# Submission:

## New Zealand Royal Commission COVID-19 Lessons Learned Te Tira Ārai Urutā

New Zealand College of Midwives

TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

13 September 2023

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# New Zealand College of Midwives | Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa submission to the New Zealand Royal Commission of Inquiry into COVID-19 Lessons Learned | Te Tira Ārai Urutā

## Introduction

The New Zealand College of Midwives (the College) | Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa is the professional organisation for midwifery in Aotearoa. The College provided extensive support to midwives and inter-sector liaison work throughout the Covid-19 pandemic response beginning in 2020. We welcome the opportunity to provide information to the NZ Royal Commission COVID-19 Lessons Learned | Te Tira Ārai Urutā about the lessons we learned and that we hope will contribute to the national planning for future pandemics.

The College offers information, education and advice to women, midwives, health and social service agencies, Te Whatu Ora districts and national agencies, Te Aka Whai Ora and Manatū Hauora regarding midwifery and maternity issues. Our members are employed and self-employed and collectively represent over 95% of the practising midwives in this country. There are approximately 3,000 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care in the community and hospitals to, on average, 60,000 women/people and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the whānau.

This response sets out the lessons the College considers should be learned for future pandemic planning, in sections that align with the Inquiry's Terms of Reference. As requested, we have provided related documentation (both publicly available and internal) to support the Inquiry

We would welcome the opportunity to discuss this submission with you as you continue the discovery phase of this important Inquiry.

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# 1. Covid-19 vaccination

## 1.1. Covid-19 vaccination during pregnancy

There are two main lessons we would like to share about the rollout Covid-19 vaccination in pregnancy. Firstly, professional associations and the Ministry of Health worked closely together to align messaging to the public about the recommendations for Covid-19 vaccination during pregnancy. Secondly, work needs to be done to develop a process and principles for the consideration of vaccine safety during pregnancy in the event of a future novel viral pandemic.

### 1.1.1. Alignment of messaging to support consistent public understanding

Internationally, Aotearoa was recognised alongside Australia as having a high degree of cross-agency collaboration and alignment with messaging to the public about the safety and recommendation for Covid-19 vaccination during pregnancy. See Giles et al. 2021 in the Bulletin of the World Health Organization, specifically p. 743:

*The Australian Technical Advisory Group on Immunisation then updated their decision aid for pregnant women, also publicly available to support clinicians in implementation of this policy. Significantly, this joint statement was also developed through collaboration with the New Zealand Ministry of Health and the Immunisation Advisory Centre, New Zealand, with almost identical statements on the safety of vaccination in pregnancy and breastfeeding being issued in Australia and New Zealand on the same day. The concurrent release of unambiguous, consistent messaging by three key organizations (Australian Technical Advisory Group on Immunisation, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and New Zealand Ministry of Health) is a positive step forward in this pandemic.*

In the pre-publication version of this article, the New Zealand College of Midwives was also referenced, but an editorial decision was obviously made to limit the commentary to include only “peak medical organizations”.

The College played a key role in Aotearoa as the professional association for the majority of maternity care providers in this country. We initially had a representative on the work group to update the National Immunisation Handbook with advice about Covid vaccination during pregnancy, alongside RANZCOG, the Immunisation Advisory Centre and the Ministry of Health. This ensured that the key professions and policymakers in maternity and immunisation were agreeing the language and messaging to ‘speak’ to health workers across the sector.

Unfortunately, as time went on and further decisions were made about vaccination during pregnancy, including boosters and second boosters, communication from the Ministry of Health (and subsequently Te Whatu Ora) with the professional associations decreased until we only found out by chance after public release of the eligibility criteria that recommendations had changed. This lack of engagement by the Ministry/Te Whatu



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Ora created avoidable confusion within the midwifery profession who had an important role in sharing information with pregnant women.

### 1.1.2. Need for a process and principles about vaccination in pregnancy for a future pandemic

The rollout of Covid-19 vaccination involved several changes to the recommendations for pregnant women and people over 2021:

| Month (2021) | National recommendation for pregnant women and people | Decision-making |
|---|---|---|
| February | Pfizer/BioNTech Cominarty mRNA vaccine rollout begins | |
| March | Women who are pregnant and at risk of exposure to SARS-CoV-2 virus can receive a COVID-19 vaccine at any stage of pregnancy. For those at low risk of exposure, it is recommended to delay vaccination until after birth. | IMAC, Ministry of Health, RANZCOG and NZ College of Midwives recommendation. Was mainly focused on border workers being redeployed away from exposure risk or vaccinated. Up until this time, data on Covid infection during pregnancy had indicated that pregnant women were generally no more affected than the non-pregnant population. |
| June | It is recommended that pregnant women/people are routinely offered the COVID-19 vaccine (Comirnaty) at any stage of pregnancy. | Collaborative agreement between the above parties to change recommendation based on real world safety data from large numbers of vaccinated pregnant women overseas, and also growing understanding that pregnant women were being more severely affected by Covid-19 infection, particularly as the virus mutated. Pregnant women are included in group 3 of the vaccine rollout. |
| October - November | Vaccine mandate announced then implemented. Pregnancy is not an indication for medical exemption. | Government decision |

As a result of the delay in recommending Covid-19 vaccination during pregnancy from the beginning of the rollout, the College and RANZCOG (NZ) co-developed a draft document titled *Framework for response to vaccines and therapeutics in pregnancy when novel infection or similar pose rapidly emerging risk in face of limited information*. The genesis of this document was a meeting between Ministry of Health maternity team and Immunisation team advisors, College of Midwives and RANZCOG representatives, where we considered the lessons learned and what needs to be in place for a future



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pandemic to protect pregnant women and people. The draft framework was submitted to the RANZCOG Women's Health Committee in Australia in 2022 to go through its formal process of further development (a process which is still underway). The intention is then to circulate the document more widely in Aotearoa to include the advice of experts in immunology and vaccinology.

The document advocates for the establishment of a National Immunisation Technical Advisory Group (NITAG) which includes a focus on maternal immunisations. This recommendation has also been made in Te Whatu Ora National Immunisation Taskforce recommendations, on which the College was represented.

The College – RANZCOG document also draws on the recommendations of the Pregnancy Research Ethics for Vaccines, Epidemics, and New Technologies (PREVENT) Working Group, which frames access to potentially life-saving vaccines during pregnancy as a women's rights issue.

The College also wrote an open letter in support of Covid-19 vaccination during pregnancy.

## 1.2. Data collection about Covid-19 vaccination in pregnancy

Data collection during the Covid-19 vaccination rollout did not include pregnancy status, which created significant gaps in understanding about the rates of vaccinated and unvaccinated pregnant women and people. The College raised concerns about this with the Ministry of Health and requested that this be urgently prioritised, particularly after the July 2021 release of a pre-print paper, *Impact of SARS-CoV-2 variant on the severity of maternal infection and perinatal outcomes: Data from the UK Obstetric Surveillance System national cohort* (Vousden et al. 2021), which found significantly increased risk for pregnant women of Covid-19 and, critically, that "*No fully vaccinated pregnant women were admitted between 01/02/2021 when vaccination data collection commenced and 11/07/2021*". Despite the need to understand pregnancy vaccination rates to support targeted promotion, there is still no national system to collect pregnancy vaccination data in a timely way for Covid-19, nor indeed for influenza or pertussis. It is possible to collect pregnancy vaccination data – see for example the above paper and the Melbourne process described in Hui et al. 2023, p. 585.e2:

> *In Melbourne, Australia, data collection on maternal COVID-19 vaccination status was mandated by the Department of Health and Aged Care for all births from July 1, 2021.*



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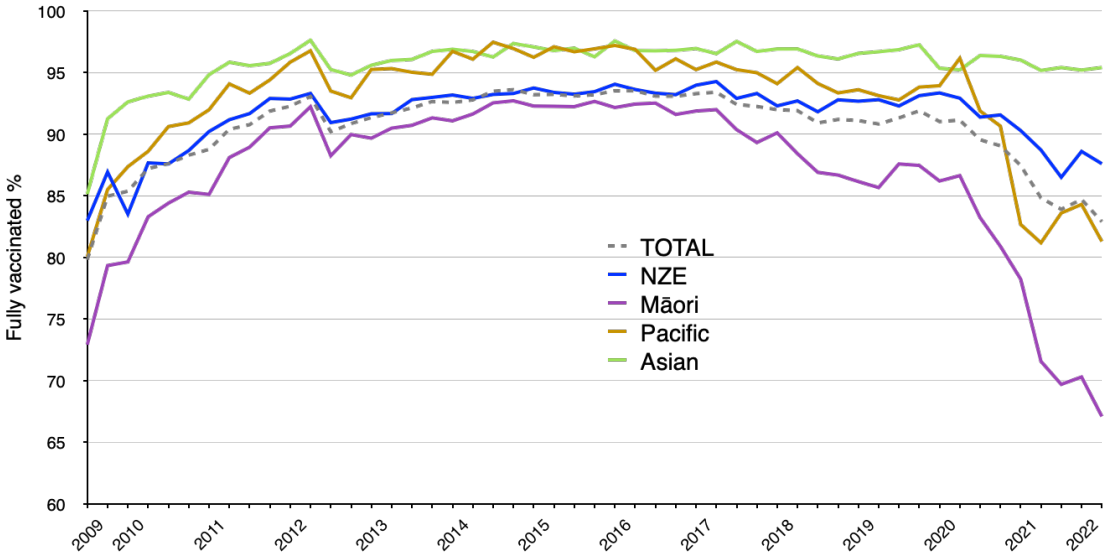
### 1.2.1. Decreased rates of scheduled immunisations during the pandemic response

Since the beginning of the Covid-19 pandemic in 2020, childhood immunisation rates have decreased alarmingly year-on-year and existing inequities have widened for immunisation at 2 years old. Figures 1 and 2 have been copied from the National Immunisation Taskforce Report, released December 2022, p. 15. Lessons should be learned from the Australian experience, where immunisation rates at one and two years old remained stable throughout the pandemic response, compared with previous years. See Australian Government Department of Health and Aged Care (2023) Historical coverage data tables for all children (Figure 3) and Historical coverage data tables for Aboriginal and Torres Strait Islander children (Figure 4).

McIntyre, Best, Byrnes, Sinclair, Trenholme and Grant[1] postulate that "infant immunity gap" now exists in Aotearoa as a result of three factors, "absence of community transmission for 3 years and, focussed on some populations, low maternal immunisation and delayed infant immunisation", which the authors argue contributed to a temporal cluster of infant deaths from pertussis in early 2023.

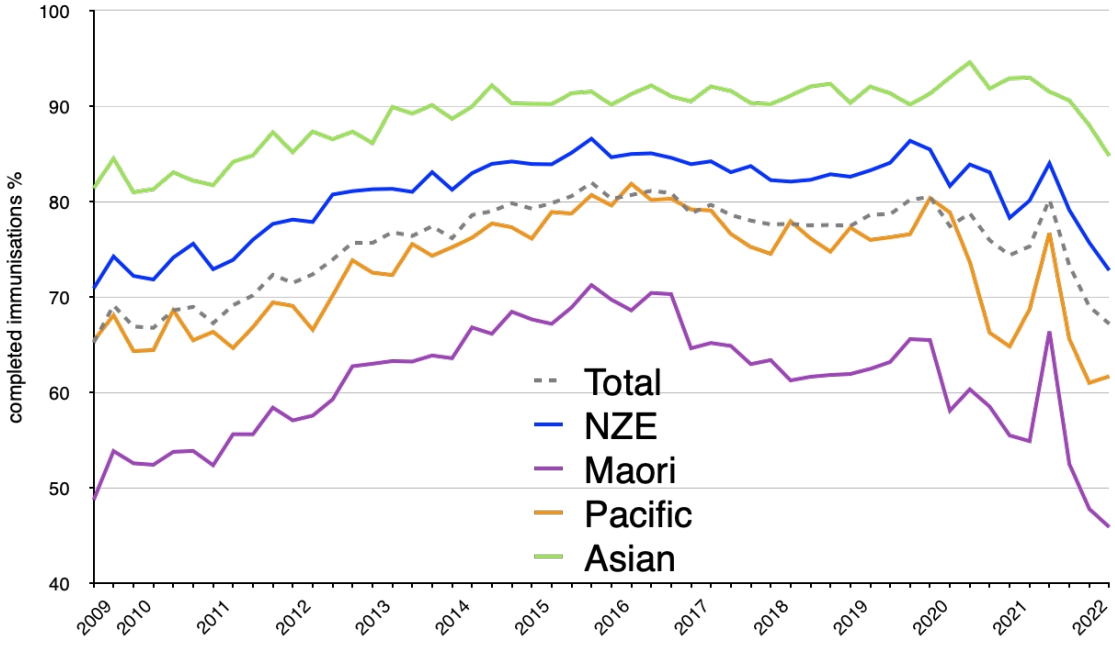
*Figure 1: Annual immunisation rates for tamariki aged 2 years (%), by ethnicity*




Note: NZE = New Zealand European.
Source: Ministry of Health

[1] McIntyre P, Best E, Byrnes C, Sinclair O, Trenholme A and Grant C. Pertussis deaths in New Zealand without community transmission—an infant immunity gap? The Lancet Regional Health -Western Pacific 2023;37: 100850.https://doi.org/10.1016/j.lanwpc.2023.100850

*Figure 2: Completed immunisations at 6 months (%), by ethnicity*




Note: NZE = New Zealand European.

Source: Ministry of Health

*Figure 3. Routine childhood immunisation rates in Australia among 2 year olds: all children*

## 2 year olds

This data table is for the 2 year old cohort (24 to less than 27 months old).*

| State | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACT | 94.81 | 94.29 | 93.29 | 93.52 | 92.55 | 92.51 | 92.14 | 90.97 | 92.84 | 92.97 | 93.21 | 93.46 | 94.04 | 93.75 |
| NSW | 91.94 | 92.48 | 92.34 | 91.33 | 90.23 | 89.85 | 90.83 | 89.09 | 90.72 | 91.84 | 92.42 | 92.41 | 92.43 | 92.30 |
| VIC | 92.57 | 92.92 | 93.16 | 92.38 | 91.17 | 90.85 | 91.61 | 89.72 | 91.59 | 92.79 | 93.38 | 93.46 | 93.15 | 93.40 |
| QLD | 91.60 | 92.70 | 92.79 | 91.89 | 91.51 | 91.67 | 92.29 | 90.23 | 92.36 | 92.65 | 92.75 | 92.81 | 92.41 | 91.93 |
| SA | 92.33 | 92.95 | 92.85 | 91.72 | 91.10 | 90.18 | 91.75 | 88.26 | 90.63 | 92.39 | 92.45 | 92.71 | 92.28 | 92.57 |
| WA | 91.02 | 91.79 | 91.44 | 90.06 | 89.63 | 89.10 | 90.35 | 88.07 | 89.92 | 90.52 | 90.54 | 91.18 | 90.52 | 91.49 |
| TAS | 91.92 | 91.57 | 90.37 | 91.88 | 90.98 | 91.13 | 92.13 | 88.33 | 90.48 | 94.09 | 93.77 | 94.09 | 93.60 | 93.48 |
| NT | 89.76 | 91.92 | 91.86 | 91.06 | 88.29 | 88.44 | 89.42 | 87.66 | 92.29 | 93.43 | 94.34 | 94.17 | 93.39 | 93.42 |
| **AUS** | **91.98** | **92.60** | **92.55** | **91.64** | **90.75** | **90.46** | **91.36** | **89.31** | **91.23** | **92.21** | **92.59** | **92.72** | **92.45** | **92.48** |



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*Figure 4. Routine childhood immunisation rates in Australia among 2 year olds: Aboriginal and Torres Strait Islander Children*

## 2 year olds

This data table is for the 2 year old cohort 2 (24 to less than 27 months old).*

| State | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015* | 2014* | 2013 | 2012 | 2011 | 2010 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ACT | 89.77 | 91.70 | 94.18 | 94.48 | 89.81 | 89.31 | 88.89 | 82.17 | 92.11 | 88.70 | 93.75 | 94.85 | 96.67 | 94.06 |
| NSW | 91.22 | 92.94 | 93.05 | 91.96 | 91.01 | 90.77 | 91.05 | 88.50 | 91.30 | 90.80 | 91.97 | 92.15 | 91.96 | 90.53 |
| VIC | 89.64 | 92.22 | 93.93 | 90.56 | 89.08 | 88.82 | 89.32 | 83.76 | 89.71 | 91.48 | 89.14 | 92.24 | 92.48 | 92.28 |
| QLD | 89.42 | 91.81 | 91.63 | 89.91 | 88.74 | 88.79 | 88.98 | 85.93 | 91.33 | 92.46 | 93.26 | 93.22 | 92.69 | 91.07 |
| SA | 90.12 | 89.67 | 88.30 | 87.14 | 86.83 | 87.56 | 87.50 | 84.45 | 84.60 | 86.63 | 86.87 | 87.59 | 91.12 | 88.75 |
| WA | 82.17 | 86.47 | 85.98 | 85.09 | 81.61 | 81.84 | 85.33 | 83.24 | 87.98 | 90.66 | 88.99 | 89.90 | 86.88 | 84.35 |
| TAS | 94.50 | 92.87 | 91.97 | 93.84 | 89.03 | 89.71 | 91.52 | 86.41 | 88.79 | 93.77 | 94.51 | 94.29 | 93.50 | 93.41 |
| NT | 84.43 | 89.29 | 90.45 | 90.25 | 83.77 | 84.58 | 88.30 | 86.56 | 93.53 | 95.86 | 96.92 | 95.60 | 94.83 | 93.76 |
| **AUS** | **89.08** | **91.38** | **91.43** | **90.03** | **88.20** | **88.18** | **89.13** | **86.18** | **90.57** | **91.68** | **92.19** | **92.46** | **91.87** | **90.29** |

## 1.3. Covid-19 vaccination for health workers: vaccine mandate

### 1.3.1. Rapid consultation on proposed Covid-19 vaccination mandate

On 29 September 2021 the College Chief Executive (CE) and advisors met the Ministry of Health maternity team and policy section, as part of their rapid consultation to develop advice to government on mandatory Covid-19 vaccination for health workers. The College was advised that the government had a 'strong appetite' for a mandate and the Ministry was asking what the consequences of making such an order would be.

The College was in strong support of vaccination for midwives and was already drafting a position statement to that effect (see 1.4.2. below). However there were a number of concerns about making the vaccination mandatory, as outlined in the CE's email to the College's board. Some of these concerns have been borne out, particularly as the mandate extended beyond the time when effective PPE was in constant use in hospitals and community midwifery services, Covid variants were increasingly causing 'breakthrough infections' and health workers were developing immunity from Covid infection acquired in the community.

### 1.3.2. College position statement on Covid-19 vaccination for midwives

In November 2021 the College's board ratified a Position statement on Covid-19 vaccination for midwives. This statement takes a proactive position in encouraging midwives to choose to be vaccinated, as noted in this paragraph from the statement:



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*From a professional and ethical perspective, and in line with the Human Rights Commission [2], the College advises midwives to consider our collective responsibility to the community as health professionals, by ensuring we minimise the risk of transmitting the virus in the course of our work. Vaccination is the best form of protection for ourselves, our whānau/families, our colleagues and importantly, the women and people we provide care to. The College therefore encourages midwives to choose to be vaccinated against Covid-19.*

### 1.3.3. Relative risks of unvaccinated workers and workforce shortage later in the mandate period

The 2021 Midwifery Workforce Survey (Midwifery Council of Aotearoa New Zealand | Te Tatau o te Whare Kahu) indicated that 3283 midwives renewed their practising certificates that year, however the number dropped to 3085 in the 2022 Midwifery Workforce Survey. The Council commented: "This is 198 less than at the same time last year. The total number of midwives with practising certificates had been steadily increasing, however has now returned to almost 2016 numbers."

With the borders opening in 2022, the risk to the public of unvaccinated health workers wearing full PPE is likely to have been far lower than the risk of understaffed maternity facilities which had been affected by midwives being stood down under the mandate. In most areas of the country, there was minimal change to staffing as almost all midwives decided to be vaccinated, but some regions were particularly affected, and this situation was compounded by sick leave with the return of influenza and other respiratory viruses.

The College CE wrote to then-Minister of Health Andrew Little in May 2022 to speak to this point and received a reply from the then-Minister for COVID-19 Response Chris Hipkins.

### 1.3.4. Need for fulsome risk assessment before any future vaccine mandate

We would like to see a lesson taken forward that vaccine mandates should be a very last option and should be firmly based on a risk assessment which balances the risks posed by unvaccinated health workers with the risks of unintended consequences (exacerbation of workforce shortages, growth of public mistrust in government and health institutions). We consider that all efforts should be made to keep health workers working at a time when the health system is inevitably put under increased strain.

This includes considering the available tools to protect health staff from infection, as explained in a video by Te Tāhū Hauora | Health Quality & Safety Commission. In this video Dr Carl Horsley explains that by taking a human factors approach to the use of PPE in the Middlemore intensive care service, "*over the 2 ½ years that we've had Covid patients – and we've had the most Covid patients of any ICU in the country – we haven't had a single member of staff acquire Covid from one of our patients."* This covers a significant period of time before the vaccine was available, demonstrating the effectiveness of thoughtful planning and access to appropriate PPE.



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### 1.3.5. High threshold for vaccine exemption

It is important to note that a number of midwives who were vaccinated with a first or second dose did so willingly, but were reluctant to have subsequent doses due to significant adverse side-effects. As a membership organisation, we were contacted by midwives who were undergoing cardiac and neurological examinations, in some cases being put on long waiting lists, after being referred by their primary care providers following adverse vaccination reactions. However, because they did not meet the high threshold for a vaccine exemption, these midwives either stopped work once the boosters were included in the mandate, or had their subsequent doses in emergency departments with several hours of post-administration monitoring. We consider that the thresholds for exemption from subsequent doses following adverse reactions were too high. This is not publicly available information because a) it involved individual conversations with a small number of our members, and b) the College considered it had a responsibility to align our messaging with government and the Ministry of Health.

Ultimately the case for a vaccine mandate was strong and likely contributed to a significant proportion of the population being vaccinated who otherwise would not have. However, the length of the mandate should be questioned, as it likely continued well after the point at which unvaccinated health workers would have presented a risk to the public, and therefore deprived the health system of essential workers when workforce shortages started to present a greater public health risk.

## 1.4. End of the Covid vaccine mandate for health workers

### 1.4.1. Lack of preparedness for end of vaccine mandate

The College calls into question Te Whatu Ora's lack of preparation for the end of the vaccine mandate on 26 September 2022. The government was clear that the mandate was only ever a temporary measure and had signalled that it would be reviewed after winter 2022. When the end date was announced on 15 September, Te Whatu Ora CEO Fepulea'i Margie Apa emailed the health workforce with the following opening statement: "*This email advises you that Te Whatu Ora will be extending the COVID-19 vaccination mandate until a national policy has been agreed*."

In response, the College CE wrote to the CEO of Te Whatu Ora requesting that any Te Whatu Ora vaccination policy must be proportional, flexible and able to be individualised (point 13 in this letter).

### 1.4.2. National Te Whatu Ora vaccination policy

The College understood, via messages from Te Whatu Ora to the unions, that a draft policy would be circulated within 2-3 weeks of Margie Apa's email and it was expected to be ratified shortly afterwards. Instead, Te Whatu Ora pre-employment policy on Covid-19 vaccination was only released on 4 July 2023, **more than nine months later**.



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During this time, **no Te Whatu Ora districts have been able to re-employ unvaccinated staff members** whose jobs were terminated during the mandate. However, these same districts have been able to engage unvaccinated health staff, including midwives, as locums, contractors and Lead Maternity Carer (LMC) Access Agreement holders. Te Whatu Ora (national) immediately reinstated unvaccinated LMCs' authorisation to claim when the mandated ended. This double standard created a large volume of contact to the College of Midwives from Te Whatu Ora district leaders asking whether and when they would be able to re-employ unvaccinated staff, and from midwives who had left under the mandate asking when they would be able to return to employed work.

# 2. Isolation and quarantine arrangements for international arrivals and limiting the movement of people through the international system

## 2.1. Pregnancy not included in Emergency Allocations to MIQ

During the border closure, pregnancy was not a criterion for access to MIQ, which meant that a number of pregnant women and/or pregnant women's partners were prevented from returning to New Zealand as they could not secure an MIQ space.

The College wrote a letter of support for the 'Baby Bridge' campaign to urge government to include pregnancy or a pregnant partner to the criteria for Emergency Allocations to MIQ, so that those citizens and residents of Aotearoa who were pregnant could access necessary antenatal care in the New Zealand maternity service, and so that immediate families can be together to welcome and parent their new baby together.

## 2.2. Health workers unable to access MIQ to return to New Zealand

The College was also aware of a number of health professionals who were stuck overseas during border closures who could not get access to MIQ, including midwives and at least one obstetrician. We consider that essential health service providers should be given priority to be able to return to New Zealand if they have a position in the health system, during any future border closure. Please see the submission from RANZCOG (dated 16 July) to this Inquiry for links to media about health professionals being denied re-entry to Aotearoa.



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# 3. Non-pharmaceutical public health measures, including vaccine passes, gathering limits, and personal protective equipment and its procurement and distribution

## 3.1. Personal protective equipment for midwives

### 3.1.1. Survey of midwives

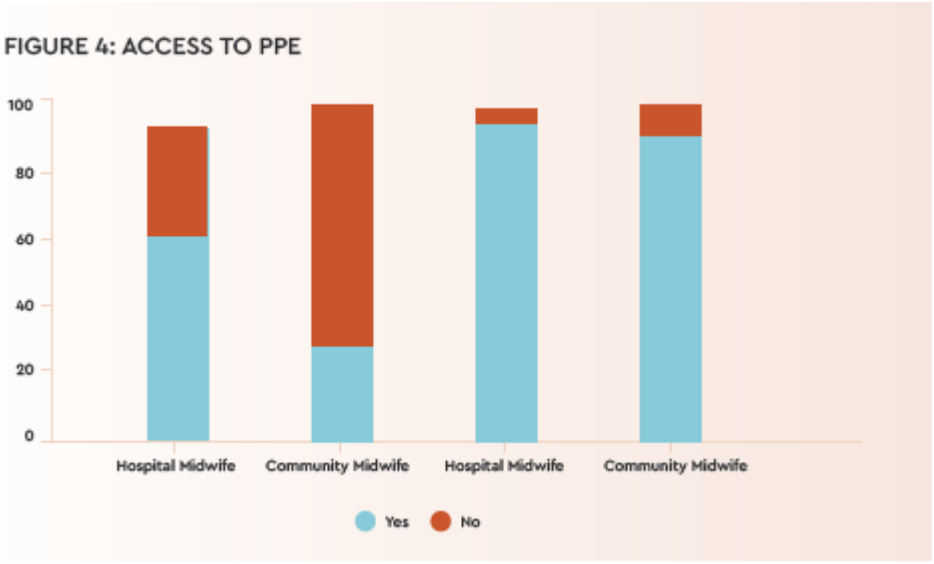
The College undertook a survey of members to assess their experience of providing care during the first months of the pandemic. The results of the survey were published in the College's quarterly membership magazine *Midwife Aotearoa New Zealand*, June 2020 edition, pp. 24-28.

781 midwives participated in the survey, representing 26% of the College's practising midwife members, of whom 206 were employed in a primary, secondary or tertiary maternity facility and 460 were LMC midwives.

We draw your attention to p. 26 'Access to PPE'. In the chart below (figure 4 from the magazine), the first two bars reflect the first fortnight of lockdown and the third and fourth bars reflect the second fortnight:

*The survey asked members whether they were able to access PPE when they needed it in the first two weeks of the Covid-19 Alert Level 4 and in the second two weeks. Responses indicated that a significantly higher proportion of community midwives were unable to access the PPE they needed in the first two weeks of Alert Level 4 when compared to hospital midwives. 61.7% of hospital midwives were able to access PPE as needed compared to only 26.5% of community midwives during this time (FIG.4).*

*This situation changed in the second two weeks of Alert Level 4 when 82.4% of community midwives and 89.3% of hospital midwives were able to access PPE when needed.*



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Access to PPE in the community was variable by district and the process for distribution of PPE had not taken the needs of community-based LMC midwives into account. Some DHBs quickly organised for LMCs to have access while others did not see it as their role to supply LMCs who were then left feeling unprotected at a time when there was limited understanding about the nature of the virus and its transmission.

### 3.1.2. Access to PPE for hospital midwives – "front door service"

In hospitals, midwives were not considered a priority for PPE due to the Ministry of health not recognising birthing suites/labour and assessment *units as a "front door service" like emergency departments were. A College report titled The Midwifery response to the COVID-19 pandemic* (August 2020) noted on pp. 8-9:

***Access and use of PPE***
*Access to personal protective equipment (PPE) for some hospital midwives and for community-based midwives was a significant problem particularly in the first two weeks of lockdown.*

- *In some hospitals, in the first two weeks there was rationing of PPE in hospitals and birthing units and in some cases, PPE was locked away and inaccessible for immediate use*
- *As a front door service, the lack of access to PPE created increased stress and anxiety for midwives who were concerned about their own safety and the risks of transmitting the virus to women in their care or their own family members.*
- *The lack of access to PPE affected midwives' abilities to provide care in the recommended environment.*

This report is included as a separate attachment due to its length.

**Media**

Midwives continue to serve despite risks and a lack of PPE

Covid-19 coronavirus: Midwives looking for masks, gloves, gowns for pandemic protection

Coronavirus: Lack of protective gear means women may be forced to birth alone

### 3.1.3. National recommendations for the use of PPE

Early in the pandemic response, the College expressed concern about the settings for the use of PPE for midwives, which it considered put them at risk of exposure to infection in the course of their work. Of note, midwifery was one of the few community-based services that continued to provide in-person care during the lockdowns, whereas Well Child services withdrew in-person contact. Following discussions with the Ministry of Health about PPE, the College issued a press release on 29 March 2020 and wrote to the Director General of Health on 1 April 2020.



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# 4. Tools, systems, and frameworks developed in response to COVID-19; and the settings needed to ensure that New Zealand's health system continues to deliver necessary services during a pandemic

## 4.1. Advice and guidance

### 4.1.1. Ministry of Health advice for health professionals, including midwives, on the provision of necessary care during a pandemic.

The College recognised early on, before lockdown was announced, that advice was needed by the midwifery profession to support the safe ongoing provision of essential maternity care. The College wrote to the Director of Public Health, Ministry of Health, to make the case for this, and provided suggested draft advice to get this underway.

The College agreed with the Ministry not to release any of its own guidance to midwives in advance of the Ministry, in order to ensure consistency of messaging. However, there was a delay of approximately 10 days between the College's letter and the publication of Ministry communications for midwifery and maternity, which created an information void and an increase in anxiety among the profession.

### 4.1.2. College advice for midwives and whānau accessing midwifery care

Once Ministry advice was available, the College collated relevant information and links for midwives on a dedicated web page, and filled in gaps with its own advice for midwives and information for pregnant women and whānau. This included a broad range of advice which we can provide if it is of interest to the Inquiry. Of particular note, midwives were encouraged to offer a hybrid appointment model, with the conversational aspect of care undertaken by phone from the car then a brief in-person physical assessment as required.

## 4.2. Midwifery model of care

### 4.2.1. Resilience and flexibility of the midwifery model of care during the pandemic

The midwifery-led model of maternity care in Aotearoa continued to function during the pandemic, with LMC midwives continuing to take responsibility for the needs of the women and whānau in their caseloads. Effective relationships, the inherent flexibility in the service delivery model and the well-established and co-ordinated close working relationships across the community-hospital interface, enabled LMC midwives to refer women suspected of having Covid-19 infection for urgent assessments and birth care by employed hospital midwives in hospital isolation spaces to minimise the potential for transmission into the community. In tandem, the community-based workforce was able to flex up the provision of community based postnatal care which occurred as a result of a trend to very early discharge which occurred following hospital births. The



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International Confederation of Midwives (ICM) (2020) recommended continuity of midwifery care during the pandemic to "reduce the number of caregivers in contact with the woman and her birth partner and decrease the chances of Covid-19 spread in hospitals".

### 4.2.2. Increase in home birth during lockdown

The ICM statement also supported birth in primary settings: "In countries where the health systems can support homebirth, healthy women experiencing a normal pregnancy and with support from qualified midwives, with appropriate emergency equipment, may be safer birthing at home or in a primary maternity unit/birth centre than in a hospital where there may be many patients (even non-maternity patients) with Covid-19."

During the alert level 3 and 4 lockdown period, the College received frequent calls from midwives about increased requests for home birth, and some from women seeking home birth care. The same was reported by the Homebirth Aotearoa association and several DHBs, and anecdotes were published in the media.

MacDonald (2022) investigated place of birth and maternal and neonatal outcomes during the 2020 national lockdown period, compared with the two years prior, with an interrupted time series analysis.

**Findings and policy recommendations from MacDonald (2022):**

- Rates of home birth doubled (compared with the predicted rates) during the lockdown period for all ethnic groups, with the highest absolute increase among whānau Māori, followed by Pākehā.
- There was no clear evidence of a change in rates of adverse maternal or neonatal outcomes.
- Pre-labour intervention rates (induction of labour and elective caesarean section) remained unchanged during lockdown.
- Whānau were able to safely change their planned place of birth without having to negotiate a change in model of care during the lockdown.
- In contrast, many UK trusts withdrew home birth services (Greenfield et al., 2021; Jardine et al., 2020).
- The findings noted a slight decrease in primary birthing unit (PBU) birth rates during lockdown across the general population, but usage remained the same for whānau Māori during lockdown, and was also highest in this ethnic group. PBUs are clearly accessible and acceptable to whānau Māori, therefore their closure is an equity issue. PBUs should be protected and upgraded to increase their use, and should not be closed in future pandemics.
- Hospital visitor restrictions during lockdown have been documented as a push-factor away from hospital and PBU birth in Aotearoa and overseas, and this study suggests there was a differential effect on whānau from communities where birth is conceptualised as a social, rather than medical event. Avoiding exposure to



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Covid-19 is also a widely cited reason cited for avoiding hospital birth during the pandemic.

- Low Covid-19 case numbers due to the effective lockdown and other public health measures may have contributed to hospital services being able to continue with the provision of pre-labour interventions at usual rates during lockdown.
- The findings highlight the importance of a flexible, integrated maternity system and the value of caseloading, community-based, midwifery-led care during a national emergency.
- Women will continue to birth and will require maternity care that can rapidly flex and adapt in unpredictable circumstances that add new environmental pressures to health, wellbeing and place of birth considerations.
- During Covid and previous emergencies, midwives were often the first or only "official" person many whānau saw (Barker et al., 2013), and women reported midwives "filling the gaps" as other community-based services, such as Well Child Tamariki Ora, suspended care (Dixon et al., 2023, cited in pre-publication 2022).
- Culturally safe care which takes into account people's social, as well as medical, needs is crucial for safe practice, including during states of emergency.

#### 4.2.3. Community human milk banks

During the lockdown period, the functions of community human milk banks, including receiving milk delivery from donors, dispensing and transportation of donor breastmilk were not included as an essential service. There were doubtless other small health services which were also omitted. Frameworks that designate essential services need to include a facility to urgently include important but overlooked aspects of health service provision like human milk banks, to support whānau breastfeeding journeys during a pandemic. See Te Whatu Ora National Breastfeeding Strategy, outcome 5.

#### 4.2.4. Gaps in service provision increased the workload of midwives

During the lockdown period and for some weeks afterwards, there were gaps in service provision among other primary care services including Well Child Tamariki Ora (WCTO) services. The College report titled *The Midwifery response to the COVID-19 pandemic* (August 2020) notes that:

- *Well Child moved to an online service, but there was not a clear process for enabling ongoing care for whanau who needed ongoing physical assessment or in person care on discharge from maternity care resulting in an increased burden on community midwives*
- *Hospital and community midwives were often required to fill service gaps due to lack of availability of face-to-face access to health services such as Well child and obstetric clinics which added to their workload* (p. 10).

As already noted in 3.1.2 above, this report is included as a separate attachment due to its length.



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## 5. The decision-making structures and arrangements that might be used or put in place during an evolving pandemic of extended length

### 5.1. Need for improved governance and decision-making for new vaccines

The College strongly supports the National Immunisation Taskforce's recommendation to establish a National Immunisation Technical Advisory Group, in alignment with World Health Organization recommendations (see p. 66 of the report). In future pandemics, a NITAG will be an important agency to consider any new vaccine/s. Processes must include early and proactive consideration of vaccine safety during pregnancy and foreground pregnant women's right to access the protection afforded by vaccination.

### 5.2. National Maternity Clinical Network

National Clinical Networks are currently being established by Te Whatu Ora, with a Maternity Clinical Network in the pipeline. Because it will include representatives of all key professional groups and will have a national mandate, this group should be well-placed to make clinical and service-level recommendations for management and risk mitigation in the event of a future pandemic.

### 5.3. Professional organisations

Professional colleges are key entities to represent professions involved with maternity care provision, and to communicate with clinicians at a professional level. The NZ College of Midwives and RANZCOG have a track record of effective collaboration, together with the Ministry of Health/Te Whatu Ora to provide expert clinical and professional perspectives during a rapidly evolving situation, to align messaging and to communicate with members.

### 5.4. Health unions

Health unions, including MERAS, the midwives' union, had good access to information and influence with the Ministry of Health during the pandemic to support the workplace needs of employed health workers.

## 6. Consideration of the interests of Māori in the context of a pandemic, consistent with the Te Tiriti o Waitangi relationship

In July 2020 the College provided a submission to the National Ethnics Advisory Committee on the *Draft Ethical Framework for Resource Allocation in Times of Scarcity* which includes a number of points relating to Te Tiriti o Waitangi responsibilities including health equity for Māori and communities who have been marginalised.



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# 7. Consideration of the impact on, and differential support for, essential workers and populations and communities that may be disproportionally impacted by a pandemic.

### 7.1. Inclusion of midwifery professional representatives in future pandemic planning

The College's submission noted in point 6 above also discusses the essential 'in person' role that midwives and some other health and social care providers have, which cannot be fully replaced with telehealth. Because midwifery traverses routine and acute care, and necessarily involves long periods of one-to-one care during unpredictable hours when supporting someone in labour, we consider that midwifery professional representatives should be prioritised for inclusion in any future pandemic and emergency planning entity. Specific issues include access for community-based LMC midwives to adequate PPE and appropriate childcare provisions to support midwives to be available on call and on shifts.

### 7.2. Student midwives

Clinical placements and study for student midwives and other health students were disrupted by the pandemic. The effect of the pandemic on students' wellbeing and resilience during the pandemic was explored in a qualitative study by Jackson et al. (2023): Uncertainty and flexibility: Midwifery students' experience during the COVID-19 pandemic in Aotearoa New Zealand.

### 7.3. Pregnancy as a vulnerability to a novel viral or bacterial infection

Very early on in the pandemic, the Ministry of Health confidently asserted that "Pregnant and postnatal women appear no more susceptible to the consequences of COVID-19 infection than the general population" and therefore pregnant women were not included in the list of factors that made people more at risk of COVID-19. However, as international data mounted, it was found that pregnancy was a risk factor for severe maternal disease and death as well as stillbirth (particularly with Delta), and also that vaccination was almost entirely protective against severe outcomes (Vousden et al. 2021).

The College considers that in any future pandemic of a novel viral or bacterial infection, the precautionary principle should be applied to situate pregnant women as being especially vulnerable to infection and therefore requiring additional protection. Decisions about pregnancy as a risk factor should include an understanding of pregnancy physiology, likelihood of adverse pregnancy outcomes with other infections that affect certain systems (e.g. respiratory), and potential risks to both mother and fetus/baby (e.g. ICU admission, preterm birth). Decisions should not rely on international surveillance data alone, particularly early on in a pandemic.

Considerations for pregnant women and people should include the likelihood of exposure to the virus, possibly redeploying pregnant workers from high-risk environments like border control, supplying pregnant women and their health care providers with PPE to minimise



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transmission, and considering vaccine safety during pregnancy from the earliest availability of vaccines.

## 8. Conclusion

The government's health-based response to the Covid-19 pandemic from 2020-2022 saved many lives with less disruption than in most other countries. The College acknowledges that decisions had to be made with the information available at the time, and that hindsight provides information about the unintended consequences of some decisions and can indicate where a different approach could have resulted in better outcomes. We offer our commentary and documentation to support improvements to the next pandemic or public health emergency response, as a result of lessons learned during this one.

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