Key findings for the maternity sector from the PMMRC's 14th annual report

Ngā kitenga matua e pā ana ki te rāngai whakawhānau i te pūrongo ā-tau 14 o te PMMRC

Perinatal and Maternal Mortality Review Committee
He matenga ohorere, he wairua uiui, wairua mutungakore

Our vision

Te mahi tahi puta noa i te pūnaha kia kore rawa ai e mate, e whara ngā māmā me ā rātau pēpi, whānau hoki mai i ngā mate, wharanga rānei ka taea te ārai.

Working together across the system towards zero preventable deaths or harm for all mothers and babies, families and whānau.

Perinatal death prevention

Congenital abnormalities are the leading cause of death in babies.

Sadly, in 2018

604

babies died

from 20 weeks of pregnancy until 27 days of age

The PMMRC continues to ask for bread and flour to be supplemented with **folic acid**, as this has been shown to reduce the number of neural tube defects (a type of congenital anomaly).

District health boards (DHBs) and primary care providers to provide active navigational support for women to find and register with their lead maternity carer with minimal delay.[1]

Routine early antenatal care should meet clinical and cultural needs and should include attention to modifiable risk factors such as supporting whānau to become smokefree and screening for other health conditions such as diabetes, sexually transmitted infections and urinary tract infections.

After-death care

Around 41% of precious babies who died had a full post-mortem (autopsy) examination afterwards, which is the investigation that provides the fullest possible information for whānau/family about why their baby died.

No woman who chose a full post-mortem examination regretted her decision. 10% of women who declined later regretted the loss of opportunity to understand more about their baby's death.[2]

Neonatal encephalopathy

Around three-quarters of babies with neonatal encephalopathy are cooled to help reduce brain damage. To be most effective, **cooling should start with 6 hours of birth** – this only happened for 80% of babies who received cooling.

Recognise
the baby who will benefit

Communicate
with a tertiary centre

Cool
promptly when appropriate

To address the social and cultural determinants of health, the PMMRC supports:

- cultural safety education for clinicians, which is essential
- the recommendations of *He Mana Kōmihana Whakae Tino Rangatiratanga Pou Tarawhao | Māori Commissioning – An alternate view of the New Zealand Health and Disability System Review* final report[3]
- the recommendations of the Welfare Expert Advisory Group report, *Whakamana Tāngata.*[4]

The PMMRC insists that:

- Government should fund the provision of specific maternal mental health services
- the Ministry of Health should resource the co-design of a national perinatal bereavement pathway.

Maternal death

Tragically, on average nearly 10 women die each year either during pregnancy, or soon after the baby is born. Post-mortem helps us to understand how we can improve care in the future.

The PMMRC recommends that a Maternal and Infant Mental Health Network is funded by the Ministry of Health and includes these areas of priority:

- **a stocktake of current mental health services** available across Aotearoa New Zealand for pregnant and recently pregnant women to identify both the strengths of services and gaps or inequity in current services and skills in the workforce
- **a national pathway for accessing maternal mental health services**, including:
  - culturally safe services, including access to kaupapa Māori mental health and maternity services and the provision of appropriate screening
  - care for wāhine/women who are or have been in the mental health system
  - communication and coordination.

1. Makowharemahihi C, Lawton BA, Cram F, et al. 2014. Initiation of maternity care for young Maori women under 20 years of age. *NZMJ* 127(1393): 52–61.
2. Cronin RS, Li M, Wise M, et al. 2018. Late stillbirth post mortem examination in New Zealand: Maternal decision-making. ANZJOG 58(6): 667–73. URL: https://obgyn.onlinelibrary.wiley.com/doi/10.1111/ajo.12790.
3. See pp 173–6 of https://systemreview.health.govt.nz/assets/Uploads/hdsr/health-disability-system-review-final-report.pdf.
4. Welfare Expert Advisory Group Report. 2019. *Whakamana Tāngata: Restoring dignity to social security in New Zealand.* Wellington: Welfare Expert Advisory Group Report. URL: www.weag.govt.nz/weag-report.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

New Zealand Government