



WELCOME, TENA KOUTOU KATOA, KIA ORANA, TALOFA LAVA, MALO LELEI, FAKAALOFA ATU.

This is the second issue of the Maternity Services Consumer Council's Newsletter for 2011.

The year is proving to be a challenging one for the MSCC. During the March meeting of the MSCC's Steering Group, the MSCC was handed a letter giving notice of the Women's Health Action Trust's decision to terminate the MSCC's sub-lease. So after 20 years of occupying a space in the WHA's suite of offices, the MSCC had to find a new place for its office. Given the MSCC's extremely limited budget, we quickly discovered that we could not afford to pay hundreds of dollars a week for an office in the city. The decision was made to shift the MSCC office out to Waitakere Village into a large room in Lynda's home. While the MSCC now has a new physical address – 16 McEntee Road, Waitakere Village – the MSCC's phone number and PO Box number remain the same.

The increased costs of mailing out the MSCC pamphlets

The MSCC will now start charging for the postage and packaging charges for small orders of its pamphlets that we were previously providing for free. Due to the continuing high demand, especially for the three pamphlets in the Your Choices series, and the effort we often have to put into getting people to pay for the postage costs that are invoiced for when mailing out the pamphlet orders, the MSCC Steering Group decided that the MSCC can no longer afford to continue funding the orders for less than 50 pamphlets. Accordingly from 1st July 2011 there will be a \$5 charge for all orders of 10 – 50 pamphlets.

What's in this issue of the newsletter

The June issue of the newsletter contains an article on a largely ignored issue in maternity care – the devastation caused by stillbirth, a summary of what the extra funding for maternity services will be used for, an account of Michel Odent's presentation at a Auckland workshop held in May and his latest book, *Childbirth in the Age of Plastics*, an article on informed consent and childhood vaccinations in New Zealand, and an item on the government's decision on the storage of Guthrie cards.

Don't forget to check the dates for the MSCC's Steering Group meetings for the rest of the year.

Happy Reading!

Lynda + Nicola

COUNTING THE COST OF STILLBIRTHS

On the 14th April 2011 *The Lancet* published a series of ground-breaking online articles on an issue that is not only invisible in the majority of societies around the world but is ignored on international policy, programme and investment agendas. The issue is stillbirth, a devastating event for millions of women and their families every year, and one that the series of articles in *The Lancet* identified as one of the most shamefully neglected areas of public health.

Stillbirth is not counted in the Millennium Development Goals; it is not counted by the United Nations (UN); nor is it counted in the Global Burden of Disease figures. This despite the fact that in 2008 there were an estimated 2.65 million stillbirths with over a million of them occurring intrapartum – during labour and birth. The international definition of stillbirth is the death of a baby after 28 weeks gestation.

Most intrapartum stillbirths are associated with obstetric emergencies, whereas deaths during the third trimester of pregnancy are associated with maternal infections and foetal growth restriction.

In the first of six papers about stillbirth entitled “*Stillbirths: why they matter,*” Dr J Frederik Froen and his colleagues report:

“To be registered, counted and recognised also has profound humane implications. Although stillbirth can be as devastating as a child’s death, often the baby is known and mourned solely by the parents. Even in high-resource settings in which psychological support might be available, one in five mothers has appreciable long-term depression, anxiety, or post-traumatic stress disorder after a stillbirth. Fathers are also affected by negative psycho-social consequences. When compared with the leading global causes of death in all age categories, all-cause stillbirths would rank fifth among the global health burdens – before diarrhoea, HIV/AIDS, tuberculosis, traffic accidents, and any form of cancer.” (1)

The focus on maternal health

Over the past few decades there has been an increasing focus on maternal and child health which has seen a number of significant initiatives and interventions. Despite this, stillbirths have been ignored and the loss of these babies remains largely invisible.

For example, in September 2010, the UN summarised the commitments to improve maternal and child health by seven UN agencies, 36 countries, and more than 75 non-governmental organisations (NGOs) and professional organisations: stillbirth is not mentioned in any of them.

Stillbirths linked to deprivation

98% of stillbirths occur in countries of low and middle incomes, and within high-income countries disadvantaged populations have a much greater risk of stillbirth than affluent populations. The five major causes of stillbirths in low and middle income countries are childbirth complications, maternal infections during pregnancy (syphilis), maternal disorders (especially hypertension), maternal undernutrition and foetal growth restriction, and congenital abnormalities.



The variation in stillbirth rates across and within high-income countries indicate that further reduction in stillbirth is possible in these countries as well. While stillbirth rates have declined dramatically from around 1940, over recent times the decline has slowed or even stalled. (2)

In most countries the causes of stillbirths are inseparable from those that result in the deaths of pregnant women and their newborn babies. The Millennium Development Goals estimate that there are 350,000 maternal deaths and 3.6 million neonatal deaths every year. In countries with high mortality rates, emergency obstetric care has the greatest effect on these deaths, as well as on stillbirths. (3)

High-income countries

In high-income countries the familiar link between low socioeconomic status and adverse outcomes are starkly evident with large increases in the risk of stillbirth in minority populations. Inuit-inhabited areas of Canada have almost three times the rate of stillbirths as compared to the rest of Canada. Indigenous Australia women have almost twice the risk of non-indigenous women, as do African-American women in the USA when compared with white women. Reports from the UK and New Zealand reveal a similar scenario. (2)

Other risk factors

Smoking is a major contributor to stillbirths in some disadvantaged populations. For example, among indigenous Australian and Canadian women smoking contributes to about 20% of stillbirths compared with 4-7% overall in high-income countries.

Obesity is another major and potentially modifiable risk factor for stillbirths.

Other risk factors include:

- A maternal age of more than 35 years
- Alcohol consumption during pregnancy
- A first pregnancy
- A previous caesarean birth
- A multiple pregnancy
- Use of reproductive technology
- Lack of antenatal care

Call to action

The sixth paper in the series calls for high-income countries to eliminate all preventable stillbirths and close equity gaps. By 2020 low income and middle income countries should aim to have reduced their current stillbirth rates by at least 50%.

However, first stillbirths need to be recognised by all countries and by the UN as a major public health issue. Then each stillbirth must be counted.

References

1. J. Frederik Froen et al. "Stillbirths: why they matter." www.thelancet.com 14 April 2011.
2. Vicki Flenady et al. *Stillbirths: the way forward in high-income countries.* www.thelancet.com 14 April 2011.
3. Robert Pattinson et al. "Stillbirths: how can health systems deliver for mothers & babies?" www.thelancet.com 14 April 2011.



MORE MONEY FOR MATERNITY SERVICES

On 5th May Minister of Health Tony Ryall announced that the May 2011 Budget would provide an extra \$54.5 million for new initiatives for maternity services over the next four years.

The extra money is to be split between \$33.2 million for various quality and safety initiatives in the maternity services sector and \$21.3 million for extra WellChild services. The announcement received wide-spread media coverage and a press release from the NZ College of Midwives (NZCOM) enthusiastically exclaimed that both the Royal Australia and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and NZCOM applauded the Minister of Health for investing in maternity care. (1)

\$33.2 for maternity services

The Minister's press release gave the following breakdown of the how the extra \$33.2 million for maternity services would be allocated:

- \$18.4 million to improve the safety and quality of services for mothers and babies, by bringing all local maternity professionals together for regular clinical reviews of all births. This funding will also increase the number of midwives in hospitals, together with medical specialists on-site and on-call.
- \$6 million to revamp new parent information services.
- \$6.8 million to help vulnerable mothers access a fuller range of health and social services. It will also assist midwives to make appropriate and timely referrals to other practitioners.
- One-off funding of \$2 million to ensure all DHB maternity data is collected nationally.

Extra WellChild visits

The \$21.3 million over four years for additional WellChild visits has a particular focus on the needs of first-time mothers. The additional funding is expected to deliver an extra 54,000 visits to around 18,000 mothers who need this additional support. For these mothers, this will mean, on average, three additional visits up to the first two months of a baby's life. WellChild currently provides two visits during the first two months of life, following on from the 7 – 10 home visits provided by midwives in the first 4 – 6 weeks.

In addition to the \$54.5 million in these initiatives, \$13 million over four years will fund the needs arising from the rising birth rate. (2)

References

1. <http://www.scoop.co.nz/stories/PA1105/S00112/ranzcog-and-nzcom-applaud-minister-of-health.htm>
2. <http://beehive.govt.nz/release/budget-2011-545m-extra-mothers-babies>



“CHILDBIRTH IN THE AGE OF PLASTICS”

The development of plastics and the resulting plastic revolution has been one of the main factors influencing the history of medicine since the middle of the twentieth century, according to French surgeon and obstetrician Michel Odent. Following the development of disposable medical devices in the 1960s and the introduction of plastic bags around 1970, the use of intravenous drips became widespread in modern hospitals. Advances in the medical use of plastics induced a new phase in the relationship between doctors, nurses and midwives. Today plastic tubes are introduced in any vessel, in any organ, and in parts of the body that until recently were accessible only through direct surgical routes.

“The plastic revolution has had spectacular effects in maternity units. It was the prerequisite for the current standardised medicalisation of childbirth. Today it is commonplace to visualise a typical labouring woman as a woman whose arm is connected to an IV plastic bag via a plastic tube, while a catheter has been introduced in her epidural space,” he writes in his latest book.

In Auckland on 12th May to address a workshop and promote his book *Childbirth in the Age of Plastics*, Michel Odent described how we are currently at a turning point in the history of intervention in childbirth.

Odent maintains that a study of other cultures and their cultural traditions surrounding birth reveals that all are based on a belief that women need help to give birth. Cultural values are imposed during birth and helping women inevitably means controlling them. Cultural conditioning results in a total lack of awareness of how what we are doing is disturbing the birth process, and this is why we are now at the bottom of the abyss, he said.

Culturally controlled childbirth

This is the dominant paradigm throughout the world and throughout history as all cultural traditions include birthing rituals that involve a labouring woman being surrounded by observers/supporters, and then the baby being given to someone other than the mother as soon as he or she is born.

Odent’s most recent books and his workshop presentations emphasise that birth is an involuntary process, and that a woman in labour needs an environment that protects her from any form of stimulation of her neocortex. Such an environment will be a quiet, private, darkened space that reduces all artificial light, minimises any feelings of being watched and observed, and where all verbal communication is used with extreme caution. He consistently refers to the many scientific studies which have revealed the role that the amazing cocktail of love hormones, especially oxytocin, plays during labour and birth and in the postnatal period, and to the great scientific discovery of the twentieth century – a newborn baby needs its mother!



The major love hormone

Oxytocin is the main birth hormone. “It is necessary to induce and maintain effective uterine contractions for the birth of the baby and for the delivery of the placenta, and also because it may be presented as the main love hormone.” (1)

These days the vast majority of women receive synthetic oxytocin while giving birth, and although chemically the synthetic form is no different from the natural hormone (it is a simple nonapeptide molecule), the amount of oxytocin reaching the maternal bloodstream via an intravenous drip is enormous when compared with the amount of natural oxytocin that the posterior pituitary gland can release. Furthermore, natural oxytocin is released through pulsations, while synthetic oxytocin is delivered continuously. (2)

Odent refers to a US study which showed that oxytocin crosses the placenta in both directions, that the permeability is higher in the maternal-to-foetal direction than in the reverse, and that 80% of the blood reaching the foetus via the umbilical vein goes directly to the inferior vena cava via the ductus venosus, bypassing the liver and therefore reaching the foetal brain immediately. (2) This raises a great many questions about the impact that such a common interference has on the development of the oxytocin system of human beings at a critical phase for gene-environment interaction. Odent refers to it an unprecedented cultural revolution, and during the Auckland workshop he said there had been no studies on the effects of synthetic oxytocin on mother or the baby, although one is now underway in Spain which is studying babies born in 2006.

Meddling with the newborn’s relationship with mother

A number of Michel Odent’s recent books describe “man’s enormous potential for meddling in the newborn baby’s relationship with his or her mother,” something he regards as universal. In *Childbirth in the Age of Plastic* he refers to George Englemann’s 1884 work “*Labour Among Primitive Peoples*” which provided an impressive catalogue of the one thousand and one ways of interfering with the first contact between mother and newborn baby. It described beliefs and rituals occurring in hundreds of ethnic groups on all five continents.

We now know a lot about the third stage of labour – the period just after the birth of the baby. Immediately after birth the mother has the capacity to release a high peak of oxytocin. Swedish studies have revealed that this peak is higher than during labour, higher even than during orgasm. Odent emphasises that this high peak of oxytocin is vital for the safe delivery of the placenta. The important factors that facilitate the release of oxytocin are that the mother is kept warm, and as her baby needs her she must be protected from being distracted. Leave everything till later, he said, leave cutting the cord, and don’t rush the delivery of the placenta. The baby needs an immediate breastfeed and to be skin to skin with the mother.

To be born is to enter the world of microbes. The ideal is for the baby to be exposed to friendly microbes, to those of the mother. Thus modern science has



challenged the cultural conditioning and customs that result in the baby being taken away from the mother as soon as he or she is born. “Scientists say a newborn baby needs its mother, but culture cannot accept that the baby should be with its mother,” Odent told those attending the Auckland workshop.

“The 1970s was a period of fast development in immunology and bacteriology. We must give a great importance to the studies about the easy and effective transfer of maternal antibodies (IgG) across the human placenta. This implies that the microbes familiar for the mother are also familiar, and therefore friendly, for the germ-free newborn baby. We had reached a new vision of human birth from a bacteriological perspective. We were in a position to understand that the main questions are about the first germs that occupy the territory and become the rulers of the territory. In other words, we were in a position to understand that, from immunological and bacteriological perspectives, ideally a newborn baby needs urgently to be in contact with the only person with whom he (she) is sharing the same IgG,” he writes. (3)

The natural childbirth movement

Odent took issue with the natural childbirth movement at various points during the Auckland workshop, accusing it of perpetuating a number of unscientific beliefs about the needs of women during labour. They included the teaching that labouring women need energy similar to that of marathon runners, that during labour women should be upright and walk around as much as possible, that they need plenty of water or other fluids to prevent dehydration, that they need companions or support people such as husbands, doulas or other attendants in order to help them give birth. “You cannot help an involuntary process,” he said, “but there are situations that can inhibit it, make it more difficult.”

A woman in labour needs to be protected against any sort of neocortical stimulation, Odent maintains. This is the prerequisite for an easy birth – during the birth process the neocortex must stop working. To achieve this a woman needs a protective midwife, a silent, experienced midwife who knows how to protect her.

On a societal level, Odent believes that rediscovering the basic needs of labouring women would lead to radically reconsidering the relationship between midwifery and obstetrics, including the ratio between the number of obstetricians and the number of midwives. While the plastic revolution has contributed to the creation of an overtreated society and the continuing medicalisation of childbirth, Odent’s latest book ends on a positive note with his vision of childbirth in the land of Utopia in the year 2031.

References

1. Michel Odent. “*Childbirth in the Age of Plastics.*” 2011. Page 4.
2. Michel Odent. “*Childbirth in the Age of Plastics.*” 2011. Page 6.
3. Michel Odent. “*Childbirth in the Age of Plastics.*” 2011. Page 42.



INFORMED CONSENT & CHILDHOOD IMMUNISATION IN NEW ZEALAND

In March 2011 the report of the Health Committee on the *Inquiry into how to improve completion rates of childhood immunisation* was presented to Parliament and published.

The Health Committee was chaired by MP Paul Hutchison and was briefed by the Chief Coroner on the coronial process, and also had briefings from Michael Tatley on the adverse reaction process, and from Professor Peter Gluckman on how to improve completion rates of childhood immunisation.

The Health Committee called for public submissions on the inquiry and received 53 submissions. They also heard 24 submissions at meetings in Auckland and Wellington. It is clear from both the language used in the report and from the recommendations that the opinions of the experts prevailed and that the submissions and testimonies from concerned parents were completely disregarded by the Committee.

Conscientious objectors

Chapter 5 of the report is headed “*Community concerns, informed consent, and conscientious objection issues.*” It is rather disturbing that the term ‘conscientious objection’ is now being used when discussing community concerns and in reference to parents who choose not to have their children vaccinated, or agree to some of the scheduled vaccines but not others.

The chapter begins with a paragraph or two on “attitudes” and of course it is referring to the attitudes of parents and not those of health professionals or health agencies.

“We received many submissions expressing fear of immunisation, distrust of the agencies that provide vaccinations, and scepticism about the information provided by the Government about immunisation. We heard stories of babies, children, and young people with ill health, and impairment, and even dying, and about their families’ belief that these events were linked to immunisations. We were disturbed about the unsatisfactory information flow between agencies and the families in this process.

We were told that about four to six per cent of parents actively decline immunisation, and that a significantly higher proportion lack confidence in immunisation.”

Thus the problem was identified as being an “unsatisfactory information flow” rather than an acceptance of the possibility that occasionally there is a severe adverse reaction to a vaccine.

The Ministry of Health advised the Health Committee that “it is useful to differentiate between the groups that do not immunise” because “this part of the population is not homogeneous.” The report states that the Ministry is “interested in taking a new approach, dividing the population into segments according to behaviour and motivation rather than ethnicity or location. This would help the Ministry to target its communication and interventions appropriately.”

According to the MOH the segment of the population who do not immunise their children consists of:



- those who are willing but who experience financial or transport difficulties in getting their children immunised
- those who are “unmotivated”
- those who are “distrustful,” and
- those who are opposed to immunisation.

The section of this chapter under the heading “Informed consent” begins with the statement that:

“The information given to parents is a key influence on their attitudes to immunisation. The New Zealand system depends upon parents making an active, informed decision to immunise their children. We consider that it is very important that parents are given helpful, evidence-based information, to balance the common belief that immunisation is an individual parent’s choice and only affects children.”

Dr Nikki Turner told the Committee that some parents question the need for immunisation, are concerned about the safety of vaccines, and attribute the absence of these diseases to other factors, including hygiene, natural immunity, and unproven products. She said that families and communities sometimes do not understand the evidence behind the immunisation programme and part of the problem is that the evidence is poorly explained to them. Parents also rely on personal experience and anecdotal evidence.

The Committee’s response to this is a recommendation to the government “that the Ministry of Health ensure that it publishes up-to-date, readily accessible evidence-based data on the positive and adverse effects of immunisation so that informed consent can be made from a robust evidence base.” This could be taken as an admission that the Ministry has not been providing such information, something that communities, parents and health groups have complained about for many years.

Media

The media came in for its fair share of criticism in the report as well. An unnamed person told the committee that “a large proportion of media reporting about immunisation contains inaccurate material that creates fear and discourages immunisation.” Of course when it works the other way there are no complaints. The report also noted that after extensive – some would call it excessive – “media coverage of outbreaks of swine flu, there was an increase in the number of people who sought seasonal influenza vaccinations.”

The committee agreed with Dr Turner that media organisations need access to “articulate and knowledgeable immunisation experts. New Zealand images and stories relating to immunisation should be made available to the media and health promoters, to guide the way that immunisation is presented in the media, and in education materials.”

Translated this means that graphic pictures of babies harmed by meningococcal B on the front page of the *NZ Herald* is fine, but photos of children whose parents believe were harmed or died as a result of a vaccine are not.

The report goes on to say that “organised groups and vocal individuals circulate material containing negative messages about immunisation” and that an unnamed individual (probably the same one) told them “the same concerns about immunisation have been present since the eighteenth century, with changes reflecting only the progress in



vaccines and information technology.” Translation – some parents are still mindlessly trotting out arguments from the 18th century, and use the internet to do it.

The fact some babies and children have been seriously, and in some cases permanently, harmed by vaccines was obviously something that the committee refused to consider despite the evidence presented to them. This is most unfortunate for the parents of these children who were once again faced with yet another health agency that refuses to believe them.

Informed consent

While the report contains a brief acknowledgement of the need for informed consent, its recommendations will result in coercive methods being used to bully parents into agreeing to vaccinate their children. They are thus more about obtaining informed compliance rather than informed consent. For example, the committee recommended that the ministry should “ensure that all contracts for immunisation services oblige the contracted party to promote immunisations, and the evidence behind it. We consider that all health care professionals should be prevented from undermining the national immunisation programme.” So just how are they going to do that?

Other recommendations include:

Recommendation 26

We recommend to the Government that the Ministry of Health strengthen the legal and contractual requirements for health professionals involved in maternity care to provide scientifically credible immunisation information, in contexts including antenatal classes.

Recommendation 27

We recommend to the Government that the Ministry of Health build websites about immunisation with content written by, and designed for, antenatal educators, lead maternity carers, and well-child providers.

Recommendation 29

We recommend to the Government that it fund free antenatal classes for all first-time parents, and ensure that scientifically credible information about immunisation is provided to them.

Such recommendations are based on the assumption that there are never any risks associated with vaccines, that the pharmaceutical industry is totally reliable when it comes to testing the safety of their products, and that parents are not capable of making decisions about the scientific evidence.

But even more importantly, they simply do not fulfil the requirements of the Code of Consumers’ Rights.



GUTHRIE CARDS TO BE STORED INDEFINITELY

Since 1969 almost all newborn babies born in New Zealand have had a blood sample taken via a heel prick with the blood being stored on a card known as the Guthrie card. The blood samples are screened for over 20 metabolic disorders.

Over the past few years there has been a great deal of contentious discussion about the storage, consent and use of these blood spot cards. In 2007 a meeting was held with stakeholders including representatives from consumer groups about the use and storage of these cards, and submissions were produced on the National Screening Unit's draft policy options document by the MSCC and other women's health groups. Consumer groups argued against the cards becoming a de facto national DNA database or being used for research. The MSCCC recommended that after 5 years the cards should either be returned to parents or disposed of.

Until fairly recently most parents were not aware that the cards were actually held indefinitely and most did not know they had the right to ask for them to be returned once the tests on their baby had been completed.

It seems that government decided last year that the cards will be stored indefinitely. This decision was not made public until the *Otago Daily Times* broke the story on 9th April.

- www.odt.co.nz/news/national/155430/blood-sample-store-subject-debate

MSCC Meeting Dates for 2011

Our MSCC Steering Group is growing and this can only mean great things for the women of New Zealand. Make sure your voice is heard - please make a note of the following dates for the coming year in your diary and come along to our monthly meetings. You can be assured of a warm welcome. The MSCC meets on a Tuesday morning – meetings start at 10 am – and the days have been fitted around school holidays.

The meetings are held in the meeting room at MAMA, 1 Taylors Road, St Lukes. The meeting dates for 2011 are: **12 July, 9 August, 13 September, 4 October, 8 November and 13 December.**

So if you have an issue of concern or would like to share information about women's experiences of maternity care then do come along. Babies and toddlers welcome.

We look forward to seeing you – at MAMA, 1 Taylors Road, St Lukes.

