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

20 May 2020

New Zealand College of Midwives submission

Office of the Auditor General is reviewing the Ministry of Health's management of personal protective equipment for the Covid-19 response

Executive summary

- Midwives were identified as essential workers, and were required to provide 'in person' care during Alert Levels 3 & 4 in both community and hospital settings
- Both professional standards and explicit Ministry of Health guidance required midwives to provide 'in person' care yet midwives were unable to access the PPE required to safely provide this care.
- This situation was exacerbated for midwives working in the community where the vast majority were unable to access the PPE they required within the first few weeks of the pandemic response
- Lack of access to PPE placed midwives at potential risk of COVID – 19 transmission to themselves, their families or the clients they were providing care to.
- DHBs were required to supply and distribute PPE to the health services within their regions. However they did not appear to do this equitably, and instead seemed to prioritize their own staff. This meant some workforces, such as employed community midwives, were highly vulnerable without access to the PPE needed
- This resulted in heightened anxiety for midwives, and affected women's access to maternity care as midwives were unable to safely provide elements of care
- Many midwives bought their own PPE at considerably inflated costs
- Once PPE became more available, the New Zealand College of Midwives regional structures had a significant role in managing and supporting distribution of PPE, which was a logistically challenging issue for some regions, particularly large urban settings and rural areas. This distribution required the College to pay for distribution costs.

1. Introduction

The New Zealand College of Midwives (the College) represents the midwifery profession in this country. Its members are both self-employed and employed. The structure and processes of the College uphold the principle of partnership between the profession and the public. The College offers information, education and advice to women, midwives, district health boards (DHBs) and the Ministry of Health regarding midwifery and maternity issues. The College has a national and regional structure, there are ten regional committees, and five sub committees in the smaller provincial centres (for more information see appendix A).

Midwives were identified as essential health care workers and were required to continue to provide maternity care during the COVID 19 alert levels 4 and 3. As such and in order for them to provide care without becoming at risk of or a vector for viral transmission, midwives required access to PPE during their work.

The College's professional standards and explicit Ministry of Health guidance required midwives to provide 'in person' care as women continued to require maternity care during Alert levels 3 & $, and babies continued to be born. However, midwives were unable to access PPE in the first few weeks of the COVID 19 alert level 4 resulting in increased clinical risk and increased anxiety within the profession.

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LMC community midwives provided a mixture of in-person and virtual / telephone contacts with women throughout the Alert Level 3 and 4 periods. This care included appointments in community clinics, in women's homes and in hospital settings. It encompassed antenatal (pregnancy), labour and birth and postnatal (up to 6 weeks following birth) care.

Midwives entering homes to provide in-person community-based care identified concerns about families not keeping integrity with their 'bubbles'. This meant that there was potential for them to come into contact with a range of additional people at any given visit.

1.1 College Survey of members

The College surveyed its practising midwifery members to identify the impact of COVID-19 Alert Levels 3 and 4 on their work. The survey was open from 6 to 13 May 2020, which was the last week of alert level 3 before moving to alert level 2 on 14 May. Specific questions were asked about access to PPE in this survey and the results provide supporting evidence of the extent and impact of midwifery issues with PPE.

2.0 Guidance on PPE

The Ministry of Health developed explicit guidance for the use of PPE for midwives, the first version of which was published on 22 March. Maternity, particularly labour and birth care was considered an area of practice which was 'high risk' for droplet transmission and the guidance developed was prescriptive and explicit. It required midwives to have access to all of the various elements of PPE, including surgical face masks, aprons, fluid resistant gowns, gloves, goggles and/or visors. In addition to PPE, midwives in the community also needed access to sufficient hand sanitiser and medical grade alcohol cleanser or cleaning wipes to clean clinical work spaces and protect against viral transmission during their work.

The College provided professional advice to the Ministry of Health to support the development of this guidance, we found a lack of transparency in the process used, with our advice ignored/dismissed and other professional groups advice prioritised. We raised our concerns with the Ministry in writing (Appendix B)

3.0 Access to PPE

There were significant PPE supply and distribution issues for midwives, particularly in the early weeks of the pandemic response (late March to early/mid-April) when access to PPE was severely limited or completely unavailable.

This was initially identified by the College though its' regional networks but was clarified and reinforced through the College survey. The survey involved responses from 781 midwives (26.8% of practising midwife members), of which 369 (47.2%) worked as a self- employed LMC midwife, 71 midwives (9.1%) were employed to work in a tertiary unit, 98 (12.5%) worked in a secondary maternity unit, 37 (4.7%) worked in a primary maternity unit and 91 (11.7%) worked in the community as an employed caseloading midwife.

In the analysis the midwives were grouped into 3 work settings, these were:

1. community midwives (included employed caseloading midwives and LMC midwives)
2. hospital midwives (included primary/secondary/tertiary facility employed midwives)
3. other (included education, management, research etc).

The survey asked members whether they had been 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 when compared to hospital midwives were unable to access the PPE they needed in the first 2 weeks of alert level 4 (table 1). With 61.7% of hospital midwives able to access PPE as needed compared to only 26.5% of community midwives able to access it during this time.

Table 1: Access to PPE by work setting in first 2 weeks of alert level 4

Work setting	Yes		No		Not applicable		Total	
	N	%	n	%	n	%	n	%
Hospital midwife	127	61.7	66	32.0	13	6.3	206	100
Community midwife	121	26.5	328	71.9	7	1.5	456	100
Other	26	40.6	28	43.8	10	15.6	64	100
Total	274	37.7	422	58.1	30	4.1	726	100

This situation changed in the second two weeks of the COVID 19 alert level 4 with the majority able to access PPE (table 2). A similar proportion of community midwives (82.4%) and hospital midwives (89.3%) were able to access PPE when needed (table 2).

Table 2: Access to PPE by work setting after the first 2 weeks of alert level 4

Work setting	Yes		No		Not applicable		Total	
	N	%	n	%	n	%	n	%
Hospital midwife	183	89.3	12	5.9	10	4.9	205	100
Community midwife	374	82.4	66	14.5	14	3.1	454	100
Other	40	64.5	8	12.9	14	22.6	62	100
Total	597	82.8	86	11.9	38	5.3	721	100

This is demonstrated more clearly in figure 1 which identifies the differences for access to PPE when needed between hospital midwives and community midwives in the first two weeks and the second two weeks of the COVID 19 alert level 4.

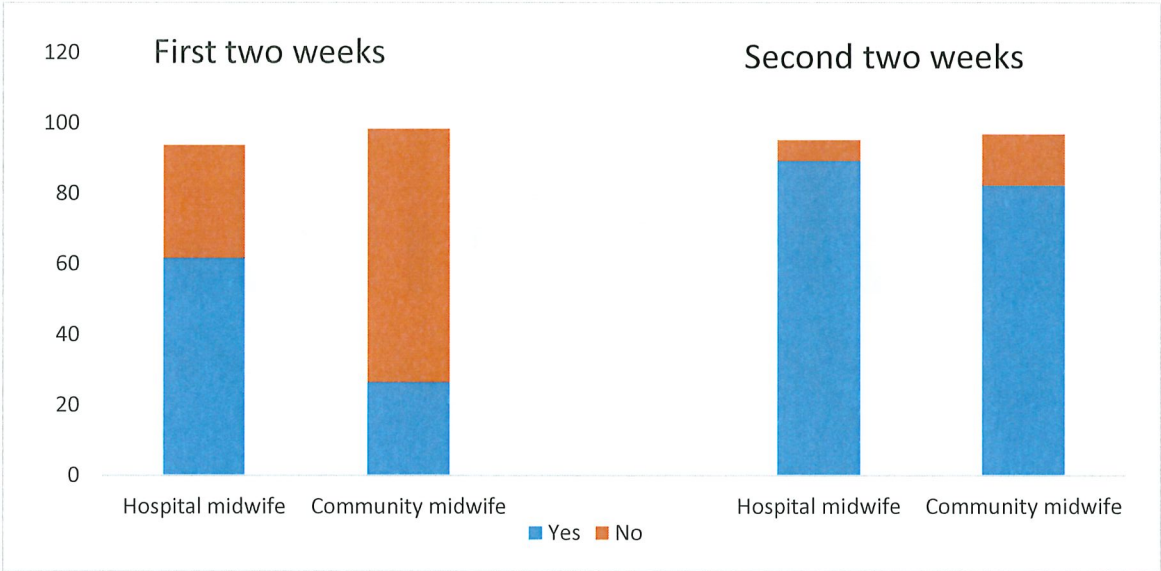

Figure 1: Responses to question – were you able to access PPE when you needed it during alert level 4

We analysed access to PPE when needed during the first 2 weeks of alert level 4 by DHB region (Table 3). Three regions appear to have had higher proportions of midwives unable to access PPE as needed: Bay of Plenty (n = 34, 77.3%), Capital and Coast (n= 32, 69.6%) and Hawkes Bay (n=23, 69.7%). One region that appears to have been successful was MidCentral DHB where 79.4% (n= 27) reported they were able to access PPE as needed. This can be seen visually in figure 2.

Table 3: Access to PPE by DHB region within first 2 weeks

DHB	Yes		No		Not applicable		Total	
	N	%	N	%	N	%	N	%
Auckland	20	43.5%	21	45.7%	5	10.9%	46	100
Bay of Plenty	10	22.7%	34	**77.3%**	0	0.0%	44	100
Canterbury	22	28.6%	50	64.9%	5	6.5%	77	100
Capital and Coast	11	23.9%	32	**69.6%**	3	6.5%	46	100
Counties Manukau	38	45.8%	43	51.8%	2	2.4%	83	100
Hawkes Bay	9	27.3%	23	**69.7%**	1	3.0%	33	100
Hutt Valley	7	41.2%	9	52.9%	1	5.9%	17	100
Lakes	4	33.3%	8	66.7%	0	0.0%	12	100
MidCentral	27	**79.4%**	5	14.7%	2	5.9%	34	100
Nelson/Marlborough	14	51.9%	12	44.4%	1	3.7%	27	100
Northland	9	36.0%	16	64.0%	0	0.0%	25	100
South Canterbury	7	77.8%	1	11.1%	1	11.1%	9	100
Southern	36	54.5%	29	43.9%	1	1.5%	66	100
Tairawhiti	5	55.6%	4	44.4%	0	0.0%	9	100
Taranaki	4	22.2%	14	**77.8%**	0	0.0%	18	100
Waikato	19	24.1%	58	73.4%	2	2.5%	79	100
Wairarapa	4	50.0%	3	37.5%	1	12.5%	8	100
Waitamata	21	27.6%	52	68.4%	3	3.9%	76	100
Whanganui	6	46.2%	6	46.2%	1	7.7%	13	100
Total	273	37.8%	420	58.2%	29	4.0%	722	100

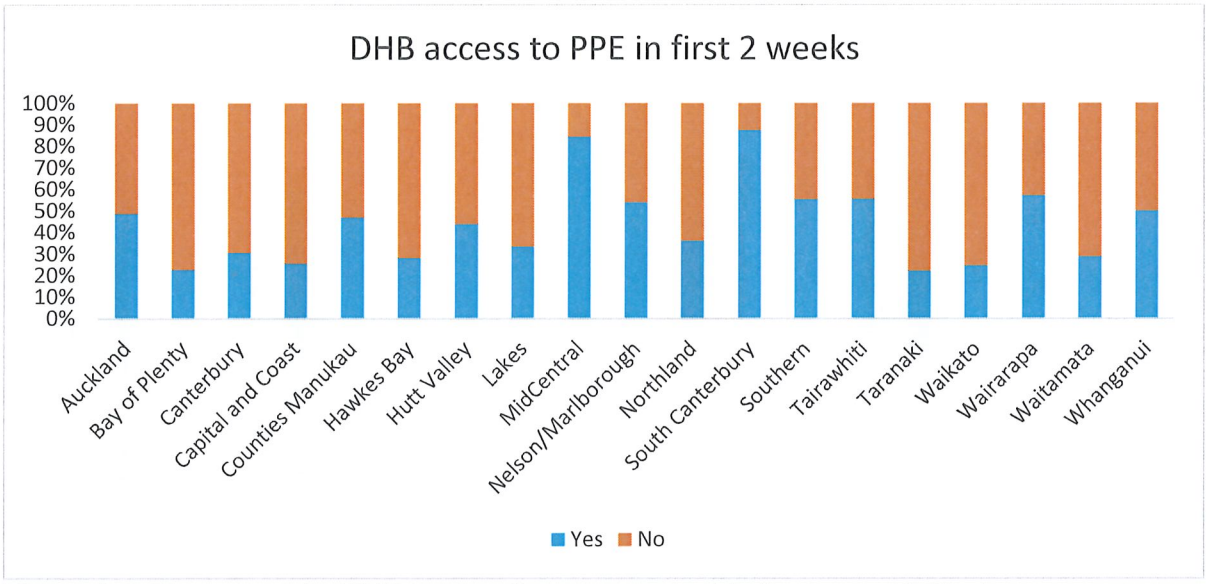

Figure 2: Responses by DHB to question: were you able to access PPE when you needed to?

Again there was a clear change in the second two weeks with higher proportions reporting being able to access PPE when needed (figure 3)

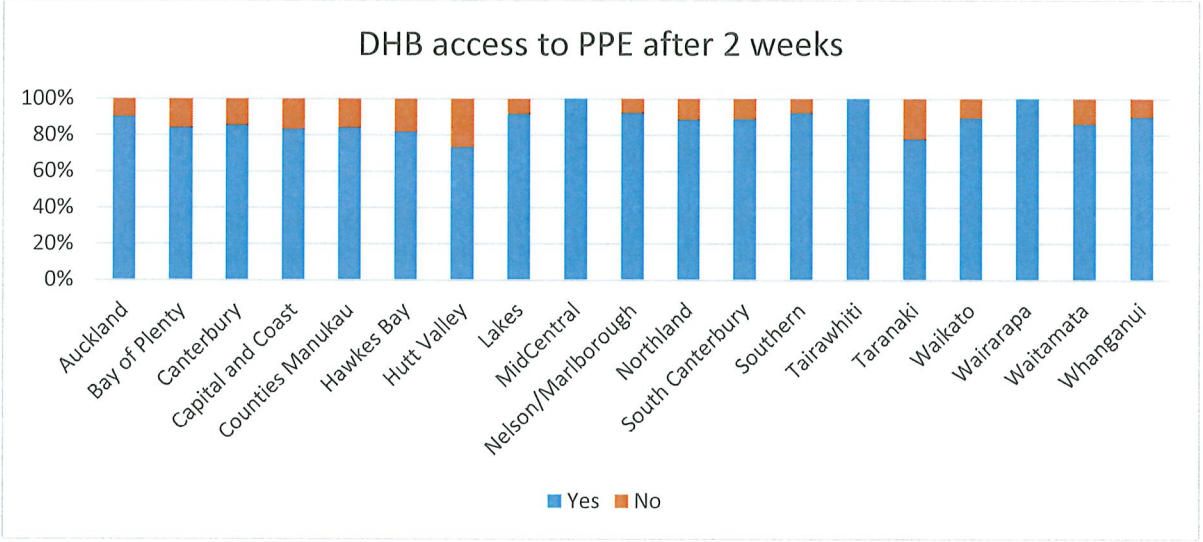

Figure 3: Responses by DHB to question: were you able to access PPE when you needed it?

Overall, these responses demonstrate that access to PPE for community midwives was problematic in the first two weeks of the COVID-19 pandemic lockdown but eased in the second two weeks. The ability to access PPE would appear to differ dependent on the DHB region of the midwife.

4.0 Supply and distribution of PPE

The supply and distribution of PPE for midwives was managed via DHBs. For DHB employed midwives this occurred in workplaces as DHBs implemented systems of distribution and educative processes around the correct use of PPE. For community based midwives, PPE was to be supplied and distributed directly by the DHBs to those LMC midwives working within their DHB regions, as stipulated in the Ministry's guidance for community midwives, published on 22 March. Access to PPE for midwives employed in smaller DHB-funded, privately run maternity facilities was also managed by DHB supply and distribution processes.

DHB services, including maternity services were undergoing major transformation at this period of time. Hospital and DHB services were implementing systems and processes to deal with COVID-19 admissions, reconfiguring services to minimise in person contacts and so on. The distribution of PPE to community workforces, such as midwives, appeared to be a low priority. DHBs prioritised hospital staff for the supply of PPE, as opposed to other workforces such as community midwives. A glaring example of this was the differing approach within one DHB setting regarding the use of PPE for the DHB employed community midwives versus self-employed community midwives. The employed midwives were ordered to wear PPE for each home visit – so up to 8 changes a day. The supply of PPE for the self-employed community midwives working in the same DHB region was minimal meaning that the midwives could not change PPE for each contact and care provision they undertook.

In order to access the PPE during this period, community midwives were required to purchase or even make their own. The survey identified that 337 midwives (65% of community midwives) purchased their own PPE during this time. Basic supplies such as hand sanitiser and medical grade cleaning wipes for equipment and clinic cleaning were also unavailable or extremely difficult to access. Midwives reported that a number of suppliers who were still able to provide equipment were price gouging and thus supplying the equipment at significant cost.

In mid April, the Ministry reviewed the availability of PPE and released additional supplies, at which stage midwives started reporting better access to the necessary equipment. However, the distribution mechanisms were often awkward and challenging for the community-based midwifery workforce.

PPE was frequently rationed, and the volume of supply available for community midwives' use varied considerably between DHBs. In some regions, midwives were given a certain amount of PPE. Once this very limited supply was exhausted, midwives were required to justify its use by identifying when it was worn by supplying the women's NHI numbers, in order to access replacement items. A number of midwives reported that they felt they had been provided with insufficient volumes of PPE.

Each DHB approached this differently. In some regions, restocking was particularly onerous for rural midwives and those in large urban centres with limited collection points. Some DHBs required community-based midwives to travel into the tertiary or secondary hospital to specifically collect PPE allocations, others distributed it via primary maternity units or other collection points.

In the Northern region, the New Zealand College of Midwives Auckland region attempted to establish a system where community midwives could directly order and have delivered the PPE they required. After considerable negotiation and advocacy on behalf of the Auckland College of Midwives regional representatives, this was partially successful for a portion of midwives. Ultimately, the Auckland College of Midwives region took on a distribution role, at financial cost to the region.

5.0 Impact on midwives and midwifery care

The inability to access sufficient PPE impacted on maternity care provision, the health and safety of midwives and the women and families they provide care to.

5.1 Increased anxiety for midwives and their families

Providing an essential service during the COVID 19 alert level 3 and 4 status increased anxiety levels for midwives with the 553 (76.4%) respondents to the College's recent survey reporting that they had felt anxious about their own health and wellbeing as essential health workers during the pandemic.
Similarly, the majority of survey respondents (81.1%) also felt anxious about the wellbeing of their family/whānau because of the essential nature of their work. With 332 midwives (43.7% hospital midwives, 47% community midwives) identifying that they made changes to their home and living arrangements during the COVID 19 levels 3 & 4 status.

5.2 Increased anxiety for families

Midwives caring for women from various cultural backgrounds have noted there are differing norms and expectations of health professionals in relation to PPE use. There was also a heightened state of anxiety amongst some members of the public about potential risks of transmission. In order to be able to provide the required 'in person' care, midwives needed to use PPE more frequently than Ministry of Health guidance indicated in some instances, otherwise women would refuse to see them and women would miss out on essential in person assessments. However PPE supply was based on modelling for use in accordance with Ministry of Health guidance. PPE supply for midwives dealing with these circumstances was particularly challenging.

5.3 Impact on service provision

The inability to access PPE had several detrimental effects of the midwives ability to provide midwifery care due to the potential clinical risk of cross infections. In some circumstances midwives rationed care because they did not have access to PPE. For some women there was also a reduction in their options for care - for example some were unable to offer homebirth as an option, as a result of lack of access to PPE. During this period there was an increased demand for homebirth as women were seeking to avoid hospitals as a potential infection source. Restricted access to support people during the childbearing process in hospital settings also influenced choice of place of birth.

6.0 Conclusion

As essential workers, midwives were required to provide 'in person' care during Alert Levels 3 & 4 in both community and hospital settings. The College's professional standards and explicit Ministry of Health guidance identified the situations in which midwives should use PPE when providing 'in person' care yet midwives were unable to access the PPE when they needed it. This situation was exacerbated for midwives working in the community where the vast majority were unable to access the PPE they required within the first few weeks of the pandemic response. Being unable to access PPE placed midwives at potential risk of COVID – 19 transmission to themselves, their families or the clients they were providing care to.

DHBs were required to supply and distribute PPE to the health services within their regions but prioritised to hospital staff and access for community midwives was inequitable and often difficult. This left midwives feeling anxious and highly vulnerable without access to the PPE they needed and resulted in many midwives purchasing their own PPE at considerably inflated costs

Once PPE became more available, the New Zealand College of Midwives regional structures had a significant role in managing and supporting distribution of PPE, which was a logistically challenging issue for some regions, particularly large urban settings and rural areas. This distribution required the College to pay for distribution costs.

Appendix A
College role and structure

There are approximately 3,300 midwives who hold Annual Practising Certificates (APCs) in New Zealand, working as either hospital employed or self-employed as Lead Maternity Carers (LMCs). Approximately 1,600 employed midwives are mainly employed by DHB maternity services or within small DHB-funded, privately run primary maternity facilities.

LMC community midwives are individually contracted directly to Ministry of Health and paid via Section 88 Primary Maternity Services Notice 2007 (Amendment Notice 2019). There are approximately 1,300 midwives working as LMCs nationally. Self-employed small group practice (around 4 to 6 midwives) is the predominant model for midwives working in these roles. LMC midwives provide maternity care to a caseload of women from early pregnancy, labour and birth to 6 weeks postpartum. The small group practice model ensures back up and support is available to enable 24/7 service coverage for acute needs and labour and birth care.

A national organisation, the Midwifery and Maternity Provider Organisation (MMPO), primarily self-funded by midwives, provides a range of practice management supports to LMC midwives. It has a limited scope of activity and significantly limited resources in comparison to Primary Health Organisations (PHOs) which provide extensive services to support general practice and primary care services. The New Zealand College of Midwives, the professional association works in close collaboration with the MMPO.

The College has a national and regional structure, with 10 regions and 5 sub-regions throughout New Zealand. Each region has an elected representative who leads a local committee, representing the regions midwives.

Appendix B – letter to MOH re Guidance on PPE

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

1 April 2020

Dr Ashley Bloomfield
Director General of Health
By email: Ashley.bloomfield@health.govt.nz

cc. Nicky Smith, Manager: Maternity, Ministry of Health
cc. Kass Jane, Principal Advisor: Maternity, Ministry of Health
cc. Abby Hewitt, Senior Advisor: Maternity, Ministry of Health
cc. Neonila Panko, Senior Advisor: Maternity, Ministry of Health

Tēnā koe Ashley,

The New Zealand College of Midwives (the College) is the professional organisation for midwives in New Zealand, representing over 90% of the country's midwives. As you are aware, midwives continue to provide community and hospital based maternity care for pregnant, birthing, and postpartum women during the COVID-19 public health emergency, as an essential service. The College supports public health measures under the alert level 4 lockdown to reduce the transmission of the virus, and we have worked closely with the Ministry to develop guidance for midwives on face-to-face appointments and personal protective equipment (PPE). However we are writing to raise concerns about the lack of transparency in the development of Ministry guidance for the midwifery profession, and specifically to identify the undue influence of obstetrics over the updated indications for midwives' use of PPE (30 March). This update will have the effect of increasing risk to midwives and has immediately caused a high level of distress in the midwifery workforce.

The College has greatly appreciated the responsiveness of the Ministry's Maternity team of advisors, with their upfront and regular communications with us, as well as their knowledge of midwifery and correspondence of our feedback to the NHCC. However, recommendations from the profession often change during the NHCC process and a final product is produced without the ability for the affected parties to see the final draft or understand the rationale for the decisions.

The College initially wrote to the Ministry three weeks ago about the urgent need to develop guidance for midwifery and maternity care provision and use of PPE during the COVID-19 outbreak, and we provided draft recommendations for consideration. We honoured the Ministry's strong request to us not to release any independent advice on PPE, so that we could ensure a consistent, unified voice and joint approach to public health during this emergency. This agreement resulted in some significant problems for the profession and for DHBs. The lengthy process of NHCC consultation caused delays in being able to provide guidance for midwives, which led to heightened anxiety for members of the profession who experienced an information void, and also impacted on DHB maternity services that could not afford to wait, given their pressing service-level requirements. DHBs therefore developed varying local guidance in the interim, and were then required to amend this once the Ministry published its first tranche of documents for midwives on 21 March.

The College has subsequently had daily meetings with the Ministry's Maternity team which have enabled productive discussions and information sharing. It is in this forum that we have raised new issues that have arisen and where we have made professional recommendations for updates to the guidance. We have maintained our agreement not to release independent advice.

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Conversely, the Royal Australia New Zealand College of Obstetricians and Gynaecologists (RANZCOG) independently published its advice on PPE use on 30 March. The RANZCOG document provides advice for the use of PPE for midwives and obstetricians, however it was developed without consultation with New Zealand midwives. It recommends that during the first stage of labour, *'Healthcare workers should minimise time in the room, allowing for provision of usual care, including CTG and abdominal palpation'*, including care provision for COVID-19 screen-negative women. This statement is neither correct nor feasible, as labour and birth care during the first stage of labour involves the midwife spending a significant amount of time in the room with the woman. In many cases the midwife cannot leave the room at all, such as when a woman requires one-to-one support to work through labour pain, when the woman is being induced or augmented with an oxytocin infusion, has an epidural in situ or has continuous CTG monitoring in place.

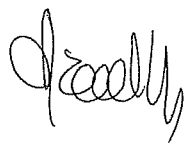
We were therefore disappointed that within 24 hours of this publication, the Ministry updated its guidance to align with the RANZCOG advice. Crucially, this advice sees a **reduction** in the indications for midwives' PPE use from the original Ministry document dated 21 March. Until now, full PPE has been recommended for all labour and birth care of asymptomatic women in self-isolation for COVID-19 risk factors. This has been reduced to PPE only for the second and third stages of labour. We categorically oppose this change. This recommendation may protect obstetricians, whose main involvement for periods longer than 15 minutes is in second and third stage of labour, but it will not protect midwives. The College has advised and requested that the Ministry implement a recommendation that full PPE (gloves, gown, surgical face mask, eye protection) should be used for the care of all women during first, second and third stage of labour and birth, as deemed clinically necessary by the midwife providing care.

We acknowledge that there are inconsistencies in recommendations for infection prevention and control between the main professions involved with pregnancy and labour care, namely midwifery, obstetrics and anaesthetics, and we would like to engage with the NHCC in a consensus development process.

In summary, the College considers this a health and safety issue for midwives and strongly urges the Ministry to heed the advice of the profession that understands its own work context. We were concerned to note the alacrity with which the Ministry revised its PPE recommendations based on the advice of RANZCOG. This indicates that the Ministry has prioritised obstetric advice over midwifery advice on an infection prevention and control issue, and also indicates a lack of recognition of the nature of midwives' work.

We look forward to your response at your earliest convenience.

Ngā mihi,



Alison Eddy
Chief Executive

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