Maternity Services Consumer Council

SEPTEMBER 2008 NEWSLETTER

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

Welcome to the third issue of the Maternity Services Consumer Council Newsletter for the year. It's been an exciting and productive three months for the MSCC.

New pamphlets

Since we sent out our last newsletter the MSCC has been busy producing new pamphlets. As well as the translation into Burmese of our *Choices for Childbirth* pamphlet, we have been working on a completely new leaflet ***Screening During Pregnancy: Your Choice.*** The latter is already proving extremely popular and the MSCC is already receiving requests to have it translated into a number of languages. A copy is included with this issue of the newsletter, along with an order form. There is no charge for the pamphlets but a donation for postage (which has now gone up considerably!) when ordering more than 40 – 50 at a time is requested. Alternatively, organisations could simply place an order by email and then get a courier to pick them up from the MSCC office in Newmarket.

What's in this issue of the newsletter

This issue of the MSCC newsletter contains a summary of some of the statistics from the National Women's Annual Clinical Report for 2007, an article on the increased risk of Type 1 diabetes in babies born by caesarean sections, a summary of some maternity cases from the office of the Health & Disability Commissioner, and an article that some of you may already have read in the June issue of the AWHC newsletter.

ANNUAL GENERAL MEETING

The **MATERNITY SERVICES CONSUMER COUNCIL** wishes to advise you of our AGM to be held on:

Tuesday, 14th October 2008, commencing at 10.00am
Level 2, 27 Gillies Avenue, Newmarket
We would love to see you there!

RSVP to Jennie: mscc@maternity.org.nz or phone 520-5314

2007 ANNUAL REPORT FROM NATIONAL WOMEN'S

National Women's released its Annual Clinical Report for 2007 in August. It is the fifteenth in the current series. The customary public seminar examining the information contained in the report took place on 8 August 2008. This year's seminar represented a significant milestone in that, for the very first time, there was a presentation from a consumer's perspective. The MSCC's Jennie Valgre gave a review of the consumer feedback received by the National Women's maternity services survey. It was the most interesting presentation of the day.

The 227-page report contains a wealth of statistical information on the 7671 women who gave birth at NWH in 2007 and the 7875 babies they gave birth to – as well as the 24 women who gave birth before they actually got to the delivery unit! There were approximately 500 more births in 2007 than there were in 2006. In 2007 there were 174 sets of twins (157 in 2006) and 3 sets of triplets (5 sets in 2006).

Normal births
Most of the intervention rates have continued to rise and as usual there is a corresponding drop in the numbers of normal births. The percentage of spontaneous vaginal births was 54.7% in 2007 – down from 59.4% in 2000.

Only 45.9% of first-time mothers had a spontaneous vaginal birth.

In terms of ethnicity, 41.1% of mothers were NZ European, 8.3% were Maori, 14.3% were Pacific, 11.4% were Chinese, 6.8% were Indian, and 4.4% were other Asian.

The majority of the women who birthed at NWH lived in Auckland Central (5,382 or 69.9%), 1136 (14.8%) of women were from South Auckland, and 1043 or 13.6% of women lived in the Waitemata DHB region.

Multiple births
The percentage of babies born in a multiple pregnancy has remained much the same for the past 10 years, and was 4.5% in both 2006 and 2007.

Out of the total of 357 babies born in a multiple pregnancy 11 died. Of the 72 twin pregnancies that reached term, 29 (40.3%) were delivered by caesarean section. Only 12 (16.7%) went into spontaneous labour.

Forty-three of the 102 pre-term births were delivered by elective caesarean section prior to the onset of labour. In total 60% of twin pregnancies were delivered by caesarean section in 2007. In 2000 41% of twin pregnancies resulted in a spontaneous vaginal birth/vaginal breech birth of both twins. This figure dropped to 24% in 2006 and rose slightly to 27% in 2007.

The NWH report says "only 16.7% of term twin pregnancies go into spontaneous labour. The ideal time of birth for twin pregnancies is debatable and is the focus of a study "Twins: Timing of birth at term" which NWH is participating in.

31.7% caesarean section rate
In 2007 the caesarean section rate was 31.7%, compared to 33.1% in 2006, 31.6% in 2005, 29.3% in 2004 and 26.6% in 2000. There was little difference between the caesarean section rates for first-time mothers (32.6%) and for mothers having subsequent births (30.8%).

Unlike previous reports the 2007 Clinical Report does not provide information on the indications for both elective and emergency caesareans. Two tables on page 198 provide information on the reasons for elective and pre-labour caesareans for 329 first-time mothers and 747 mothers expecting subsequent babies (multips) but this accounts for less than half of the women who had a caesarean section at NW in 2007.

For the 329 first-time mothers malpresentation was the indication given for 108 (32.8%) of the elective caesareans, maternal request for 58 (17.6%), placenta previa for 25 (7.6%) and maternal age for 20 (6.1%) and maternal medical condition for 18 (5.5%). For the 747 multips repeat caesarean section was the indication given for 541 (72.4%) of the elective caesareans, obstetric history for 56 (7.5%), malpresentation for 38 (5.1%), maternal request for 34 (4.6%), and placenta previa for 20 (2.7%).

Low VBAC rate

The report reveals that at 21.3% (compared to 22.6% in 2006 and 24.9% in 2005) the rate of vaginal births after a previous caesarean section (VBAC) continues to drop. Among the 268 women with one prior caesarean birth who go into labour spontaneously, 143 (53.4%) achieved a vaginal birth. The report states "Analysis of the VBAC data for 2007 shows that for women of all gestations there was a VBAC rate of 53% if labouring spontaneously and one of 49% if induced."

Induction of labour

The rate of induction of labour was 24.8% in 2007 (compared to 24.6% in 2006). As for last year the report notes "the possibility remains that the numbers given under-represent the true induction rate." Due to the increase in pre-labour caesarean sections, the rate of interruption of pregnancy before the onset of spontaneous labour rose in 2007 – 41% of pregnancies ended prior to spontaneous onset of labour.

Post dates is the most common reason (5.3% of all births) given for induction at term, followed by hypertension (3% of all births) and not in established labour (2.8%) and PROM or premature rupture of membranes (2.2% of all births). Maternal request was the reason cited for 44 inductions (0.6%).

Induction of labour increases with maternal age from 21.8% among mothers under 20 years of age to 34.9% of mothers over 40, while spontaneous onset of labour dropped from 74.9% to 24.8% in these age groups. The report notes that "there was an increased induction rate with advancing age, more pronounced in the multiparous group, where the rate of induction in women older than 35 years was over 60%."

Induction of labour is also associated with maternity care provided by private obstetricians (28.8%) who also have the lowest rate of spontaneous onset of labour at 38.3% compared to 62 - 76% among other major LMC provider groups.

For first-time mothers an induction of labour results in an emergency caesarean section rate of 33.8% compared to 19.1% in those who go into labour spontaneously. The caesarean section rate among women having subsequent births but no previous caesarean sections is double that following an induction (8.8%) compared to 4.2% of those who spontaneously went into labour.

Inductions and epidurals
Epidural rates were consistently higher among induced labours – 81.4% in first time mothers and 55.2% in mothers having a subsequent baby – than among those who went into spontaneous labour – 58.3% in first time mothers and 33% in mothers having a subsequent baby.

The report notes that "The epidural rate among labouring women was 53% in 2007, 70% if induced and 46% if labouring spontaneously."

Forceps and Ventouse
The rate of forceps and ventouse deliveries (combined under the term "operative vaginal deliveries") was 13.8% in 2007, with the rate having changed little over the past decade. 21% of first-time mothers had their baby with the aid of forceps or ventouse compared with 5% of mothers having subsequent babies. The ventouse was used in 8.9% of all births compared to 2.9% for forceps.

Epidurals
In 2007 59.9% of women giving birth at NW had an epidural which includes women who had a caesarean section after going into labour, but excludes 1230 women who had an elective caesarean. 65.6% of first-time mothers had an epidural in 2007 compared to around 39.2% of mothers having a subsequent baby.

Breech births
Of the 7875 babies born at NW in 2007, 449 (5.7%) were breech births. Excluding twins and triplets, there were 48 vaginal breech births out of a total of 351 breeches. There were 303 caesareans sections comprising 154 elective and 149 emergency caesareans.

Postpartum Haemorrhage
Postpartum haemorrhage (PPH) remains a cause for considerable concern and is associated with the increasing caesarean section rate. Primary PPH equal to or less than 500mls has risen over the past decade from 10.6% in 1992 to 32.6% in 2007. The rate for 500-1000mls has risen from 1.5% in 1992 to 5.3% in 2007. The report notes that "Postpartum transfusion occurred in only 2.2% of women with blood loss between 500 and 999mls, but 24.6% of women with loss of 1000mls or greater."

Postpartum Hysterectomy
In 2007 nine women had an emergency postpartum hysterectomy compared to six women in 2006. Hysterectomies following birth are usually associated with repeat caesarean sections.

Maternal Deaths
There were 5 maternal deaths in 2007 although only one of these occurred at National Women's. Two women died in the second trimester, one of meningitis and one of complications of undiagnosed diabetes. The other three women died postpartum.

Length of Postnatal Stay
Postnatal care for women having their baby at NW is provided either at the hospital or at Birthcare. This arrangement is the result of a contract set up with Birthcare in 2003. During the antenatal period women are informed that if there are no complications they will be expected to transfer to Birthcare for their postnatal care. In 2007 32.4% of women transferred to Birthcare after giving birth at NW, 59.6% stayed at NW and 7.6% went straight home.

In 2007 the average length of stay at NW for the 26% of mothers who went home after a spontaneous vaginal birth was 2.1 days, 3 days for mothers who went home after an operative vaginal birth, and 4.2 days for mothers going home following a caesarean section.

Breastfeeding
In 2007 77.1% of mothers were discharged from NW exclusively breastfeeding their babies compared to 74% in 2006. This enabled NW to demonstrate that it had met the criteria for application for a Baby Friendly Hospital Initiative audit. The audit was completed in December 2007 and NWH was awarded a Baby Friendly Certificate in early 2008.

The report comments that "the increase in exclusive breastfeeding is demonstrated across all modes of birth and reflects the culture of early initiation of breastfeeding. A reduction in the use of supplements during the short recovery stage has contributed to the increase in exclusive breastfeeding for women having an elective caesarean section."

- **Copies of the 2006 Annual Report can be obtained from Marjet Pot at: National Women's Health, Auckland City Hospital, email: marjetp@adhb.govt.nz**

CAESAREAN BABIES MORE LIKELY TO HAVE TYPE 1 DIABETES

Tuesday 26th August 2008

New research[1] reveals that mothers giving birth by Caesarean section have a 20 per cent higher risk of their baby developing Type 1 diabetes in childhood compared to those having natural births, warns leading health charity Diabetes UK.

The research examined 20 published studies on children with Type 1 diabetes born by Caesarean section and found that there was a 20 per cent increase in the risk of babies born by Caesarean section developing Type 1 diabetes. This could not be explained by other factors such as birth weight, the age of the mother, order of birth, gestational diabetes and whether the baby was breast-fed or not.

On average 24 per cent of pregnancies in England are delivered by Caesarean section, which is significantly higher that the World Health Organisation's recommended rate of 15 per cent.[2] Dr Iain Frame, Diabetes UK Director of Research, said: "Not all women have the choice of whether to have a Caesarean section or not, but those who do may wish to take this risk into consideration before choosing to give birth this way.

"We already know that genetics and childhood infections play a vital role in the development of Type 1 diabetes in children, but the findings of this study indicate that the way a baby is delivered could affect how likely it is to develop this condition later in life. Diabetes UK would welcome more research in this area."

Dr Chris Cardwell from Queen's University Belfast led the research. He said: "This study shows a consistent 20 per cent increase in the risk of Type 1 diabetes. It is important to stress that the reason for this is still not understood although it is possible that the Caesarean section itself is responsible, perhaps because babies born via that method are first exposed to bacteria originating from the hospital environment rather than to maternal bacteria.

"Type 1 diabetes in childhood has become much more prevalent across Europe recently and the rate of this increase suggests that environmental factors are the cause. However, despite much investigation, these actual factors remain largely unknown."

Diabetes is a serious condition that, if not managed, can lead to fatal complications including heart disease, stroke, kidney failure and amputations. There are 2.3 million people in the UK diagnosed with diabetes and 250,000 with Type 1 diabetes.

- For more information visit www.diabetes.org.uk

HEALTH AND DISABILITY COMMISSION
SUMMARY OF REPORTS – JUNE TO AUGUST 2008

For quite some time now the MSCC have received copies of HDC reports relating to maternity by email. We have decided to summarise these reports in our newsletters for your information. Generally there are very few (if any) reports each quarter; however July and August were a busy time for the release of maternity related HDC reports!

Case 07HDC16053 – Released 9 July 2008

Overview (as per page 1 of the report)
At 4am on 13 January 2007, Ms A, a young woman in the 41st week of her first pregnancy, was admitted in labour to a private rural maternity hospital by her midwife, Mrs B. At 10.35am, after a prolonged second stage, Mrs B arranged for Ms A to be transferred to a public hospital by ambulance. Ms A was admitted to the public hospital at 1.45pm. Her baby was delivered by a difficult emergency Caesarean section at 3.15pm with severe bruising to his brow and face, and a crush injury to his nose.

Complaint and investigation (as per page 1 of the report)
On 7 September 2007, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by midwife Mrs B. The following issue was identified for investigation:
The appropriateness of midwife Mrs B's management of Ms A's labour and transfer to the public hospital on 13 January 2007.

An investigation was commenced on 24 September 2007.

Summary of the report
After what appears to be a longish latent phase, Ms A laboured well to full dilation. When her waters ruptured they were clear to slight meconium stained, however both Ms A and her baby continued to remain stable. The second stage of labour was a long and arduous affair - 8 hours - with slow descent of the head and a posterior presentation being questioned. Presentation would appear to have been difficult to ascertain due to the level of swelling (thought to have been a caput) on the baby's head. After nearly fours hours of active pushing the decision was made to transfer to the secondary hospital, a 2-3 hour ambulance ride away. After admission to the hospital, Ms A laboured for a further hour before being taken to theatre for an emergency LSCS due to a brow presentation. ACC accepted the claim for treatment after seeking advice from an obstetrician.

The key issues examined under the report were:
- Labour management – this includes exploring a difference of opinion between what is deemed reasonable care between the ACC expert (an obstetrician) and the HDC's expert (a midwife)
- Meconium stained liquor
- Transfer to secondary services – both timing and mode (ambulance versus helicopter)
- Documentation

Opinion – No Breach (pages 11, 12 and 13 of the report)
The report states "I hesitate to find that Ms A did not receive services of an appropriate standard given this difference of professional opinion. What is clear, however, is that midwives and obstetricians working as lead maternity carers should spell out to women their own philosophy of care in the event of delay or difficulties during labour."

The report also notes that "Mrs B's documentation did not meet professional standards."

Of interest is the Commissioner's recommendation that NZCOM develop a consensus statement that notes the limitations of services available and implications for intrapartum and postpartum care when birthing at a stand-alone primary unit. He states that "At least in this way women may be better informed about possibilities and more empowered to ask for intervention at an earlier point." While this case is focused on what can go wrong in the case of a highly unusual presentation, the Commissioner also needs to remember that such a consensus statement would of course need to include all the benefits of birthing at a primary unit!

To read the full report, go to: http://www.hdc.org.nz/files/hdc/opinions/07hdc16053midwife.pdf

Case 07HDC03243 – Released 7 August 2008

Complaint (as per page 1 of the report)
In March 2007, the Commissioner received a complaint from Mr and Mrs A, forwarded by Health and Disability Advocacy Services, about the services provided by independent midwife Ms B. The following issues relating to the care provided to Mrs A were identified for investigation:

- *The appropriateness of the care provided by midwife Ms B to Mrs A during and after pregnancy in 2005.*
- *The adequacy of communication between midwife Ms B and Mrs A during and after her pregnancy in 2005.*

An investigation was commenced on 15 March 2007.

Summary
After a normal pregnancy, Mrs A went into spontaneous labour towards the end of 2005; her labour appears to have progressed normally, albeit with a longish second stage. The report notes "Baby A's head birthed at 4.30pm, with thick meconium-stained liquor draining from her nose… Baby A was delivered at 4.33pm in the next contraction … Baby A was described as floppy, pale and without heart or breathing rates. Following resuscitation, Baby A was transferred to the Special Care Baby Unit (SCBU)."

Mrs A was noted to have a first degree tear which Midwife B was "too shaken" to repair. A second midwife was called in to undertake the repair, however she felt that the perineum was too swollen and applied a pressure pad and ice-pack. There appears to be some discrepancy as to whether the tear was first or second degree, however it remained unsutured and consequently caused considerable physical and emotional anguish for Mrs A.

The following morning staff in SCBU recorded seizure activity and Baby A was transferred to Hospital 2 for investigation and management of her seizures. Baby A's diagnoses on the transfer summary were convulsion, severe birth asphyxia, congenital renal failure, hyponatraemia and hypotension. At the time the report was written Baby A was described as "…now 20 months old and making good progress, although she requires ongoing assessment."

Right 4 of the Code – Rights to Services of an Appropriate Standard – were considered applicable to this complaint.

The key issues examined under the report were:

- Care – especially the recording of fetal heart monitoring
- Documentation – antenatal, care planning and perinatal
- Co-ordination – particularly with regards to the perineal laceration
- Communication – particularly during labour and birth

Opinion – Breach (pages 22 to 26 of the report)

The report notes:

- "In my opinion, Ms B did not exercise reasonable care and skill when monitoring the FHR and therefore breached Right 4(1) of the Code."
- "Although Ms B saw Mrs A regularly during the antenatal period, her documentation of these visits in the pregnancy record is inadequate … The notes of each antenatal appointment are very brief and do not provide an adequate record of Ms B's discussions with Mr and Mrs A."
- "In my view, it was inappropriate for Ms B to assume that a detailed birth plan evidenced detailed knowledge."
- "Ms B's documentation for the antenatal and perinatal periods is not of an appropriate standard for a registered midwife. Accordingly, Ms B breached Right 4(2) of the Code."
- "In failing to seek the assistance of medical staff to suture the perineal tear, Ms B did not ensure co-ordination of care for Mrs A and therefore breached Right 4(5) of the Code."
- "Remind Ms B of the importance of clear communication with her clients at all times."

Actions Taken (page 27)
Ms B advised that she has undertaken a Special Review of the case with a MSR committee and will follow the recommendations on her professional development plan; she also agreed to attend a one-day accredited working on documentation and to use MMPO notes.

The case was referred to the Director of Proceedings who decided not to issue a disciplinary charge or any other proceedings.

To read the full report, go to: http://www.hdc.org.nz/files/hdc/opinions/07hdc03243midwife.pdf

Case 06HDC12769 – Released 7 August 2008

This is a lengthy report which contains significant expert commentary and an extensive opinion. I have therefore utilised the summary provided by the HDC to the MSCC.

"The Commissioner received a complaint about the services provided by a United States trained obstetrician and gynaecologist, Dr B, and Southland District Health Board. The complaint concerned a difficult ventouse-assisted birth at Southland Hospital in June 2006. During the delivery, the baby suffered a subgaleal haemorrhage and tearing of the umbilical cord. Despite intensive care at Southland Hospital and Dunedin Hospital, the baby died 3 days after her birth.

The Commissioner found that Dr B breached the Code of Health and Disability Services Consumers' Rights (the Code). However, for the reasons set out in the report, he was satisfied that Southland DHB did not breach the Code.

Dr B has been referred to the Director of Proceedings to decide whether any further legal proceedings will be taken.

The report considers the adequacy of the obstetric services provided by Dr B to the consumer, Ms A. This case and the report highlight the importance of respect, informed consent, accurate documentation and open disclosure. The report also discusses a district health board's duty to exercise reasonable care and skill when recruiting and supervising staff in order to protect patients, in the context of a US-trained specialist with a malpractice background."

To read the full report, go to: http://www.hdc.org.nz/files/hdc/opinions/06hdc12769o&g.pdf

WHAT PRICE A FREE DINNER?

The following article appeared in June issue of the Auckland Women's Health Council newsletter and this slightly abridged version is printed with permission.

On a wild wet windy evening in late June that made crossing the Auckland harbour bridge no mean feat, an event took place in the Spencer on Byron hotel in Takapuna that made even the most hardened cynics amongst us turn ashen-faced.

As the storm raged outside complete with thunder and lightning and a tornado or two waiting in the wings, inside it was all cosy and warm, with immaculately-clad waiters handing out free drinks and delectable nibbles as the guests drifted in and mingled with their colleagues. The guests were nearly all GPs who at the end of May had received a letter from the drug company Bayer inviting them to a presentation by a senior paediatrician and a drug company representative, after which dinner would be served. The invitation was enough to bring out over 100 GPs on such an inclement night.

The topic of what the letter described as "a dinner presentation" was *Feeding Options for Women Not Fully Breast Feeding*. After half an hour or so of "arrival drinks and canapé" we were ushered into a room and seated at tables set for dinner. Paediatrician Peter Nobbs was introduced and began his presentation on the history and politics of breastfeeding. He began setting the scene for the message he was there to give by focusing on an aspect of the environment that some new mothers in New Zealand 100 years ago were subjected to. The Plunket Society was put under the spotlight as Peter Nobbs described their staunch support for breastfeeding, their objections to an advertisement for an early version of what was then known as "humanised milk mixture" that appeared in the *Otago Witness* in the first decade of last century, and the two-faced behaviour of Plunket Nurses who, according to a letter that appeared in the *Otago Daily Times* in 1915, were telling mothers to breastfeed while they themselves were bringing up their babies on Glaxo.

We were told Plunket Society's founder, Sir Truby King's Melrose property in Wellington is listed as a category 1 Heritage Building, and that it was here that the earliest attempts to make "humanised milk mixture" or infant formula in New Zealand began. Vegetable oil, cod liver oil and dextrose were added to cows milk and this humanised milk mixture was marketed by the Plunket Society under the name of Karilac.

Peter Nobbs then showed a slide documenting the falling breastfeeding rates in the middle of last century – recorded as 91.5% in 1939, 82.1% in 1945, and 74.4% in 1952.

By now it was clear that the message we were being given was that not fully breastfeeding was normal and natural, that health authorities were often hypocritical about the advice they were required to give to new mothers about breastfeeding and what they actually said and did, and that the pro-breastfeeding stance was just a lot of politically-correct behaviour. Along with this were some subtle and not so subtle messages about the problems and risks of breastfeeding.

Turning his attention to the politics of breastfeeding Peter Nobbs went on to talk about the WHO Code on the International Marketing of Breast-Milk Substitutes, the advice given to new mothers in hospital, and the argument around whether complementary feeding with a bottle does have any affect on breastfeeding. He referred to the erroneous perceptions of groups like La Leche League and quoted a sentence from one of the group's 2007 newsletters: "Formula companies' only aim is to make money." He assured the audience that formula companies in New Zealand do comply with the WHO Code and see themselves as providing a complementary service.

NZ Breastfeeding Authority

The next organisation to come under attack was the NZ Breastfeeding Authority. He described their website, their current proposals around the Baby Friendly Hospital Initiative, and the accreditation of the hospitals in the Auckland region in critical terms. The NZBA website refers to the benefits of breastfeeding but not the risks, and risks of infant formulas but not the benefits. He cited as an example the fact that the

website mentioned bacterial contamination of infant formulas. He was very critical of how ridiculous this was when the incidence is less than one in a million.

Bottles and pacifiers
The issues surrounding the use of pacifiers and bottles featured next with Peter Nobbs referring to some of the evidence about their supposed effects on breastfeeding. Studies on the use of pacifiers show no consistent results, he said. The effects of supplementary bottle-feeding had been studied in two studies from the USA and one from Switzerland. The duration of breastfeeding in both groups was the same.

No RTCs
The lack of randomised controlled trials (RTCs) on the supposed benefits of breastfeeding was something Peter referred to several times during his presentation.

Peter ended his presentation with a list of the five most common conditions that mothers and babies present with at the doctor's office. They included reflux, colic, poor weight gain, allergies, and diarrhoea. As he talked about each condition he showed a slide with the image of the appropriate Bayer Infant Formula (brand name is Novalac) product – Novalac Reflux, Novalac Colic, Novalac Hypoallergenic, Novalac Diarrhoea. There was even a Novalac Sweet Dreams! With the exception of Novalac Diarrhoea, all products are described as suitable for use from birth onwards and as a "nutritionally complete formula suitable for long-term everyday use." Given that each of these special formulas costs around $30 a tin (almost double that of ordinary infant formula), the statement that the aim of the drug company is to make money does not seem at all unreasonable.

Bayer Consumer Care
The presentation by Ayumi Uyeda, the young female drug company rep was unremarkable in that it was clearly her job to promote the wonders of the Novalac range of specialised infant formulas. She consistently described them as "premium products', and the higher cost was simply "a price differential."

Ayumi Uyeda referred to the EDEN study of 3.500 babies, "an observational study of what happens in private practice" that was firstly an epidemiological study on presenting problems, and secondly the effects of Novalac on the problem. However, there was no mention of RTCs! Her slides showed the "scientifically developed" range of specialised infant formulas and how they differed from each other. The slick marketing of solutions to "problems" such as reflux, colic and constipation, the expansion of the diagnostic criteria used to identify such commonplace events as spilling or spitting up, periods of prolonged crying and distress, and constipation and diarrhoea, along with the supply of free drinks and good food, was both impressive and incredibly dishonest.

MSCC MEETING DATES FOR 2008

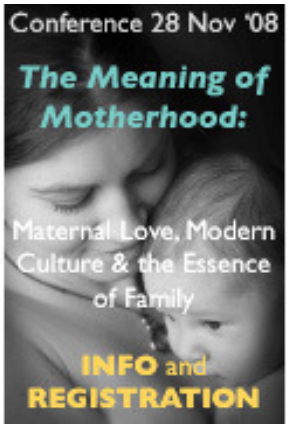
Please make a note of the following MSCC Steering Group meeting dates for 2008 in your diary and come along to our monthly meetings. You can be assured of a warm welcome. The MSCC meets on a Tuesday morning – meetings start at 10 am – and the days have been adjusted to fit around school holidays.

The meetings are held on the 2nd floor, 27 Gillies Avenue, Newmarket. The meeting dates for 2008 are: **14 October (MSCC AGM), 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.

CONFERENCES & WORKSHOPS



Centre for Attachment - together with the Families Commission, Parents Centres New Zealand, Great Potentials and the Parenting Council - is proud to announce a 28 November 2008 conference on motherhood: ***The Meaning of Motherhood*: Maternal Love, Modern Culture and the Essence of Family.**

AUT Tech Park Conference Centre, Auckland
Cost: $195.00

For more information or to register, visit
www.centreforattachment.com

KEEPING MOTHER'S HEALTHY:

Improving Maternal Healthcare in New Zealand

You are invited to register your participation in a one-day workshop *"Keeping Mothers Health: Improving Maternal Mental Healthcare in New Zealand."* This workshop is being organised by the Perinatal and Maternal Mortality Review committee and supported by the Ministry of Health.

Date: 9am to 5pm, Wednesday, 29th October 2008
Location: Waipuna Hotel & Conference Centre
Cost: $95.00 plus GST (early bird $85 plus GST – before 30 September)

For further information go to www.pmmrc.health.govt.nz or to register email: pmmrc@moh.govt.nz