

Women's Health Update

Maternal body weight and stillbirth: Implications of the Perinatal and Maternal Mortality Review Committee report recommendations for women's health

By George Parker

The recently released 8th annual report of the Perinatal and Maternal Mortality Review Committee (PMMRC) has focused, as one of its key recommendations, on the link between maternal body weight and stillbirth. George Parker, WHA Senior Policy Analyst, describes the report's findings and questions the impact in a maternity sector increasingly orientated towards the risks of higher maternal body weight.

The PMMRC is responsible for reviewing maternal deaths, pregnancy loss from 20 weeks gestation, and the deaths of all babies up to 28 days after birth, or weighing at least 400g if gestation is unknown. It advises the Health Quality & Safety Commission on how to reduce these deaths. According to the PMMRC there has been a significant reduction in stillbirths between the years 2007 and 2012, which is an encouraging trend.

This year for the first time, the Committee has included in its report the findings of a review of the National Maternity Collection (MAT) dataset, which has enabled analysis to determine the separate effects of the known predictors of stillbirth and neonatal death. The significant predictors were found to be: women who have a body mass index over 25 with the risk increasing as BMI increases; women who smoke; women of Indian ethnicity; and women having their first baby. The Committee notes that while stillbirths are often unexplained the identification of risk factors such as smoking and higher BMI, that are considered to be "modifiable", allows women to be given information to reduce their own risk of stillbirth. The Report's recommendation in relation to BMI states:

As high body mass index (BMI) at booking is an independent risk factor for stillbirth, public health initiatives to prevent obesity prior to pregnancy should be supported. Optimal weight gain according to BMI should be emphasised and

encouraged during pregnancy.¹

Referencing the Ministry of Health's newly developed Guidance for Healthy Weight Gain in Pregnancy,² the report goes on to advise that prior to planned pregnancy, Health Practitioners should discuss healthy nutrition and activity to support pre-conceptual health and recommend weight-loss for women whose BMI falls in the obese category. During pregnancy, BMI should be calculated at the first visit, recommended weight gain should be discussed and women should either be encouraged to weigh themselves regularly throughout pregnancy or be weighed at antenatal visits.

The PMMRCs focus on maternal weight as a "modifiable" stillbirth risk factor comes at a time when the impact of women's body weight on fertility, pregnancy and childbirth outcomes is receiving much scrutiny, resulting in maternal weight management and nutrition becoming a health priority in New Zealand. There has recently been a proliferation of research pointing to an association between high maternal body weight and a plethora of adverse reproductive health outcomes including infertility, miscarriage, stillbirth, congenital abnormalities, rates of caesarean section, postpartum haemorrhage, failed breastfeeding and neonatal unit admission.³ This research has been highly publicised in



Big Latch On event in Kaikoura, see article on page 3

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the media⁴ and has resulted in a range of changes to reproductive health care including the exclusion of women with a high BMI from publicly funded fertility treatment;⁵ BMI cut-offs for access to some primary birthing units; the inclusion of obesity in the maternity referral guidelines;⁶ and most recently the development of the Ministry of Health's Guidance for Healthy Weight Gain in Pregnancy and associated resources.⁷ This guidance urges a much greater focus in routine maternity care on women's weight and weight gain during pregnancy. There is also a general trend towards focusing health policy efforts to reduce levels of overweight and obesity in the population on interventions targeted at women during their reproductive years with the rationale that the cycle of obesity can be broken by tackling it at its point of origin - the womb. For example, the Healthy Eating Healthy Action programme funding, which targeted the general population, has recently been reallocated to Gravidia's Healthy Start Workforce Project.⁸

Efforts to reduce poor outcomes for mothers and their babies, including the tragedy of stillbirth, are of course important goals and the prioritisation of resources to meet this end are always welcome and a very worthy investment. However, targeting women's body weight as a modifiable risk factor for stillbirth and other poor reproductive health outcomes raises some important issues and questions that need to be explored.

According to the Ministry of Health and University of Otago 2011 report 'A Focus on Nutrition: Key Findings of the 2008/09 Adult Nutrition Survey', among New Zealand females aged 15 and over, 32.8% of females were classified as overweight (BMI >25) and a further 27.8% were classified as obese (BMI >30).⁹ Applying the PMMRC recommendation of stillbirth risk from a BMI 25 and above means the significant majority of New Zealand women are considered to possess a modifiable risk factor for stillbirth due to their weight. Which is fine if evidence supports the assumption that weight is indeed easily modifiable through information and behaviour change for all women before, during and after pregnancy. But does it? What do we know of such evidence and has it been critically examined? If there is not conclusive evidence that weight loss, or at least weight maintenance before, during and after pregnancy is a reasonable goal for most women then the vast majority of New Zealand women are dangerously positioned as at risk of blame (both from others and themselves) for stillbirth and other poor reproductive health outcomes, which are not as easily in their control as public health messaging might be making out. The well-established links between high BMI and deprivation,¹⁰ and the variation in average BMI between different ethnic groups¹¹ and age groups of women,¹² suggest that a person's body weight will never simply be a matter of choice.

Further, what do we know about how an increasing focus on maternal body weight

might interact with the already documented damaging effects of weight/size stigma and discrimination that currently exists in maternity care, and on women's body image and mental health adjustment during this significant period of change in their lives? A growing body of research is starting to recognise the dynamics of weight bias in maternity care and how it impacts on the care provided to women with high body weight, and in turn, on the reproductive health outcomes for these women and their babies.¹³ Women in these studies describe negative interactions with maternity care professionals relating to their weight including derogatory comments about and constant references to their weight even when such references seemed irrelevant to their maternity care.¹⁴ Participants described feelings of embarrassment, humiliation and guilt in the course of routine reproductive health care, especially at ultrasound appointments. Nyman et al¹⁵ found this intensified women's feelings of 'being less worthy of good care than other women who were not obese'. Women described their frustration at health professionals' assumptions that they eat poorly and don't exercise because they were a certain BMI, and the stigmatising effect of this.¹⁶ Some women also reported being treated in a 'sarcastic and negative manner' and being 'suspicious' of health professionals as a result.¹⁷

Weight bias, stigma and discrimination were found in these studies to contribute to some of the poor outcomes associated with high maternal body weight. Furness¹⁸ found that obesity stigma and health provider attitude had a negative impact on communication between midwives and women, in some instances resulting in the provision of poor or contradictory information for women. This was compounded by participants' reports that they avoided 'confronting healthcare professionals about humiliating treatment relating to their obesity, due to the fear of jeopardising their maternity care', meaning that women were

less likely to advocate for themselves to be active participants in decisions about their care.¹⁹ For some women, the fear of humiliating treatment meant avoiding or delaying seeking care altogether.²⁰ Participants also reported being labelled with a higher risk of medical complications because of their size and stereotyped as unlikely to be able to give birth normally.²¹ This led to their exclusion from low-risk care options that promote normality and low interventionist birth such as midwife-led care, birth in primary maternity facilities, and the use of water and other aspects of active birth.²² It also led to increased screening and surveillance, increasing the identification of abnormalities and potentially leading to a series of interventions. For example, women in Furber and McGowan's²³ study described a mandatory referral for an anaesthetic consultation during pregnancy because of their obesity, which they perceived was used to promote the use of epidural anaesthetic for labour to them. Smith and Lavender²⁴ suggest that the effect of medicalised maternity care for women labelled as 'obese' is to 'further increase the risk of a cascade of interventions in labour and birth with important implications for intrapartum and neonatal outcomes'.

These studies are largely United Kingdom-based and more research is needed on how New Zealand women experience maternity carer attitudes and practices related to body weight, particularly when they have a high BMI. What is clear, however, is that weight-related interventions with the goal of improving reproductive health outcomes for women and babies need to take into account the dynamics of weight stigma and discrimination. More research is also needed on women's experiences of trying to manage their weight before, during and after pregnancy to ensure public health advice is informed by, and relevant to, women's lived experiences.

Footnotes for this article are available online at: <http://www.womens-health.org.nz/resources/womens-health-update/>

La Leche League 50th Anniversary Conference

By Isis McKay

Women's Health Action's Maternal and Child Health Promoter recently attended the La Leche League 50th Anniversary Conference "Breastfeeding Support: Our Foundation, Our Future – Te Tautoko Whakangote: To matou tuapapa, haere ake nei".

The conference took place at the Waipuna Conference Centre in Mt Wellington over three days. The event was well attended with a mixture of La Leche League members and alumni, physicians and other breastfeeding supporters present.

In addition to some amazing international and national speakers, the new book *Latching On* was launched during the conference. *Latching On* covers the 50 year journey of

La Leche League in Aotearoa New Zealand. Written by freelance public historian Louise Shaw, this is much more than a 'who said what, where and when'; it is a valuable insight into the history of breastfeeding in New Zealand and the societal context La Leche League grew up in.

There was also a short screening of the new DVD *Finding the founder, a birthday tribute*. This DVD included interviews with remaining founding members of La Leche League International and historical video footage. This was a fascinating account of the history of La Leche League both internationally and nationally.

Contact admin@lalecheleague.org.nz for information on how to purchase the *Latching On* book and the *Finding the founder* DVD which includes extended interviews and footage.

The Big Latch On 2014: Launch of the breastfeeding selfie

By Holly Coulter

This year marked ten years of the Big Latch On, the annual event co-ordinated by Women's Health Action to build community support for breastfeeding. Once again, a new record was set with 1628 latches across Aotearoa New Zealand.

Each year since its inception, participation in the Big Latch On has grown, not only by breastfeeding mothers and their children, but also their partners, whanau and friends. Peer and community support has been shown to be important in initiating and continuing breastfeeding, with research indicating a lack of support by family and friends is a significant barrier to breastfeeding.¹

The Big Latch On aims to promote breastfeeding by encouraging people across New Zealand to host their own Big Latch On event to provide community support for breastfeeding women in their area. This year there were Big Latch On events held in 114 venues throughout the country over two days.

While past Big Latch Ons have focused on building support for breastfeeding within local communities, research has shown the merit of online communities in providing breastfeeding support, with evidence that breastfeeding campaigns utilising technology may be more effective in changing breastfeeding behaviour.² With this in mind, this year in addition to the physical Big Latch On events, the 'I latched on' breastfeeding selfie campaign was launched.

The selfie initiative enabled women and babies who could not make it to an event to participate online, by sharing a photo of themselves breastfeeding on Facebook. Over the official period of the Big Latch On, over 150



Teesha Thompson's selfie.

selfies were sent in, and many more were received after the official count.

Reported experiences of participation in the selfie campaign were overwhelmingly positive. Almost every participant (97%) said they would take part in the selfie campaign again in the future.

The majority (86%) of participants indicated that taking part had a very positive or positive impact on how supported they feel breastfeeding. Comments included 'This is [an] important way of reaching young Māori mamas and whanau' and 'the support is important for people who don't feel confident enough to feed in public. Just like

fighting for the right to vote this has to be done!'

There is also evidence that the selfie campaign played a role in increasing connectedness to other breastfeeding mums and supporters, with 91% of participants saying that it had either a very positive or positive impact. Through sharing their breastfeeding selfies on Facebook, women were able to connect not only with others already taking part in the Big Latch On, but also breastfeeding supporters within their own networks. This could enable them to identify new sources of peer support, both online and in person.

The introduction of online participation in the Big Latch On is designed to coexist with the physical participation, rather than replacing it, as a way of creating more ways for women to feel supported and connected while breastfeeding.

Several of those who took part in the selfie campaign indicated that they had planned to attend in person, but were unable to at the last minute, and were glad of the selfie option to still take part. One participant stated 'If you're from a small town having access to a BLO event is difficult... Having an alternative to being at the event in person is awesome. It's also great for mums who have newborn babies or sick little ones.'

84% of those who participated in the 2014 selfie campaign said they would like to attend Big Latch On events in person in the future, indicating the ongoing importance of the physical Big Latch On in providing breastfeeding support within local communities, and the role of the online option in complementing this.

A full evaluation report of the Big Latch On 2014 by the University of Auckland School of Population Health will be available early next year.

Footnotes for this article are available online at: <http://www.womens-health.org.nz/resources/womens-health-update/>

Mesh Update

By Dr Sandy Hall

Since 2012 Women's Health Action's Policy Analyst, Dr Sandy Hall, has been investigating surgical mesh, including liaising with consumers, reviewing the latest research, and engaging with various government agencies to discuss addressing the concerns about mesh.

Over the past year, Women's Health Action has been in contact with the Health and Disability Commission (HDC) to provide them with information about mesh surgeries in Aotearoa New Zealand and to engage HDC support, particularly around issues of informed consent and patient safety, as well as the monitoring of medical devices.

At an October meeting with Women's Health Action and consumer advocates Carmel Berry and Charlotte Korte, Health and Disability

Commissioner Anthony Hill expressed his concern about these issues and confirmed he had approached the relevant surgical colleges about informed consent. The Commissioner has also engaged with ACC and is awaiting the outcome of their audit of mesh surgery treatment injuries due out early next year. Commissioner Hill expressed his interest in working with other agencies on this issue.

Meanwhile, the new Minister for Health, Hon Dr Jonathan Coleman, has been briefed on the concerns around mesh and has had a series of questions posed to him in the house which he will respond to in time.

Women's Health Action continues to urge for specific informed consent processes for patients considering mesh surgery with information about the risks involved and the alternatives available, and for information about surgeons' training and experience in mesh surgeries to be publicly accessible.

The continued hard work of Carmel Berry and Charlotte Korte in highlighting concerns with surgical mesh and advocating for improvements to patient care is to be congratulated.

Women's Health Action hopes both the involvement of the HDC and the Health Select Committee will lead to a situation where a proper informed consent process is developed, only well-tested and researched products are used, and expert services for mesh removal are provided to patients who suffer complications.

Correction

Women's Health Action would like to note an omission from the prior issue of Women's Health Update (September 2014). Author of "Abortion: an impossible choice?" Jade Le Grice, would like to thank and acknowledge Dr. Tim McCreanor for his assistance.

Update on the Maternity Quality and Safety Programme *By Isis McKay*

The Ministry of Health launched the Maternity Quality and Safety Programme (MQSP) in 2011 as part of its Maternity Quality Initiative. WHA's Maternal and Child Health Promoter, Isis McKay, reflects on the implementation of the programme and where to next.

At the national level, the programme consists of specific national tools to guide the provision of maternity services, including the New Zealand Maternity Standards and New Zealand Maternity Clinical Indicators. At the local level, the New Zealand Maternity Standards and Clinical Indicators underpin a programme of ongoing, systematic review by a local multidisciplinary team that works together to identify ways that services and care can be improved, and works to implement those improvements.

Since the launch in 2011 the MQSP has been implemented to varying degrees in all 20 DHB regions. The aim of MQSP was to bring together professional and consumer stakeholders to collaboratively monitor and improve the delivery of maternity care within the each DHB region. It was intended that the MQSP would broaden the scope and visibility of maternity quality improvement activities that were already in place in DHBs.

The elements required for implementing the Maternity Quality and Safety programme at DHB level are:

- Governance and clinical leadership
- Systems for sharing information

- Data monitoring
- Management and administration
- Clinical networking
- Consumer engagement
- Quality improvement

The Ministry of Health provided establishment funding for each DHB region to implement the above required elements, with the expectation that the programme would be absorbed into DHBs budgets as business as usual within two years. The establishment phase will come to an end in June 2015.

In August this year the regional MQSP consumer members were invited to attend a consumer forum held by the Ministry of Health. It was evident that a number of DHBs were still in the early stages of establishment, especially when it came to the consumer engagement element of the programme. The consumer members expressed a strong desire to continue their engagement with the MQSP, citing a number of improvements that have been made through their involvement in the programme.

The Ministry of Health recognises the importance of the programme and has set up the MQSP Expert Advisory Group (EAG) to support the Ministry of Health and an evaluation provider with expert advice and guidance to deliver a robust and meaningful evaluation of the MQSP.

The group comprises of eleven Ministry of Health appointed members with appropriate expertise in relation to the maternity sector,

including Women's Health Action's Maternal and Child Health Promoter appointed as one of two consumer representatives.

The EAG will represent their constituencies' perspectives with regard to maternity quality and safety evaluation priorities and provide expert review of evaluation documents including the MQSP logic model, draft evaluation findings, interim and final reports. The group will also be responsible for supporting the development of recommendations as a result of the findings of the evaluation.

The evaluation team will seek to engage with a range of stakeholders to understand their views and experiences of the MQSP. This includes national level stakeholders, such as health agencies and professional bodies, and local MQSP stakeholders, such as local midwifery and clinical leaders, community organisations and consumers in quality and safety governance structures.

The term of the EAG is one year from 1 October 2014 to 30 September 2015, with evaluation expected to be completed by the end of June 2015. The EAG will not be responsible for determining the future direction of the MQSP or the government's allocation of funding to the MQSP now or in future.

More information on the Maternity Quality Safety Programme can be found on the Health Improvement & Innovation Resource Centre website at <http://www.hiirc.org.nz/section/20254/maternity-quality-and-safety/?tab=5057>.

NOTICEBOARD

WHA Resources can now be ordered online

WHA pamphlets such as 'Third Stage of Labour', 'Ultrasound scans during pregnancy', and 'Vitamin K - Does my baby need it?' as well as breastfeeding resources, can now be purchased directly through our website. To order, visit www.womens-health.org

WOMEN'S STUDIES ASSOCIATION (NZ) SUMMER SCHOOL

23-26 JANUARY, KERIKERI

The theme for the summer school will involve looking at Māori and Pākehā women talking together two hundred years ago and talk between Māori and tauwi women today. <http://www.wsanz.org.nz/>

GENDER AND SEXUAL POLITICS FREE SYMPOSIUM

28 JANUARY, VENUE TBC

Speakers include Ann Cahill and Michael Flood. <http://www.sexualpoliticsnow.org.nz/projects/public-events/>

THE 2ND ANNUAL WOMEN IN LEADERSHIP SUMMIT

17-18 FEBRUARY, AUCKLAND

A leadership development and networking platform designed to explore effective leadership strategies,

share inspirational stories and provide critical tools for women's leadership success. <http://www.eventfinder.co.nz/2015/the-2nd-annual-women-in-leadership-summit-2015/auckland>

THE 2ND PUBLIC SECTOR WOMEN IN LEADERSHIP SUMMIT

24-25 FEBRUARY, WELLINGTON

Professional development and networking opportunity for existing and emerging female leaders across the public service. <http://www.eventfinder.co.nz/2015/the-2nd-public-sector-women-in-leadership-summit/wellington>

14TH AUSTRALASIAN CONFERENCE ON CHILD ABUSE AND NEGLECT

29 MARCH - 1 APRIL, AUCKLAND

This conference will consider how to respond cross-sectorally and collaboratively to best prevent and address the complexity of child abuse and neglect, exchange ideas, practices, knowledge and expertise and develop a shared understanding between those of different professional backgrounds, cultures and locations.

<https://www.etouches.com/home/index.php?eventid=95484&>

HOME AND COMMUNITY HEALTH ASSOCIATION CONFERENCE

28-30 APRIL, AUCKLAND

The conference will explore the challenges and opportunities of changes occurring in home and community services as a result of consumer and cultural needs; demographics and choices; and strategy around workforce, community supports and integration. <http://www.hcha.org.nz/conference-2015>

EARLY NOTICE FOR ALCOHOL AND CANCER CONFERENCE

17 JUNE, WELLINGTON

Conference organised by Alcohol Action NZ and the Cancer Society of New Zealand, addressing epidemiological, biological and clinical aspects of the link between alcohol and cancer. <https://www.rnzcgp.org.nz/events/details/680>

NO 2 BULLYING CONFERENCE

29-30 JUN, QUEENSLAND, AUSTRALIA

Australian & New Zealand Mental Health Association's third annual Bullying Conference. The Conference will address bullying policy, prevention and management strategies and will examine bullying in schools, workplaces and cyberspace. <http://no2bullying.org.au/>



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