific n=511		Other Asian n=924		Indian n=305		European n=1502		Other n=177	
	n	%	n	%	n	%	n	%	n	%	n	%
Spontaneous vertex	213	69.8	372	72.8	576	62.3	165	54.1			103	58.2
Vaginal breech	6	2.0	3	0.6	9	1.0			9	0.6	3	1.7
Forceps	5	1.6	3	0.6	13			3.3	29	1.9	3	1.7
Ventouse	5	1.6	7	1.4			15	4.9	49	3.3	7	4.0
CS elective	40	13.1	62			24.9	69	22.6	452	30.1	39	22.0
CS emergency	36	11.8			67	7.3	44	14.4	145	9.7	22	12.4

PPEs – identifying contributing factors which could be modified resulting in a different outcome

Profiling of European women from Annual report

- 51% of European women are having their first babies (Maori 36%)
- 30% of European women are over 35 years of age (Maori 14%)

- 2.5 % of European women smoke
- 65.6 live in Deprivation Quintile 1-3
- 28.3% live in Quintile 4-5 the most deprived
- 39.0 of European Women have a BMI >25 (lowest % other than Asian)



51% of European women Nullipara

30% of European women are over 35 years of age

Table 1: Maternal characteristics and perinatal related mortality NWH 2016

	Births		Stillbirths			Neonatal deaths			Perinatal related deaths		
	n=7368		n=66			n=31			n=97		
	N	%	n	%	SB rate*	n	%	NND rate‡	n	%	Perinatal related mortality rate†
Maternal smoking at booking											
Currently smoking	346	4.7	6	9.1	17.3	5	16.1	14.7	11	11.3	31.8
Not smoking	7021	95.3	60	90.9	8.5	26	83.9	3.7	86	88.7	12.2
Missing data	1		0	0.0		0	0.0		0	0.0	
Maternal BMI (WHO)											
<18.5	285	3.9	2	3.0	7.0	0	0.0	0.0	2	2.1	7.0
18.5-24.99	4063	55.1	35	53.0	8.6	8	25.8	2.0	43	44.3	10.6
25-29.99	1630	22.1	11	16.7	6.7	10	32.3	6.2	21	21.6	12.9
30-34.99	684	9.3	9	13.6	13.2	6	19.4	8.9	15	15.5	21.9
35-39.99	366	5.0	3	4.5	8.2	4	12.9	11.0	7	7.2	19.1
>=40	246	3.3	5	7.6	20.3	1	3.2	4.1	6	6.2	24.4
missing	94	1.3	1	1.5		2	6.5		3	3.1	
NZDep 2006 (quintile)											
1	1203	16.3	7	10.6	5.8	1	3.2	0.8	8	8.2	6.7
2	1337	18.1	11	16.7	8.2	5	16.1	3.8	16	16.5	12.0
3	1485	20.2	14	21.2	9.4	5	16.1	3.4	19	19.6	12.8
4	1454	19.7	13	19.7	8.9	7	22.6	4.9	20	20.6	13.8
5	1433	19.4	20	30.3	14.0	9	29.0	6.4	29	29.9	20.2
Missing data	456	6.2	1	1.5		4	12.9		5	5.2	

Stillbirth rate = number of stillbirths per 1000 birth/,Neonatal Death rate = number of neonatal deaths per 1000 live births/ Perinatal related mortality rate = number of stillbirths & neonatal deaths to 27 days per 1000 births/

∞

2.5 % of European women smoke

39% of European Women have a BMI >25

65.6 live in Deprivation Quintile 1-3

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"Too much, too soon" means care before, during and after childbirth that is too much, unnecessary, inappropriate, and possibly even harmful. It is one extreme of maternity care, with "too little, too late" at the other extreme end. "Too little, too late" means a lack of access to good quality care, or care that cannot be accessed quickly enough, and covers inadequate access to services, resources, or evidence-based care. Efforts to improve maternal health have traditionally focused on "too little, too late", but "too much, too soon" can also harm. "Too much, too soon" care is increasing everywhere as more women around the world give birth in health facilities.

Place of Birth

7241 women birthed in 2016

- 45% (1453) Nullipara women had spontaneous vaginal birth
- Multipara women 58% (1365) spontaneous vaginal birth
- 314 birthed at Birthcare

4.3% of women birthed in a primary setting

Potentially over 30% of women could have birthed in a primary setting

Care of the nulliparous woman in labour would **seem to be ripe for review in terms of setting and implementing evidence -based standards. These include attention to place of birth.** Annual report pg. 14


BMJ
BMJ 2011;343:d7400 doi: 10.1136/bmj.d7400 (Published 24 November 2011)
Page 1 of 13
RESEARCH
Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregna
Birthplace in England national prospective co
OPEN ACCESS
Birthplace in England Collaborative Group
DOI: 10.1111/1471-0528.13283
www.bjog.org
Intrapartum care
Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study
ht,[a] L Linsell,[a] A Macfarlane,[c] C McCourt,[c]
,[a] J Sandall,[e] L Silverton,[f] J Hollowell[a]
Journal List › J Perinat Educ › v.22(2); Spring 2013 › PMC3647739
The Journal of Perinatal Education
Advancing Normal Birth
A Lamaze® International Publication
J Perinat Educ. 2013 Spr
doi: 10.1891/
PMCID: PMC3647739
esearch—Implications of New Evidence
, RN, HV
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ew evidence from recently published research on maternity
England Research Programme was commissioned in 2007 to
those who plan, deliver, and use maternity services. These
ailability of different models of care; the ways in which
ttings; their comparative cost-effectiveness; and the
that might affect the quality and safety of care.
rth, safety
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Childbirth
Low-risk pregnant women urged to avoid hospital births
NHS guidance from National Institute
45% of births 'unsuitable'
NEW ZEALAND RESEARCH
Place of birth and outcomes for a cohort of low risk women in New Zealand: A comparison with Birthplace England
A retrospective cohort study to evaluate the
effect of 'Place Presenting in Labour' and
lodel of Midwifery Care' on maternal and
onatal outcomes for the low risk women
ng in Counties Manukau District Health
Board facilities 2011-2012
Annabel Farry

Labor in South Auckland free-standing birth centers was associated with significantly lower maternal intervention and complication rates than labor in the hospital maternity unit, and was not associated with increased perinatal morbidity.

Received: 1 June 2016 | Revised: 1 February 2017 | Accepted: 1 February 2017

DOI: 10.1111/birt.12287

ORIGINAL ARTICLE

WILEY

Birth outcomes for women using free-standing birth centers in South Auckland, New Zealand

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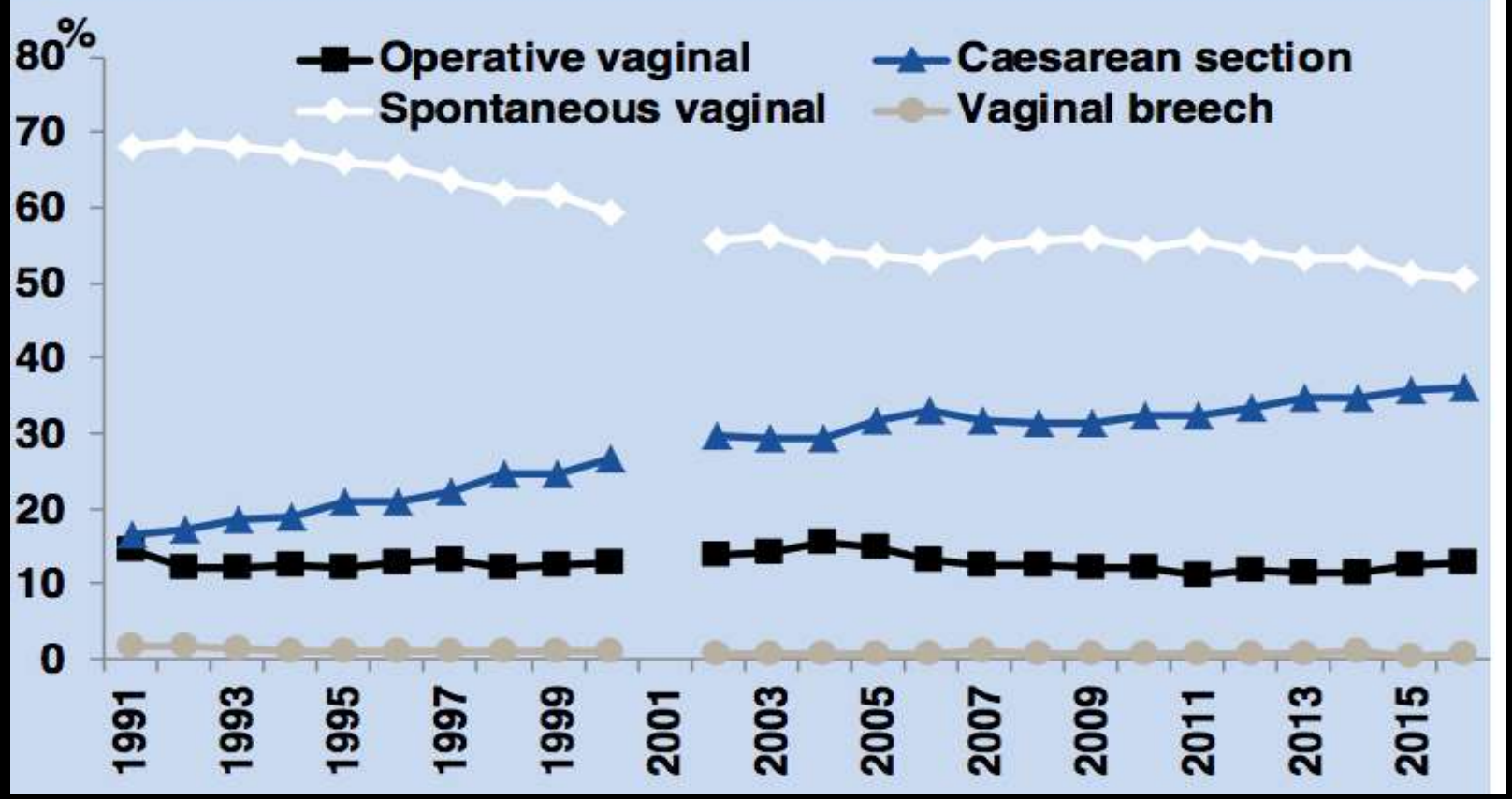
Correspondence
David John Bailey, Department of

Abstract

Background: This study investigates maternal and perinatal outcomes for women with low-risk pregnancies laboring in free-standing birth centers compared with laboring in a hospital maternity unit in a large New Zealand health district.

Figure 79: Mode of birth NWH 1991–2016



6.11 Labour and birth at Birthcare Auckland

Birthcare Auckland is a primary maternity hospital located 1km across the Auckland Domain from Auckland City Hospital. Birthcare is contracted by Auckland DHB to provide primary birthing and postnatal facilities. Birthcare is midwifery-led supporting LMCs to provide labour and birth. Birthcare provides postnatal care for women who birth at Auckland City Hospital and also to North Shore, Waitakere and Counties Manukau Hospitals. Birthcare has four birthing rooms and 45 postnatal beds.

Birthcare also provides free childbirth education classes, lactation consultant services, physiotherapy and classes. LMCs have access to rooms for antenatal assessment and care.

The data for mothers birthing at Birthcare were provided by Birthcare. The data in for mothers transferred to NWH in labour and birthing at NWH were extracted from the NWH clinical database Healthware. (Table 132 and Table 133)

PPEs – identifying contributing factors which could be modified resulting in a different outcome


We are the people that we
have been waiting for and
no one else is coming.
T.D. Jakes
quotefancy