New Zealand
College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

18 January 2019

Child and Youth Wellbeing Strategy: Health Sector Engagement Workshops Feedback

Feedback from: New Zealand College of Midwives
PO Box 21 106
Christchurch 8143
Tel (03) 377 2732

The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent 90% of the practising midwives in this country. There are around 2,900 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to, on average, 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby.

Midwives undertake a four-year equivalent undergraduate degree to become registered followed by a first year of practice program that includes full mentoring by senior midwives. The undergraduate curriculum meets all international regulatory and education standards. Midwives are authorised prescribers in relation to their Scope of Practice as determined by the Midwifery Council.

Midwives provide an accessible and primary health care service for women in the community within a continuity of carer model as Lead Maternity Carers. Midwives can also choose to work within secondary and tertiary maternity facilities, providing essential care to women with complex maternity needs.

The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and wellbeing.

New Zealand College of Midwives
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18 January 2019

Department of the Prime Minister and Cabinet
Wellington
childandyouthwellbeing@dpmc.govt.nz

Child and Youth Wellbeing Strategy: Health Sector Engagement Feedback

The New Zealand College of Midwives (the College) appreciates the opportunity to provide further feedback on the Child and Youth Wellbeing Strategy following attendance at a health sector workshop and a review of the feedback from all workshops. We would like to make the point that this submission supports the original submission we made on the Child and Youth Wellbeing Strategy and both documents should be taken into account.

As the College noted in our original submission in 2018 the wellbeing of mothers is integral to the wellbeing of infants and children. What is required as the very basis of infant and child wellbeing is support for maternity services. Midwifery continuity of care has been shown to contribute significantly to maternal wellbeing. Ensuring that mothers are thriving and that pregnancy, birth, and transition to motherhood experiences are positive and fulfilling is of great significance.

Midwives have an important function in terms of public health protection, preventative care, health promotion and support. Health care engagement between a pregnant woman, her partner and whānau, may represent one of the lengthiest health care engagement periods which makes midwifery continuity of care provided within a partnership model significantly important to any infant and child wellbeing strategy. Continuity of midwifery care has demonstrated benefits for improved pregnancy outcomes.

Executive Summary

The College hopes for significant social change, with the use of evidence-based policies, and the necessary political will to address issues of inequity, and within this summary we have re-highlighted what we consider to be the key points in our submissions:

- Acknowledgment of midwifery as a preventative health service which impacts positively on maternal, infant and child wellbeing.

- Acknowledgment that support for health professionals' (midwives and well child) home visiting services, and childbirth / parenting education, are strongly evidence-based in terms of having positive influences on infant wellbeing in the first year.

- Recognition of the evidence of home visiting as a positive health strategy, recognition of the time needed need for home visits, and the need for adequate resources to provide this service.

- Midwifery needs more support / resourcing / funding to enable midwives to respond to women with higher needs, and to continue to provide quality services to all women.

- The inclusion of the protection, promotion and support of breastfeeding within an infant and young child wellbeing strategy is essential

- Acknowledgment of the pregnancy / labour and birth/ and postnatal periods as crucial to the establishment of bonding / attachment, and the evidence linking this to short and long-term infant, child and maternal wellbeing.

- Acknowledgment of the importance of birth in primary maternity units for well women, the availability of well-resourced secondary hospitals for women with complex medical needs, and the positive contribution of these services to infant, child and maternal wellbeing.

- The need to increase support for maternal mental health services, including access to funded education for midwives.

The College feedback on the draft of sector feedback for discussion is below.

1.0 Current barriers to child and youth wellbeing (4.1 – page 13-32)

1.1 The College considers that a major barrier to wellbeing for infants and young children is the lack of funding and support for midwifery services. We are fortunate that the New Zealand maternity model of care enables women to access midwifery care free of charge. However, over the last decade under the approach taken by the previous government, community midwifery services were denied increases in funding to compensate them for the increased costs associated with service delivery. In addition to this, the current funding model for primary maternity services (the Section 88 Primary Maternity Services Notice) funds a 'one size fits all' approach which does not allow community midwives to access additional funding for women who have greater needs. This lack of resourcing has seen a decline in the number of midwives, meaning that some women are unable to access midwifery care.

1.2 Women who are less likely to engage in care are from population groups who are more likely to experience inequitable outcomes, thus further entrenching inequities, as these women are unable to access the benefits associated with continuity of midwifery care.

1.3 There is accumulating evidence of an urgent need to improve working conditions for midwives, in both the hospital and community sectors.

1.4 The College notes that equity and inequity are included within the current barriers section of the feedback document. Gender inequity remains unrecognised in terms of action to address these issues effectively. We remain concerned that women's unpaid work is undervalued and this includes breastfeeding and child care.

1.5 As the College noted in our original submission, any wellbeing or health promotion strategy is unlikely to be effective where there are conditions of serious inequity, hardship and poverty, despite the best of intentions. Parenting requires support, and attention to issues of inequity and poverty represent a good opportunity to really make a positive difference for parents, families and whānau. Socioeconomic and environmental conditions need to be addressed urgently within the development of any strategy concerned with wellbeing, as inequity represents the context in which we are aiming to make positive changes.

1.6 In regards to the point above and reflecting on the section on poverty and social determinants of health in the feedback document, the College would also like to see recognition of the commercial determinants of health. As noted by the WHO Director-General Margaret Chan, efforts to prevent non-communicable diseases and improve population health are in direct opposition to business interests.[1] Kickbusch et al. in the Lancet note that corporate influence is exerted through four channels, marketing to enhance the desirability and acceptability of unhealthy commodities; lobbying which can impede policy barriers; corporate responsibility strategies which can deflect attention and whitewash reputations; and extensive supply chains which amplify corporate influence. [2] Continued work to counter corporate influence is necessary to achieve infant, child and youth wellbeing.

1.7 The College recommends that during the further development of the wellbeing strategy there should be the avoidance of focus on individual behaviour change and a move towards recognition and acknowledgment of the inequalities within society, the challenges experienced by many parents, and the pervasive marketed influence of products and 'choices' that are detrimental to health.

1.8 Funding issues were identified as barriers within the feedback. The College acknowledges ongoing funding challenges for Māori and iwi organisations within Crown funding and contracting practices, which were identified by Came et al. in 2015, as "a contemporary breach of Te Tiriti o Waitangi and a colonial legacy of missed opportunities to improve Crown practice."[3] We would also suggest that inequitable funding occurs for women's groups and work with a main focus on women's issues. The College also feels that work which includes home visiting, which has been shown to be effective for whānau support, is also unrecognised, under-supported and underfunded.

1.9 The College agrees with the feedback suggesting that high administration costs significantly, and possibly unnecessarily, reduce the available contract funding which could be spent on frontline services, and also that contract service specifications may be restrictive and focused on rigid targets which may not deliver meaningful results. Short term contracts, which Came et al. found were often given to Māori organisations, also represent a barrier to longer-term impacts. The College agrees that inflexible contracts that do not focus on the best care for individuals and communities ae unduly bureaucratic and present barriers to innovation. The College also does not entirely agree

[1] WHO. (2016). WHO Director-General address, 8th Global Conference on Health Promotion, Helsinki. Geneva, WHO.
[2] Kickbusch, I., Allen, L., & Franz, C. (2016).
[3] Came, H., Doole, C., Lubis, D., & Garrett, N. (2015). *Benchmarking Crown Practice: Public Health Contracting and Funding. Preliminary report for public health providers*. Auckland University of Technology, Massey University, Keruru Research and Evaluation Associates

that innovative new approaches should always be prioritised over existing programmes. Not allowing time for programmes to develop, or providing sufficient funding to safeguard programme fidelity, reduces both programme effectiveness and sustainability.

1.10 The College would also like to support the feedback in relation to the negative effects of competitive funding models. This not only inhibits collaboration but in the midwifery context it can delay implementation of programmes. One example is the rural midwifery locum service which relies on the professional and personal networking between midwives and their connections with what is a very mobile workforce. There is only one natural provider for a midwifery locum service and that is the profession.

1.11 The College also considers that medical focussed contracts are prioritised over others and yet have less impact in infant and child wellbeing, maternity, well child, mental health and drug and alcohol addictions. Wellbeing is the focus of maternity and well childcare and this requires a different lens than medical services where people present in the main with a health *problem*. Health wellbeing requires the promotion of self-determination, and improved personal health knowledge to prevent the need for medical intervention.

1.12 There was feedback about services that do not focus on building authentic and meaningful relationships with clients and whānau. The College would like it noted that midwives provide relational care and continuity of care within their partnership model but that this evidence-base practice has been undervalued, under-supported and underfunded.

1.13 The feedback highlighted that a kaupapa Māori approach is more time consuming and that funding needs to take this into account. The College also feels that all effective public health preventative services are time consuming, particularly those that involve home visiting services, and we would like to see this factored into the finished report and strategy.

1.14 In regards to the issues of non-attendance at paediatric clinics the College considers that there are numerous issues including location, accessibility, cultural appropriateness and affordability. Home visiting and the restoration of community-based locations for paediatric clinics need to be supported. This would also support the identified overarching strategy of 'closer to home; in ensuring the appropriate care is provided in the appropriate place at the appropriate time.

1.15 In regards to data collection and measurements, the College would like it noted that the Midwifery and Maternity Providers Organisation (MMPO) are working with Plunket Well Child Services on this issue despite any resources from the government because the need is so great.

1.16 In respect to the education barriers, the College notes that there is extremely limited access to appropriate childbirth education that meets the needs of all parents and parents to be. We recognise that greater support is necessary for fathers but would like to emphasise once again that programmes still require focus and support for mothers as not all men are supportive or present in families.

1.17 The College supports the call for more services and better support for women with postnatal depression. We consider that access to and provision of free pregnancy and parenting education, midwifery care, contraception and reproductive services, well child services, and mental health services are part of the stated project of wellbeing.

1.18 The College would like to emphasis again the importance of midwifery care, continuity of midwifery care enabling relationship development, home visiting, access to culturally appropriate, accessible and free mental health services, rural services and breastfeeding support services. There is also “robust evidence” to support midwifery care and breastfeeding as public health imperatives. This includes the contribution of midwifery continuity of care to the prevention of preterm births,[4] and better birth outcomes for women of low socioeconomic position.[5]

1.19 The College notes that the Australian Government has developed a document focussed on the social and emotional development and wellbeing of infants in pregnancy and the first year of life. This document is underpinned by discussion of relationships with parents and caregivers and also uses the GRADE approach to assess quality of evidence for effectiveness of interventions.

1.20 The College also notes that there is evidence for benefits of:

(a) Antenatal and postnatal education, in terms of infant cognitive and social development, infant mental health, parenting quality and couple adjustment, reduction in maltreatment, and health promoting behaviours.

(b) Home visiting interventions were also found to be of benefit starting before birth and in the first year of life.

These are all aspects of care delivered by midwives and delivered in homes around New Zealand. For further results of the interventions assessed using the GRADE approach the link to this document is in a footnote.[6]

1.21 The College considers that discussion about practices that have interfered with the physiological process of childbirth is critically important. Protecting birth physiology has been a cornerstone of midwifery practice, with the aim of improving the health and wellbeing of mothers and infants, while avoiding unnecessary and costly interventions. Women’s confidence in their abilities to make positive parenting decisions, are enhanced through positive birthing experiences.

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[4] Medley, N., Vogel, J.P., Care, A., & Alfirevic, Z. (2018). Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews. *Cochrane Database of Systematic Reviews, 11* Art. No.: CD012505. DOI: 10.1002/14651858.CD012505.pub2

[5] McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ*, 8(10): e022220.doi: 10.1136/bmjopen-2018-022220.

[6] Australian Government / National Health and Medical Research Council. (2017). *NHMRC Report on the evidence: Promoting social and emotional development and wellbeing of infants in pregnancy and the first year of life.* https://aifs.gov.au/cfca/2017/05/08/report-evidence-promoting-social-and-emotional-development-and-wellbeing-infants

1.22 The College would like to re-emphasise that a recent randomised control trial provides a timely example of the short and long-term repercussions of routine practices that disregard physiology. Mercer et al. studied the effects of the timing of umbilical cord clamping on infant ferritin levels, brain myelin content and neurodevelopment.[7] Midwives have long been supporters of delaying cord clamping at births and the results of the Mercer et al. RCT has provided more evidence for this practice. Babies in the delayed cord clamping group had greater ferritin levels and increased brain myelin in areas important for early life functional development. The endowment of iron-rich blood cells from the placenta, obtained through a delay in cord clamping may offer a longitudinal advantage for early white matter development.

1.23 In terms of workforce development the College has some concerns about the call for more lactation consultants as we feel this confuses primary care with secondary care. Lactation Consultants provide a medicalised service which has in many instances pathologised breastfeeding. Rather, we support the upskilling of midwives, urgent attention to midwifery staffing levels, and the recruitment and retention of midwives. We also consider that community access to a funded breastfeeding peer support service could be beneficial, as peer support provides social support to mothers and does not pathologise breastfeeding. Lactation Consultants are part of secondary / tertiary services and for clinical breastfeeding / lactation pathology.

1.24 The College, while supportive of its development, is cautious about recommending training for 'Tūranga Kaupapa' as mandatory for the whole maternity sector as it is not universally available and its effectiveness has not yet been evaluated sufficiently to be a mandatory programme. However we welcome increased support from Government to help develop and refine this training as an effective cultural tool for the maternity workforce.

1.25 The College questions why breastfeeding protection, promotion and support are still missing from a document with a focus on infant and child wellbeing. The evidence about the significance of breastfeeding to short and long-term health and wellbeing is indisputable and the College will provide a detailed reference list if required. As mentioned previously, up to 98% of women initiate breastfeeding in New Zealand and being mindful of the fact that breastfeeding is a public health initiative, we should also be aware that the majority of reasons for why women discontinue breastfeeding are due to issues totally outside of their own control. [8] [9] [10] [11]

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[7] Mercer, J. S., Erickson-Owens, D. A., Deoni, S. C. L., et al. (2018). Effects of delayed cord clamping on 4-month ferritin levels, brain myelin content and neurodevelopment: A randomised controlled trial. *The Journal of Pediatrics*, 203:266-272.

[8] Brown, A. (2015) Milk supply and breastfeeding decisions: the effects of new mothers' experiences. *NCT Perspective*, 29:1-11.

[9] McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., Veitch, E., Rennie, A.M,, Crowther, S. A., Neiman, S., & MacGillivray, S. *(2017)*. Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database of Systematic Reviews,* 2*, Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub5.*

[10] Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M., & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet*, 387(10017):491-504.

[11] Payne, D. and Nicholls, D. A. (2010), Managing breastfeeding and work: a Foucauldian secondary analysis. *Journal of Advanced Nursing*, 66: 1810–1818. doi:10.1111/j.1365-2648.2009.05156.x

2.0 Facilitators of child and youth wellbeing (page 33- 46).

2.1 In respect to calls for co-design models, the College notes that the co-design model did not work for midwifery under the previous government, as it was used as a delaying mechanism and this delay contributed to a decimation of an already stressed workforce. Addressing the issues that were inherent in the original process first would be necessary before co-design models with government could be supported as a guaranteed way to develop partnerships.

2.2 The College agrees that outcome-based reporting should be favoured over output-based measurements.

2.3 The College agrees that parents need support to raise children. By this we do not mean unnecessary state interference in families and their parenting. As previously mentioned in our original submission, Bilson found that children separated from their families were predominantly from families who are poor, deprived or socially excluded and his work confirmed earlier findings that one in five children in the UK are referred to children's services before the age of five.[12] It also shows rapidly increasing levels of child protection investigation and rapidly growing numbers of children separated from their parents in the UK. These trends suggest that the impact of reduced family support funding and the increasing stress put on families through growing inequality are impacting strongly on children and families. The College would like to see urgent research done in New Zealand to examine these issues.

2.4 As we previously mentioned in the original submission we recommend some analysis of the repercussions of discontinuing the Parents as First Teachers programme (PAFT). It was one of only a few programmes supporting parents using a home-visiting model.

2.5 As previously described in a PAFT evaluation, families who received the service reported improvements in their knowledge of child development and parenting strategies, parenting ability and confidence. The evaluation also indicated that staff retention and quality were important to the strong child outcomes and that PAFT addressed some of the risk factors associated with child maltreatment.[13]

2.6 The College supports the establishment of longer, more flexible maternity leave and parental leave, flexible work arrangements, and family and breastfeeding friendly workplaces and early childhood services.

2.7 The College supports a kaiāwhina workforce working alongside midwives providing social and cultural support. However, we do not support any dilution of the midwifery role or midwifery tasks shifting to unregulated and almost always poorer paid workers. Rather, we see their role as additional to that which midwives provide.

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[12] Bilson, A., & Martin, K. E. C. (2016). Referrals and Child Protection in England: One in Five Children Referred to Children's Services and One in Nineteen Investigated before the Age of Five. *British Journal of Social Work*, 0:1-19. http://cdn.basw.co.uk/upload/basw_43143-3.pdf

[13] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/evaluation/parents-as-first-teachers/index.html

2.8 The College feels that more explanation is necessary for the comment on page 46 which states, “A greater role for midwives that enables them to care for women of child-bearing age.” This comment suggests a change in scope for midwives which would require much more detailed discussion in terms of support, valuation of midwifery services and funding. A role in pre-conception services could complement existing midwifery services but we do not consider that it would be feasible to provide services from “puberty to menopause” as described, when midwives in this country (unlike Australia and the USA) provide twenty-four hour continuity of care. This lead maternity carer role is already full and complex, and the impact on services and the already stressed workforce of additional roles have not been evaluated. Currently midwifery work, as it is, fails to be valued or resourced for the current expected services.

2.9 The College would like to point out again that infants and children cannot experience optimal development, safe and positive pregnancy, birth and parenting, without recognition of the support necessary for women and their whānau during these periods in their lives. Recognition of the importance of well-funded and supported midwifery care to these outcomes should also underpin this focus area.

3.0 Feedback on the draft child and youth wellbeing strategy (page 47 - 50)

3.1 The College agrees that the word ‘safe’ is problematic in this context as it means different things to different people. We feel that ‘safe’ in the context of risk is a neoliberal construct that pathologises physiology and creates a climate of risk-reduction that is a barrier to effective, humanising, compassionate care. Comfortable environments and evidence informed choices with care from registered midwives, brings safety to mothers and their newborns.

4.0 Health sector response (page 51- 87)

4.1 The College has some concerns that the kaiāwhina role is relatively undefined in terms of the place of an unregulated workforce, particularly within the maternity sector. The development of unregulated workforces has resulted in the deskilling of health professionals, task shifting, and underpaid and abused workers globally, with an associated reduction in the educated, professional, regulated and qualified workforce. We recommend thorough discussion and consultation of this issue. An example of the significant concerns internationally in relation to the development and use of unregulated workforces is the International Confederation of Midwives (ICM) position statement on community health workers and their role in maternity services.[14]

4.2 The College is aware that in some areas the provision of Health Hubs has had some success, however, the effectiveness of these ‘one stop shops’ has been limited in socially and economically deprived areas and more analysis is needed to understand this. The College is concerned that Health Hubs do not replace home visits for maternity and well child services in particular, as their effectiveness has been clearly identified.

[14] International Confederation of Midwives. (2017). *Role of the Community Health Care Worker in Maternity Care Provision*. Position Statement, ICM. https://www.internationalmidwives.org/assets/files/statement-files/2018/04/eng-role_cwh.pdf

4.3 The College agrees there should be greater investment in encouraging and supporting healthy behaviours and strengthening collaboration and integration of these activities, especially in relation to breastfeeding and other public health services.

4.4 The College supports the provision of free community dental services for pregnant women as a proactive prevention strategy.

Further comments

- The College notes that the development of IT systems that enable access to a variety of community services, for example GP practices, Well Child Services and district health boards, would support integration. The College notes the term 'work in isolation' and is concerned that some practitioner groups have a view that working as a home-based practitioner in the community means that the practitioner is isolated. This is not the case for midwifery which has significant and wide networks with all agencies concerned with maternal and infant health.

- The College notes that the health of refugee and asylum seeker children is still missing from this strategy and we recommend this be added. Measures to ensure more effective protection for refugee and asylum seeking women, and their children, requires long term effective solutions and a broad policy approach that encompasses health, social services, welfare, economic policy, education, gender equity and employment policy. Many refugee and asylum seekers have experienced significant traumatic events and although there are complex health problems that require urgent attention there are many barriers to address including language and communication, inadequate information, and cultural awareness issues.

- The College considers that some significant issues are still not tabled for discussion. We would like to see environmental issues / climate change threats to public health, the issue of poor management of our water supplies and the threat of water shortages and contamination, and the lack of regulation of the marketing of unhealthy foods included in this strategy document.

- The Child and Youth Wellbeing Strategy will need to clearly define how all goals and objectives are to be met, how the sustainability of these goals are to be accomplished, and who is responsible for accomplishing them.

The College looks forward to participating in the further development of this strategy.

Ngā mihi

Carol Bartle
Policy Analyst