



Maternity Services Consumer Council

JUNE 2008 NEWSLETTER

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

Welcome to the second issue of the Maternity Services Consumer Council Newsletter for the year.

The MSCC has as one of its objectives this year making the need for considerable improvements to the postnatal care and support available to new mothers an election issue. Among other things we intend to use every media opportunity we get to push this issue.

Inadequate postnatal care

The MSCC received a letter from a very concerned grandmother several months ago. Although receiving a letter is unusual, receiving calls or emails from concerned grandmothers is not. The woman's daughter-in-law had given birth at North Shore Hospital earlier this year and was then provided with two nights of postnatal care at a different facility. The grandmother believed this was insufficient time to recover from the birth, learn the skills of breastfeeding and allow the supply of milk to be established. Various problems arose after the woman was unwillingly discharged home but the midwife was very busy and could not visit each day.

The appalled grandmother wrote: "For a first-time mother to return home so soon without establishing breastfeeding and without adequate support, in my view, is a breach of adequate care ...The decline in level of care, especially for first time mothers, is most disappointing." She ended her letter with a request that the MSCC use every avenue at its disposal to rectify this inadequate service. We will do our very best.

Her comments were subsequently very poignantly reinforced by a number of the women who took part in last year's survey on maternity services. The descriptions of the care they received make for emotional reading. See article on page 5.

What's in this issue of the newsletter

This issue of the MSCC newsletter contains a summary of the information in the report on the 2007 National Maternity Services Satisfaction, an article on the use of misoprostol in midwifery practice, an item on the *Healthy Start to Life Project*, an update on the revised vaccination schedule, and an article which reports on the release of the *Antenatal HIV Screening Guidelines* and reveals that the need for informed consent to antenatal HIV tests does not seem to be registering with some GPs.



MATERNITY SERVICES CONSUMER SATISFACTION SURVEY REPORT

Last month the Ministry of Health released the results of its third maternity services satisfaction survey. The survey of mothers who gave birth in April and May 2007 was undertaken in mid 2007 and the report was released on 9 May 2008. The previous two maternity surveys were carried out in 1999 and 2002. The objective of the latest survey was to obtain women's perceptions of maternity services, and to assess whether there has been any change since women were last surveyed in 2002.

The survey report presents the views of 2936 out of 8,079 women who were recorded as having given birth in New Zealand during April and May 2007. 3.1% of the survey forms were returned unopened which means that the response rate from the survey recipients was 37.5%.

Pregnancy care

The percentage of women who knew that they had to register with an LMC had increased to 80% in 2007, an improvement from 65% in 1999 and 77% in 2002. Registrations with self-employed/independent midwives increased from 54% in 2002 to 71% in 2007.

However, there was a marked increase in the percentage of women who found it difficult to find an LMC – up from 11% in 2002 to 19% in 2007. Nine percent of women could not find an LMC, and 46 women did not have any antenatal care at all. The problem was most evident in urban areas such as Christchurch and Wellington. Asked how satisfied they were with their antenatal care, 78% “felt well looked after” and 18% said “it was satisfactory”, with the remaining 4% chose the third option to the question, “I didn’t feel well looked after.” The reasons given for not feeling well looked after included the LMC’s poor attitude, lack of availability, lack of good, relevant or timely information, hurried, postponed or cancelled visits, lack of overall care and poor knowledge or expertise.

In response to the question “Did your LMC give you enough information to make an informed choice about antenatal test?” 95% of women replied yes. Maori women were more likely than European women to report that they did not receive enough information to make an informed choice.

Less than half (43%) reported attending antenatal classes, 57% said they had not. For first-time mothers the percentage of those who attended classes was 78%.

While 84% of women reported that a care plan was discussed with them in 2007 (compared to 86% in 2002), 66% reported that they were given a copy of their care plan to keep, up from 63% in 2002.

The birth of the baby

Thirty-six percent of the mothers who responded to the survey gave birth in Auckland, 11% in Christchurch and 6% in Hamilton. Five percent of the births were homebirths.

The same three questions were asked about satisfaction with the level of care during the birth, with 82% of women reporting they felt “well looked after” and 12% said it was satisfactory, while 6% replied that they “didn’t feel well looked after.” When asked what could be improved, mothers suggested increasing the LMC’s availability before and after the birth, more all-round care, better communication, more positive attitude, higher degree of expertise and various other aspects of

care. One mother wrote: “Don’t have so many clients to attend to – then you would have time to get to know your clients. As opposed to just being a number.” Another wrote: “The midwife is too old to find my blood vessel and he had to do several times to do the injection correctly because his hand is shaking.”

Hospital stay

When asked to evaluate their overall satisfaction with their stay in hospital, 58% of women reported being “very satisfied” and an additional 32% said they were “satisfied.” However, 4% were undecided and 7% were either “dissatisfied” (5%) or “very dissatisfied” (2%). Asked what could be improved, women said there was a need to improve overall care, aspects of the hospital facility, staff attitude, the need for more staff, problems caused by early discharge, and the need to improve communication, the availability of beds and the level of staff expertise. Comments included “Hospital room wasn’t clean I wasn’t given a meal,” “it was filthy. Cleanliness must be improved,” “more single bed rooms so that you can rest,” “more privacy, bigger space, partners able to stay overnight. Not sharing the same toilets/showers with 8 women.” Another wrote: “The bathroom was filthy and while in labour I couldn’t bring myself to sit on the toilet.”

Compared to the 2002 survey there was a significant increase in the numbers of mothers who were discharged within the first 12 hours after the birth of their baby – 14% compared to 8% in 2002. When asked if they felt ready to leave, 85% of mothers said yes, and 13% said no and a further 2% could not make up their minds. Women often described how having to leave before they were ready had resulted in them not being able to breastfeed effectively, experiencing untreated severe pain, feeling inadequate and unsafe to look after their new baby, and in some cases contributed to them developing postnatal depression.

Postnatal care

The survey revealed that major improvements are needed in the delivery of postnatal care. When asked about the number of times the midwife made postnatal visits, 27% reported fewer than 5 visits, 41% reported between 5 and 6 visits, 16% said they received 7 – 8 visits, 10% had between 9 and 10 visits and 6% said they had more than 10 visits. The report stated that 66% of mothers reported being “very satisfied” with a further 24% being “satisfied” with the number of home visits. “Women who had fewer than 5 visits are much less likely to report being “very satisfied” than those who received more than 5 visits.” No surprises there!

In the 2002 survey, women were asked to indicate how they fed their baby in the first four weeks. The same question was asked in the 2007 survey. In the latest survey 74% said they had breastfed (compared to 77% in 2002), 5% said they had bottle fed (6% in 2002) and 21% said they had used both methods (16% in 2002).

The Cost

In the 2002 survey 50% of women reported being charged for services they considered were related to their pregnancy, childbirth and postnatal needs. In the 2007 survey this figure had risen to 72%. Most frequently this was related to charges for ultrasound scans, antenatal classes, care from an obstetrician or a GP, or a positive pregnancy test.

What mattered most to women?

The report listed the following in order of importance:

- Supportive care from competent professionals who collaborated and communicated well with one another
- A midwife whom they liked and respected

- Provision of timely, comprehensive and useful information and advice at all stages of maternity care
- Professionals who were warm, reassuring and made them feel safe
- Receiving respect for their preferences and having control over their pregnancy and birth experience
- The availability of competent professionals and services, including specialist services, at the time the woman needed them.
- A hospital or neonatal facility experience where professionals were cognizant of their vulnerabilities, and supportive and accommodating of their needs.

What was also important?

Other aspects that mattered significantly to women were:

Continuity of service, including access to the same professional(s) and facilities throughout their pregnancy, delivery and postnatal care; LMC home visits; a positive birth experience; good postnatal services; support with breastfeeding; good hospital facilities and services; antenatal classes and specialist antenatal services; free maternity services (of all kinds); family/husband included; midwife-led maternity care; an obstetrician as LMC (vs a midwife); privacy; close proximity to services; and culturally sensitive services.

- **The 2007 Maternity Services Survey Report is available on the Ministry of Health website: www.moh.govt.nz**

THE DARK SIDE OF MATERNITY CARE

At the end of the 2007 maternity survey women were asked three open-ended questions about their maternity care:

Q 31 – List what was best about the maternity care you received

Q 32 – List what you like to stay the same

Q 33 – List what was good about the maternity care you received. What would you like to happen differently?

The majority of the 2336 women who responded to these questions answered questions 31 and 33. There were fewer responses to Q 32. Many answers were lengthy, especially those to Q 33. In regard to Q 33 the report notes; “This question elicited not only complaints and concerns, but also frequent emotional outpourings of the impacts that perceived inadequate service had on new mothers. It was noteworthy that women giving considerable responses to Q 33 had often left Q 31 blank and vice versa.”

The areas of concern raised most often were a direct reflection of the aspects of the maternity experience where women felt most vulnerable. They were:

- Inadequate support or services during hospital stay

“I didn’t get sheets changed and no one offered to show me how to wash my baby for the whole 5 days. By day 3 I hardly saw a nurse/midwife.”

“More care for mothers in vulnerable state. Not given any real care – just left to deal with it. Shoved around hospital room to make room for others.”

- Lack of breastfeeding support

“All midwives advise different methods of breastfeeding which makes it very confusing.”

“The midwives at the hospital were also so rough that I ended up with bruised breasts from them attempting to ‘help’ me feed. Needless to say within 2 weeks my child was on formula.”

- Poor treatment by hospital staff

“I have another health condition due to bowel cancer when I checked in and after my child was born, staff treated me like I was a major inconvenience in spite of the fact that I required no additional assistance from them. They effectively argued between wards over who should have me and upset me quite badly. I think the hospital midwives should be more considerate and less judgmental particularly as I added nothing extra to their workload.”

“Once the babies were born and taken to NICU I was not encouraged to come and feed them every 3 hours (rather discouraged).”

- Privacy and space lacking in hospital

“Hospital staff should ask mother permission to allow groups of ‘students??’ into the birthing suite.”

“Maternity Unit needs to expand, women were labouring out in the hallway when I went in.”

- Insufficient time in hospital

"I did not like being discharged so quickly after giving birth. My son was in an incubator for the first day and then I could only hold him for short periods during the second day and then I was discharged."

"I feel that 1st time mothers should be able to stay up to 5 days. 48 hours is not long enough even for 2nd – 3rd time mothers. Your milk needs to have come in."

- Inadequate basic hospital services

"My bathroom was not cleaned, the food was inedible and un-nutritious – for breastfeeding mother. My catheter was left in plastic bag on the floor for 2 days."

"It sounds crazy, but I never felt like we had enough to eat in hospital! I am not an obese food addict or anything but with 2 of my children they forgot about our meals after delivery. My 3rd (2007) was born at 3am and I couldn't get anything to eat until about 11.30am."

- Inadequate postnatal care

"Care after birth not good. Not enough home visits. Visits promised then cancelled. Too much reliance on text messages."

"I found it hard to get decent help – it took 7 weeks before I could feed properly, but stuck with purely breastfeeding. It would have been nice to get more help and support during that time."

Other issues detailed by mothers included their partner/family not being allowed to stay during the birth or during the hospital stay, bad experiences during the birth, inadequate pain intervention, LMC not at the birth and didn't pre-advise of their unavailability, inadequate information, costs, poor continuity of care, lack of attention to mothers of second or subsequent babies, and cultural issues.

The voices of the women provide a good indicator of where much need improve-ments to the maternity care system are most needed. While the Ministry of Health's press release claims that nine out of ten women were happy with their maternity care, the percentages of women who by their own reports received a totally inadequate level of postnatal care says otherwise. Women need to be able to choose when they are ready to leave hospital and to obtain a much better level of care both in hospital and in the community. Workforce issues regarding the shortage of midwives also need attending to.

THE USE OF MISOPROSTOL IN MIDWIFERY PRACTICE

In April 2008, the Auckland College of Midwives hosted an interactive education forum, exploring the current use of Misoprostol within New Zealand maternity care.

Wikipedia has this to say about Misoprostol:

“Misoprostol is a drug that is FDA-approved in the United States for the prevention of NSAID-induced gastric ulcers. It is also used (and approved in other countries) to induce labor and as an abortifacient. It was invented and marketed by G.D. Searle & Company (now Pfizer) under the trade name Cytotec (often misspelt Cyotec), but other brand-name and generic formulations are now available as well.

Chemically, misoprostol is a synthetic prostaglandin E₁ (PGE₁) analogue.”

Exploring off-label use in the United States, Wikipedia notes that misoprostol is considered mostly useful for labor induction and bereavements. It goes on to note:

“The manufacturers of misoprostol have never sought to license misoprostol for labor induction. Recently, however, generic forms of misoprostol have become available, and it is now licensed for labor induction in Egypt and Brazil, and a licensed induction product is expected in the UK in 2008.

The American College of Obstetricians and Gynecologists advocates misoprostol for labor inductions, and it is on the WHO essential drug list for labour induction.

The last paragraph in Wikipedia reads: “Misoprostol is also used to prevent and treat post-partum hemorrhage, but it has more side effects and is less effective than oxytocin for this purpose.”¹

Here in New Zealand Misoprostol is used as part of an early induction and in the management of the third stage where there is excessive blood loss. What defines a post-partum hemorrhage seems to be debatable, but current thinking in New Zealand appears to fall within the average of 500mls for a vaginal birth and 1000mls for a caesarean section.

Anecdotal feedback at the forum would suggest that the use of misoprostol in the treatment of PPH has become common practice in certain areas of New Zealand. There have been reported instances of misoprostol being used in a primary environment in spite this particular medication being considered a secondary or tertiary level drug. In fact, every time an unapproved drug is used in Zealand it should be reported to the authorities.² It would be fairly safe to assume that this probably doesn't happen often, if at all!

Elaine Grey, from the New Zealand College of Midwives, noted in her presentation that the side effects of misoprostol included shivering, fever, diarrhea, nausea and cramping and that a search of the current literature would suggest that 70% of the time the drug works and that 30% of the time it doesn't work, sometimes with catastrophic results. In fact in a search through the abstracts, the only consistent theme that I identified was that as it was a relatively stable medication it may be suitable for use in developing countries.

Elaine also noted that as research on misoprostol has been restricted to its use for treating gastric ulcers, the effect on the newborn infant is not known. Further to this, RANZCOG have this to say about

¹ <http://en.wikipedia.org/wiki/Misoprostol>

² <http://www.medsafe.govt.nz/profs/RIss/unapp.asp>

misoprostol: “As the use of misoprostol in pregnancy is “off label”, clearly no liability would be accepted by the company for adverse reactions.”³

My summary this drug has little evidence to support its safety or efficacy for use in obstetrics, the manufacturer will accept no liability for any adverse reactions, it is not registered for use in New Zealand as an uterotonic and when used for PPH the potential side effects for a new mother are horrendous; and yet it continues to be used by various practitioners throughout the country!

Google Cyotec and you will invariably end up with the number of horror stories clearly outweighing support for the use of this medication in obstetric practice. On Ina May Gaskin’s website I discovered a very useful 2005 summary of research, entitled *A Summary of Articles Published in English about Misoprostol (Cytotec) for Cervical Ripening or Induction of Labor*.⁴

One consistent theme I discovered while surfing was that much of the information about the usefulness (or otherwise) of this drug has been established purely through trial and error. With the 20th Anniversary of the Cartright Inquiry this year, I would like to ask, are New Zealand women and their infants again being submitted to “trial and error” medicine?

Clearly the issues for women lie firmly around their rights to receive services of an appropriate standard, to be fully informed and to give informed consent (or informed refusal). In the case of a PPH, urgency can limit the amount of information that can be effectively provided. However women must be aware that a medication being recommended is not licensed for that use in New Zealand and where possible written consent should also be gained. Midwives have a role to play in not only ensuring that this consent is carried out, but in also having a high awareness of the implications on their own practice of administering or being part of a multi-disciplinary team that administers misoprostol.

Finally, this serves as a reminder to us all that there continues to be very little in the way evidence to support many of the practices in use within the maternity sector.

Jennie Valgre



³ The Use of Misoprostol in Obstetric and Gynecology, RANZCOG College Statement, November 2007

⁴ http://inamay.com/archive/view_article.php?Article_ID=18&page_number=1

THE HEALTHY START TO LIFE PROJECT

New Zealand scientists researching the early life origins of adult conditions such as obesity and diabetes, learning difficulties, psychological and social adjustment have taken the unusual step of joining with economists and public health experts to bring the long term implications of their work to the attention of policy makers.

Professor Peter Gluckman, the Director of the Liggins Institute at the University of Auckland, is leading an international research project that will quantify the costs to a country of factors such as poor nutrition in pregnant women and during the first few years of a child's life, and the lack of support for breastfeeding. The research will focus on the developmental origins of disease and cognitive development.

The International Healthy Start to Life project emphasises action that focuses on the root of the problems rather than the consequences. It will bring together a unique grouping of world leading economists, policy advisors and medical scientists from both developed and developing countries. Together, they will devise an appropriate economic model they can use to evaluate the social and financial costs across lifetimes and populations that arise from children not having a healthy start to life. The study has the potential to make a major impact on our economy through a healthier, wealthier and more productive society.

The work to date has shown that comparatively simple measures and interventions aimed at improving the health and nutrition of women before and early in pregnancy would result in long term gains, for example by reducing disability, obesity and the risk of chronic diseases while improving learning potential, productivity and community involvement.

"We hope the project will encourage policy makers to take a long term view rather than applying isolated, short term fixes driven by electoral cycles," says Gluckman. "In recent years science and medicine have looked to the genome for answers and neglected the importance of the processes of development in building the foundations of healthy lives," he said. What is needed now is a focus on human development, and for individuals, families, communities, politicians and agencies to understand that a healthy start to life will pay dividends for the whole of society.

The international project team which included medical scientists, policy advisors and a World Bank economist held working sessions in Auckland on 15th and 16th April before attending a landmark meeting in Wellington on 17th and 18th April.

www.liggins.auckland.ac.nz/

ANTENATAL HIV SCREENING GUIDELINES

The National Screening Unit (NSU) has recently released “*Guidelines for Maternity Providers offering antenatal HIV screening in New Zealand.*” The guidelines for best practice have been developed to support maternity providers deliver an effective HIV screening programme.

Pamphlets for pregnant women are now available nationally. However some women may want more detailed information about screening, particularly what happens after receiving an inconclusive or positive HIV result. The guidelines include this information.

They also include information on the informed consent process that should be followed. A diagram on page 13 describes a process in which all pregnant women are given written information on antenatal HIV testing, preferably prior to the consultation. A pre-test discussion with the woman takes place, the woman is given the opportunity to have any questions she might have answered, verbal consent is obtained or the woman declines to have the test. This is then documented in the woman’s case notes. The standard also includes providing access to interpreters if needed.

This process provides a sharp contrast to what happens a good deal of the time when a woman turns up at her local GP practice, has a pregnancy test and is then sent off to have her first lot of antenatal blood tests. Many GPs currently tick the lab form and say little to the woman about what tests will be carried out on her blood sample. As the HIV screening programme unrolls, there have been repeated reports of GPs simply ordering HIV tests and saying nothing or very little to the woman. Waikato DHB’s HIV screening programme which began in March 2005 achieved a 99.7% uptake of the HIV test in the first 12 months by making it one of six routine antenatal tests.

However, 12% of doctors who responded to a survey admitted that they did not discuss the test with their patient beforehand. This coupled with the high uptake seems to indicate that women were not always asked to give informed consent to the test. Indeed, one of the two women in the Waikato DHB area who tested positive for HIV did not know she had been tested for HIV until it was diagnosed.

Although GPs and midwives are required to attend HIV screening workshops prior to the DHB beginning implementation of the antenatal HIV screening programme, this seems to be having little impact on some GPs. This does not seem to be of concern to Waikato DHB’s infectious disease specialist, Graham Mills. He says some groups were obsessed with consent issues and ignored patients’ right to good treatment. The MSCC is one of those groups who believe that the two must go hand in hand.

The HIV Screening Guidelines booklet is on the NSU website: www.nsu.govt.nz

UPDATED VACCINATION SCHEDULE IN NEW ZEALAND

With the introduction of the new Prevenar vaccination, there has been extensive changes to the Vaccination Schedule in New Zealand. As Prevenar must be administered on its own, the existing vaccines will now be combined into one injection.

In a press release on the 29 May 2008, the Ministry of Health also noted:

“The Meningococcal B (MeNZB) Immunisation Programme was a special programme and not part of the National Immunisation Schedule. From 1 June 2008 this vaccine will no longer be routinely offered to babies and preschoolers. Parents whose babies started their MeNZB doses before 1 June 2008 should try to complete the course by 31 December 2008.”

The National Immunisation Schedule*	
Age given	Diseases covered and vaccines
6 weeks	Diphtheria/Tetanus/Whooping cough/Polio/Hepatitis B/ <i>Haemophilus influenzae</i> type b 1 injection (INFANRIX®-hexa) Pneumococcal 1 injection (Prevenar®)
3 months	Diphtheria/Tetanus/Whooping cough/Polio/Hepatitis B/ <i>Haemophilus influenzae</i> type b 1 injection (INFANRIX®-hexa) Pneumococcal 1 injection (Prevenar®)
5 months	Diphtheria/Tetanus/Whooping cough/Polio/Hepatitis B/ <i>Haemophilus influenzae</i> type b 1 injection (INFANRIX®-hexa) Pneumococcal 1 injection (Prevenar®)
15 months	<i>Haemophilus influenzae</i> type b 1 injection (Hiberix™) Measles/Mumps/Rubella 1 injection (M-M-R®II) Pneumococcal 1 injection (Prevenar®)
4 years	Diphtheria/Tetanus/Whooping cough/Polio 1 injection (INFANRIX-IPV™) Measles/Mumps/Rubella 1 injection (M-M-R®II)
11 years	Diphtheria/Tetanus/Whooping cough 1 injection (Boostrix™)
12 years girls only	Human papillomavirus** 3 doses given over 6 months (GARDASIL™)

* from 1 June 2008 ** from 2009

References:

<http://www.moh.govt.nz/immunisation>

<http://www.immune.org.nz/default.asp?a=625&t=561&View=FullStory&newsID=108>

CONFERENCES

"Twenty Years After The Cartwright Report:

What Have We Learned?"

An interesting array of speakers including; Dame Silvia Cartwright, Sandra Coney, Professor Charlotte Paul, Clare Matheson, Dr Ron Jones, Dr David Collins QC, Justice Lowell Goddard, Professor Alastair Campbell, Dr Robin Briant, Dr Kenneth Clark, and Ron Paterson HDC.

Where: The Hyatt Regency, Auckland

When: 8.30am – 5.30pm Friday 29 August 2008

Contact Jane Kilgour at k.j.kilgour@paradise.net.nz to reserve a ticket

<http://www.law.auckland.ac.nz/uoa/law/notices/twenty-years-after-the-cartwright-report.cfm>



The New Zealand College of Midwives (NZCOM) Conference is to be held in Auckland at the SKYCITY Auckland Convention Centre, from the 12th to the 14th of September 2008. The conference theme is 'Choices, Challenges and Diversity.'

NZCOM conferences never fail to provide you with new knowledge, renewed friendships, expanded networking opportunities and a lot of fun. This conference promises to be no different as Judith McAra-Couper and her conference committee have enthusiastically incorporated the spirit of Auckland into all aspects of this, midwifery's major occasion for the year. We hope you will be able to attend.

For all conference queries please contact: Trish or Kim, Conference Managers, at
conference@nzcom.org.nz

MOH APPOINTS COMPLIANCE PANEL TO MONITOR THE CODE

The Ministry of Health has appointed a Compliance Panel to consider unresolved complaints relating to *The Code in New Zealand*. The latter is a self-regulatory Code to guide the marketing of infant formula in New Zealand written by the New Zealand Infant Formula Marketers Association (NZIFMA).

The fact that self-regulation has for the past 12 years resulted in a situation that is seriously in breach of the spirit and intent of the International Code on the Marketing of Breastmilk Substitutes is something that the Ministry of Health has thus far refused to acknowledge. The MOH has also put in place an unwieldy process of dealing with complaints, as complaints have first to be made to the NZIFMA via the MOH. If the complaint is unresolved between the complainant and the respondent only then can it be considered by the compliance panel. So those wishing to lodge a complaint about the marketing activities of the industry have to do it twice.

The members of the new Compliance Panel are:

Prue Kapua, (chair of the panel); an Auckland-based barrister/solicitor

Dr Fiona McCrimmon, (adjudicator); a graduate in both medicine and law

Hiki Pihema, (health practitioner); a senior dietician with the Tairāwhiti DHB

Sharron Cole, (consumer representative); Deputy Chief Commissioner for the Families Commission, member of the Hutt Valley DHB

Nimisha Waller, (academic member); a caseload midwife and senior lecturer at the School of Midwifery at AUT.

Jan Carrey, (NZIFMA representative); executive director of both the NZ Infant Formula Marketers Association and the Infant Formula Manufacturers Association of Australia.

MSCC MEETING DATES FOR 2008

Please make a note of the following MSCC Steering Group meeting dates for 2008 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 adjusted to fit around school holidays.

The meetings are held on the 2nd floor, 27 Gillies Avenue, Newmarket. The meeting dates for 2008 are:

1 July, 12 August, 2 September, 14 October, 4 November, 2 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 – on the 2nd floor, 27 Gillies Avenue, Newmarket.