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

15th June 2020

COVID-19 Psychosocial and Mental Wellbeing Recovery Plan

New Zealand College of Midwives

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The New Zealand College of Midwives is the professional organisation for midwifery. Our members are employed and self-employed and collectively represent over 90% 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 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

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15th June 2020

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COVID-19 Psychosocial and Mental Wellbeing Recovery Plan

Tēnā koutou

The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the COVID-19 Psychosocial and Mental Wellbeing Recovery Plan. The College supports the goal of the recovery framework which is to protect and enhance the mental wellbeing and recovery of people in Aotearoa whose lives have been disrupted by the COVID-19 pandemic. The recovery plan needs to have a future focus to be meaningful, effective and sustainable, and to be informed by what we already know about mental health issues, equity, the effects of racism, and the gaps in services in Aotearoa.

The College has a professional focus on midwifery, midwives and their wellbeing, and the wellbeing of pregnant, birthing and postnatal woman and their whānau. We have previously made submissions related to mental health and would like to see the concerns we have raised about lack of services and the importance of maternal health taken into consideration. The College fully understands that transforming mental health and wellbeing systems in Aotearoa New Zealand will take time and alignment across sectors, and require effective relationships between Government and non-Government players. The COVID-19 pandemic may provide the impetus for planning and action within public health and mental health services that go way beyond the usual ways of working.

Midwives in Aotearoa New Zealand work in partnership with women to give them the necessary skilled support, care and advice during pregnancy, birth, labour, and the post-birth period. Partnership is a key concept for the midwifery profession and midwives engage with women and their families in relationships of trust, shared decision making and responsibility, negotiation and shared understanding. It is this quality relationship that supports the midwife-woman connection and which fosters trust and meaningful dialogue about a range of concerns and issues. Midwifery has a role in public health and is both a preventative and acute response front-line health service which impacts positively on maternal, infant and child wellbeing, both short and long-term.

With the College focus in mind here is our feedback on the Recovery Plan

1. Do the vision, principles and focus areas in the plan resonate with you?

1.1 The College supports the concept of a people and whānau focussed shared vision of collective action. A vision which involves fostering and developing partnerships, with a Tiriti o Waitangi framework, and a human rights, equity and community led focus.

1.2 We have some comments about the six guiding principles (p. v). The principle stated as equipping "people to look after their own mental wellbeing" suggests a level playing field approach without recognition of the impact of inequity, racism and poverty on abilities to 'look after yourself'. A shift towards recognition and acknowledgment of the inequalities and injustice within society, and the challenges experienced by many people due to inequity, poverty, racism, and systemic bias will have a greater impact on health outcomes, and is a building block towards achieving health equity. Although it is important to use a strengths-based focus it is also important to recognise the long term effects of colonisation, racism and deprivation. We note that Principle 4 (achieve equity) indicates a recognition of disadvantage and ways in which equity can be achieved.

1.3 The section outlining the impacts of COVID-19 recognises that some groups will be disproportionally disadvantaged in terms of achieving wellbeing. The issues for pregnant, birthing and new mothers do not appear to have been considered fully in the recovery plan as they are not included in the section on those disproportionately impacted. The College recommends that this omission be remedied.

1.4 We note that the section on 'actions' does contain a brief reference to addressing maternal mental health impacts on mothers, infants and children (p.22) but the means by which this is to be achieved are not explained. Midwives were able to see and experience directly the impact on women of pregnancy, birth and adjustment to parenting during the pre-lockdown and the lock down period and we discuss this further within section 2.

1.5 We support the empowerment of community-led solutions, driven by the community, but only in the context of sustainable and equitable funding, access to resources, and support for capacity building for the organisations and communities involved. We also support a trauma-informed approach.

1.6 The College has called for a wider focus in previous health related submissions. A focus that includes the social and corporate determinants of health in submissions related to public and

population health. The Families and Whānau Status Report 2016, highlighted how financial and psychological stressors impact on the ability of whānau to function well.[1].

2. **In what ways does your organisation see itself contributing to the focus areas in the plan?**

2.1 Midwives are aware of the mental health concerns that arise for some women during their pregnancies, their labours and births, and during the adjustment period of becoming a new mother and all that this entails, including sleep deprivation and relationship changes. These issues can overshadow both pregnancy and the postnatal period. The COVID-19 pandemic is likely to have intensified these issues for many women. During the COVID-19 levels 4 and 3 in particular, midwives played a central role in providing information and support to women and whānau as they navigated what it meant to be pregnant and become parents during this uncertain time. The College considers that supporting mothering and parenting is an investment and that all efforts to support perinatal mental health and well-being are critically important for not only women but for infants, children and whānau.

2.2 The stress of unsafe and unhealthy living environments and the highly likely deterioration in physical, spiritual, and psychological health places an unacceptable burden on pregnant women, women with newborn infants and young children and their whānau. During the COVID-19 response midwives were a critical part of the health service and one of the only, if not the only, primary health professional group that continued to provide visits to women, their babies and whanau in their homes.

2.3 The College is undertaking work looking at the experiences of both midwives and women during the COVID-19 pandemic and we see this work as potentially providing a significant contribution to the recovery plan. A survey aimed at identifying the impact of the COVID-19 pandemic, and the alert status levels 3 and 4 on the work of members, was undertaken. A total of 781 midwives responded which was a response rate of 26.8% of practising midwifery members. We received responses from a broad range of midwives from throughout New Zealand.

2.4 The vast majority of hospital and community midwives who participated in the survey agreed that the COVID-19 alert levels 3 and 4 had impacted on their work environment – either a great deal or a lot. Midwives identified there had been a need to reassure women (89.5%), and a need to change ways of interacting with women and families (91.7%), as ways in which their working environments had been impacted. The changes in work environment increased the workload for many midwives.

[1] Social Policy Evaluation and Research Unit. (2016). *Families and Whānau Status Report*. Wellington, Superu.

2.5 There were 199 (27.4%) midwives who reported that they had provided care to a woman who was a suspected, probable or confirmed case of COVID-19. 87 of these respondents were hospital midwives (42% of hospital midwife respondents) and 99 were community midwives (21% of community midwife respondents). Providing an essential service during the COVID 19 alert levels 3 and 4 increased anxiety levels for midwives with 553 (76.4%) identifying that they had felt anxious about their own health and wellbeing as essential health workers during the pandemic.

2.6 A high proportion of the community midwives responding to the survey questions agreed with the statement that they provided more homebirth care (46.2%) than usual and more care at home during labour (47.3%) (for women going to a birthing unit or hospital for birth). The majority also agreed that they needed to spend more time discussing child care (69.8%) and labour support (90.3%). The College recognises the significance of the stressors involved for both birthing women and midwives during the COVID-19 pandemic lock down period

3. What do you think are the critical factors to ensure success of this plan?

3.1 Addressing issues of racism, inequity and poverty will be critical to success. Racial and ethnic inequities contribute to poor health outcomes. Discrimination and its effects on health and wellbeing and exposure to racial discrimination are associated with poorer self-rated health, poorer mental health and greater life dissatisfaction.[2] Any recovery plans will need to take this into account.

3.2 Cormack et al., found that Māori, Pacific and Asian ethnic groups reported much higher levels of discrimination, and experienced multiple forms of discrimination. Eliminating indigenous and ethnic health inequalities and supporting mental health and wellbeing recovery requires the social determinants of health, which include institutionalised racism, to be addressed.[3] A shift to an approach based on a transformative concept of cultural safety, which involves a critique of power imbalances and critical self-reflection is necessary to improve health inequities. Evidence of cultural safety as a requirement for accreditation of all services involved in the recovery project is recommended.

3.3 The development of more kaupapa Māori mental health services that are well-funded and sustainable is necessary. The College supports services and programmes for Māori, created, developed and delivered by Māori. The ability to be responsive to whānau needs requires a different approach to service delivery and a strong community focus is needed, not just during a COVID-19 recovery but also as part of future services. Douglass et al (2020) highlight how racism needs to be

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[2] Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health*, 17(26).
[3] Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, 18(174): https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3

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addressed as a determinant of health and significant investment made to identify and dismantle bias and discrimination in health systems and institutions, as well as at individual levels. [4]

3.4 The addition of women's health and wellbeing, particularly maternal mental health, and recognition of the importance of the First 1000 Days to the recovery plan is critically important.

4. What positive examples of actions to support mental and social wellbeing are you aware of?

4.1 The Perinatal Anxiety and Depression Aotearoa (PADA) charitable organisation works towards the elimination of stigma around perinatal mental health in New Zealand by raising awareness and facilitating best practice in perinatal mental health. They provide advocacy and awareness through training for health care providers who support families with anxiety & depression due to pregnancy, childbirth and early parenting.[5]

5. **Do you think there is anything missing from the plan?**

5.1 The College has some concerns about the absence of discussion in the recovery plan about the health and wellbeing of refugee, migrant and asylum seeker populations in Aotearoa. As Aotearoa is about to increase the refugee quota from 1,000 to 1,500 people per year, effective from July 2020, and is also expanding the resettlement locations, we feel that the needs of these populations should be part of the recovery plan.

5.2 The College would like to see more of a focus on women's health and wellbeing, particularly during the times of pregnancy and parenting, recognition of the importance of the First 1000 Days, and consideration of the stressors involved for midwives in continuing to provide an essential antenatal, birthing and postnatal service during lock down. A project examining the costs of perinatal mental health problems in the UK found that perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK – and this work was not related to the COVID-19 pandemic.[6] The Chair of the Mental Health Alliance, Dr Alain George, states in the foreword, *"We hope this shocking statistic will motivate policy makers, commissioners and providers to act urgently."* The report also notes that to bring the full pathway of perinatal health care up to national recommended guidelines in the UK would be £280 million per year and suggests, *"This is a case for investment that cannot be ignored."* Perinatal mental health in Aotearoa New Zealand also requires significant investment. The College recommends this report be

[4] Douglass, C., Fyfe, M., & Lokugamage, A. U. (2020). Structural racism in society and the covid-19 "stress test". *BMJ Opinion*, June 8, https://blogs.bmj.com/bmj/2020/06/08/structural-racism-in-society-and-the-covid-19-stress-test/

[5] *Perinatal Anxiety and Depression Aotearoa* (PADA) https://pada.nz/

[6] Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., and Adelaja, B. (2014). *The costs of perinatal mental health problems*. Personal Social Services Research Unit (PSSRU), London, Centre for Mental Health and London School of Economics.

taken into account, particularly in light of the likely deterioration in wellbeing as a result of COVID-19.

5.3 In terms of maternal mental health concerns the Perinatal and Maternal Mortality Review Committee (PMMRC) reported that the single largest cause of maternal death in Aotearoa New Zealand was suicide. The 2019 PMMRC report describes 66 direct maternal and 44 indirect maternal deaths over the period from 2006–2017 inclusive, with suicide accounting for 30 deaths during this time (45%).[7]

5.4 In 2018 the Perinatal and Maternal Mortality Review Committee (PMMRC) recommended that the Ministry of Health should fund a maternal and infant mental health network to review current mental health services available across Aotearoa New Zealand for pregnant and recently pregnant women. They also recommended the establishment of a national pathway for accessing culturally appropriate maternal mental health services.[8] In 2019, the PMMRC again drew attention to the issue of maternal mental health and suicide, and recommended comprehensive action.[9] These recommendations, and the repeated call for maternal mental services, make the omission of pregnant, birthing and new mothers from the recovery plan a very serious concern.

5.5 Some issues that arise for midwifery care are related to a lack of support services, or specialist services to refer women to, in situations where additional needs have been identified. Barriers to accessing support for mental health or addiction services are many and include geographical difficulties for rural women, inequity, financial pressures, unavailability of timely culturally appropriate services for women, and the overwhelmingly difficult lives that women in poverty or deprivation experience. These conditions add extra challenges for midwives in terms of the degree and intensity of their workloads. It is important to note that the workloads for midwives increased significantly during the COVID-19 pandemic response.

5.6 The College considers that it may be optimal to undertake a review and map regional non-acute mental health services to identify what is available for women in each region and to determine their referral requirements. This would provide a more comprehensive understanding of service availability and accessibility and would help practitioners identify the appropriate services in each region. At the same time this mapping will identify the gaps in support services. The development of

[7] Perinatal and Maternal Mortality Review Committee. (2019). *Whakarāpopototanga Matua o te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki* | *Executive Summary of the 13th Annual Report of the Perinatal and Maternal Mortality Review Committe*e. Wellington, PMMRC
[8] Perinatal and Maternal Mortality Review Committee. (2018) Annual Report: Frequently asked questions https://www.hqsc.govt.nz/assets/PMMRC/NEMR-images-files-/PMMRC12thReport2018_FAQs.pdf
[9] Perinatal and Maternal Mortality Review Committee. (2019). Whakarāpopototanga Matua o te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki | Executive Summary of the 13th Annual Report of the Perinatal and Maternal Mortality Review Committee. Wellington, PMMRC.

a single point of entry referral system for women with mental health concerns during pregnancy or postpartum would assist a seamless referral process.

5.7 The College strongly supports a significant investment in the first 1000 days of life, which requires a dedicated focus on health and wellbeing in pregnancy, and early childhood. There is a growing body of evidence showing maternity care is a critical building block for the foundation of health. Giving every infant the very best start in life is crucial to preventative health care and to reducing health inequalities across the life course.

5.8 Breastfeeding protection, promotion and support are integral parts of all public health planning, including psychosocial and mental wellbeing recovery plans. Culturally appropriate breastfeeding support systems for women, including breastfeeding supportive workplaces and early childhood centres, alongside increasing paid maternity / parental leave are necessary as part of future planning. In view of the very real risk of more pandemics in the future, attention to supporting women who plan to breastfeed, and a revitalisation of the infant feeding in emergencies plans for Aotearoa, and the inclusion of young children in these plans, would be timely (Infant and Young Child Feeding in Emergencies IYCF-E rather than IF-E). A recent pre-COVID-19 examination of the emergency preparedness plans for IYCF-E in Aotearoa New Zealand suggests that infant and young child feeding issues may not be viewed as a priority. District Health Board information was hard to find on DHB websites and not all DHB's linked to the Ministry of Health information (Bartle, 2019)[10]

5.9 Maternal wellbeing is essential to child wellbeing, and needs to be at the centre of decision making at policy level across all sectors such as health, mental health, social services and education. It needs to be at the centre of a psychosocial and mental wellbeing recovery plan. A healthy confident mother provides the essential environment for a healthy nurtured infant. The infant's environment is the mother. Midwives and midwifery care have the potential to reduce inequities that continue to threaten maternal and infant mental health and wellbeing and midwives can play a significantly important role in the COVID-19 Recovery Plan.

5.10 There is evidence that the COVID-19 pandemic has had a significant impact globally on mental health in general populations, although there is as yet no published research on perinatal psychological wellbeing.[11] Matvienko-Sikar et al. recognise midwives as being critical to support for women's mental health during the pandemic.[12]

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[10] Bartle, C. (2019) Snapshot of emergency preparedness plans for IYCF-E in Aotearoa. Unpublished project.
[11] Matvienko-Sikar, K., Meedya, S., & Ravaldi, C. (2020). Perinatal mental health during the COVID-19 pandemic. *Women and Birth,* 33:309-310.
[12] Ibid

5.11 The health workforce is predominantly women and the gender inequities that continue to face women in this workforce represent an urgent priority for action. The COVID-19 Psychosocial and Mental Wellbeing Recovery Plan provides yet another opportunity to consider the effects of gender inequality, while also recognising and addressing economic and social inequalities that affect health and wellbeing. Health systems and society are reliant on the caring professions but health systems often fail to promote, protect, support and reward those who do the caring. Gender-transformative policies and measures must be implemented and addressing gender inequality in the health workforce must be a priority. A report by the United Nations, which recognises the deepening of pre-existing gender inequalities, recommends equal representation in all COVID-19 response planning and decision making; addressing the care economy, paid and unpaid, with transformative change for equality; and targeting women and girls in all efforts to address the socioeconomic impact of COVID-19.[13]

5.12 A framework for identifying and mitigating the equity harms of COVID-19 policy interventions was recently released.[14] This framework identifies potential physical and psychological health harms that may have resulted from policy interventions, and which may have not only exacerbated pre-existing inequities but generated new ones. Harms such as anxiety, depression, food insecurity, loneliness, stigma and violence were repeated across many groups and exacerbated by several COVID-19 policy interventions. Identifying policy interventions that may have generated inequitable adverse effects and mitigating policy and practice interventions by systematic examinations of evidence was recommended.

Conclusion

The College is grateful to have the opportunity to provide feedback on the COVID-19 Psychosocial and Mental Wellbeing Recovery Plan, and we look forward to support for the services of midwives and midwifery, and the development of free, accessible, equitable and culturally appropriate services for women and their whānau. Recognition of maternal mental health issues and appropriate action is well overdue. Failure to invest in maternal health services appears to have weakened the global response to COVID-19 and investing now in maternal health and midwifery services is a high priority.

Pandemics will continue to be a risk globally, and to avoid future catastrophe Aotearoa New Zealand needs to urgently address factors that exacerbate ill health such as institutionalised racism, poverty, and the social, political and commercial determinants of health, fairness and justice. There is also a need to examine and address the wider environmental picture which encompasses water quality, climate crisis

[13] United Nations. (2020). *Policy Brief: The Impact of COVID-19 on Women*. https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women

[14] Glover, R. E., van Schalkwyk, M, CI., Akl, E. A., Kristjannson, E., Lofti, T., Petkovic, J., Petticrew, M. P., Pottie, K., Tugwell, P., & Welch, V. (2020). A framework for identifying and mitigating the equity harms of COVID-19 policy interventions. *Journal of Clinical Epidemiology*, doi: 10.1016/j.jclinepi.2020.06.004

and food security, because concerns about climate change have a significant negative effect on mental health and wellbeing, and climate change must be considered as a significant threat to human health, as well as pandemics.

Ngā mihi

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