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Maternity Services Consumer Council

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

Welcome to the fourth and final issue of the Maternity Services Consumer Council Newsletter for the year. It has been a very productive year for the MSCC with the production of three new leaflets, the redesign and reprint of the *Choices for Childbirth* leaflet in several languages.

It has however been all smoke and mirrors for improvements to maternity services promised by the current government. The process of making submissions on the Ministry of Health's *Maternity Action Plan* finally went ahead following a six-month delay, but nothing has happened since. The increase in postnatal care turned out to be only available for a small minority of women.

MSCC's new leaflets

We have been working on two more leaflets, the first being *Labour and Birth: Your Choice* – the second in our ***Your Choice*** series. Following on from the *Screening During Pregnancy: Your Choice* leaflet this new leaflet focuses on choices during labour and birth. A copy is included with this issue of the newsletter and copies can be ordered by emailing the MSCC office. These leaflets are available free of charge but we will request a donation to cover postage and handling costs for orders over 50 copies.

The second leaflet is the third leaflet in this series and focuses on screening tests and procedures that occur after birth. It currently being circulated for feedback and suggestions. We plan to have the leaflet printed and ready for distribution at the beginning of 2010.

What's in this issue of the newsletter

The December issue contains a summary of some of the statistics from the NZ Health Information Services document on what the MOH refers to as "hospital-based maternity events" for 2005, an article on the "pain talks" which are given by anaesthetists who spend more time promoting epidurals than any other forms of pain relief, some information on safe sleep for babies, an article on the 3rd report of the Perinatal and Maternal Mortality Review Committee which contains statistical information on the deaths of 11 mothers and 677 babies during the year 2007, and finally the story of how a bunch of breastfeeding advocates took on Trademe in an effort to keep the Ministry of Health's fabulous new DVD *Breastfeeding Naturally* free of charge – and won!

Don't forget to check out the dates for the MSCC's Steering Group meetings for 2010.

Happy Reading!

And we wish you all a safe and fun Summer Solstice, Christmas and summer holiday.

Lynda & Jennie

NATIONAL MATERNITY REPORT FOR 2005

At some point during the past year the New Zealand Health Information Service (NZHIS) put the *Statistical Information on Hospital-based Maternity Events for 2005* on its website. Over the past two years the MSCC had made numerous enquiries as to when the Annual Report on Maternity 2005 would be available, and each deadline has failed to produce the promised report.

The *Statistical Information on Hospital-based Maternity Events* paper does not contain the primary and community health care data for 2005. The paper states "when these data becomes available they will be incorporated with the hospital information in this paper to produce the Annual Report on Maternity. Publication of the Annual Report on Maternity is expected in the first quarter of 2009."

The paper contains information on the outcomes, availability and ulitilisation of maternity services for women who gave birth in New Zealand in 2005. As with the 2004 and 2003 report there is significantly less data than there was in the maternity reports for previous years. When the stakeholder advisory group that provided input into the production of the report was disbanded in 2004 the impetus for producing timely information was lost.

NMDA

The data is based on information reported to the National Minimum Dataset (NMDA) with some information provided by Statistics New Zealand from the Birth, Deaths and Marriages register.

The NMDA has complete coverage of all hospital births, but does not contain information on births that occur outside the hospital.

In 2005 a total of 54,849 mothers gave birth (compared to 54,875 in 2004) in New Zealand hospitals to 55,712 liveborn babies (compared to 55,213 in 2004) and 520 babies who were stillborn. However Statistics NZ reported the registration of 58,727 liveborn babies to 57,196 mothers for the same period. The report says that births outside hospitals may account for the difference between in-hospital birth numbers and the Statistics NZ numbers.

MOTHERS

Age of women giving birth

The data reveals that in 2005 the median age for NZ women to have a baby was 30.4 years (compared to 30.3 in 2004). For Maori mothers the median age was 26.0 years and for Pacific mothers it was 27.8 years.

The percentage of mothers aged 30 years and over continued to gradually increase, accounting for 51.4% of births in 2005 (compared to 51.2% in 2004). Correspondingly the percentage of mothers aged 20-29 years continued to decrease – 41% in 2005 compared to 41.6% in 2004. 7.5% of mothers were less than 20 years of age (compared to 7.2% in 2004).

Ethnicity of mothers

The majority of mothers who gave birth in 2005 were European (57.2%) while 20.2% of births were to Maori women (19.9% in 2004), 10.2% were to Pacific women (10.1% in 2004), and 8.5% to Asian women (8.8% in 2004). Maori women tended to have children at a younger age than women in other ethnic groups and in 2005 their fertility rate peaked in the 20 – 24 age group. Maori girls also accounted for nearly half of births to teenage mothers.

In comparison, the peak for Pacific women was in the 25-29 age group and for Asian and European women in the 30-34 age group.

Decline in normal births
The report reveals that in 2005 66.8% of mothers had a vaginal birth, compared to 66.5% in 2004. In 2005 23.8% of women had a caesarean section compared to 23.7% in 2004. Of this figure 14.1% were acute caesarean sections and 9.7% were elective. Operative vaginal births (forceps 2.9% and ventouse 5.9%) extractions accounted for 8.9% of births in 2005 – 0.1% had both forceps and ventouse, although the latter continues to increase as these are considered to be less traumatic for both mother and baby.

Breech births
There were 125 unassisted spontaneous breech births in 2005, and 124 assisted breech births.

Caesarean sections
Age is one factor associated with the caesarean births as the percentage of normal births decreased markedly with the increasing age of the mother – in 2005 40.1% of women over 40 years of age had a caesarean section (37.6% in 2004) compared with only 13.2% of women in the 16 – 19 age group. Maori and Pacific women were more likely to have a normal birth (spontaneous birth without assistance) compared with women in other ethnic groups. In contrast, caesarean sections were more common among Asian and European mothers.

While acute/emergency caesarean sections accounted for the majority of caesarean sections, European women are more likely to have an elective caesarean section.

Like other developed countries New Zealand's overall caesarean section rate has continued to increase – from 11.7% of all births in 1988 to 20.8% in 2000 and 23.8% in 2005. The report notes that "currently no consensus exists in New Zealand regarding the optimal caesarean section rate for the best health outcomes. However, there is general consensus that the current rate is too high."
The highest rates of caesarean section in the North Island were Auckland DHB's National Women's at 31.6%; Hutt Valley DHB at 27.3%, and Wairarapa DHB at 26.1%. In the South Island it was Southland DHB at 27.5% and Canterbury DHB at 26%.

Inductions
Inductions are one of the factors associated with the rise in the caesarean section rate. In 2005 the rate of inductions per 100 births was 19.8 (excluding elective caesarean sections). The report notes that the rate of induction increased with the age of the mother and was slightly higher for European mothers. Southland DHB had the highest rate at 26.3 per 100 births, followed by South Canterbury at 25 per 100 births, and the West Coast at 24.8 per 100 births.

Epidurals
One in four births had an epidural administered (excluding elective caesarean sections). There are major ethnic differences in epidural use with the rates for Asian and European mothers being double those of Maori and Pacific mothers. Maori mothers had the lowest rates for both induction and the use of an epidural. Mothers aged between 30-39 years had the highest rate of epidural administration – 32.1 per 100 births.

Rates of epidural use per 100 births ranged from a high of 45.2 in Auckland, 45.0 in Capital and Coast region, and 43.7 in the Nelson Marlborough region to 6 in the Lakes DHB region, 8.4 in Taranaki and 9.3 in Tairawhiti (Gisborne).

Hysterectomies
In 2005 40 women had a hysterectomy that was related to giving birth, compared to 29 in 2004. This is directly related to the increasing rate of caesarean sections being performed.

Maternal deaths
There were three maternal deaths due to obstetric complications that arose during pregnancy, labour and birth, compared to one maternal death in 2004.

BABIES

Pre-term births
In 2005 7.2% of babies were born before 37 weeks of pregnancy – the same rate as in 2004. The report notes that babies of Maori and European women were more likely to be pre-term at 7.6% and 7.3% respectively.

In 2005 1.1% of live babies were born with a very low birth weight – ie, less than 1500g. Of the babies born before 37 weeks gestation, 57.2% has low birth weight, compared to 2.1% of babies born at 37 week and over.

Postnatal readmissions
In 2005 2789 mothers required a postnatal re-admission, compared to 2726 in 2004. Taranaki had by far the highest rate of postnatal re-admission for mothers. The majority of mothers were readmitted for 'postpartum care and examination' (29.5%), and 'infections of the breast associated with childbirth' (14.6%). The average length of stay for these mothers was 2.4 days.

The document contained no information on Lead Maternity Carers, the postnatal care that was provided, breastfeeding rates. Presumably this information will be included in the *National Maternity Report for 2005* when it is finally produced.

The *Statistical Information on Hospital-based Maternity Events for 2005* is available on the Ministry of Health's New Zealand Health Information Service (NZHIS) website: http://www.nzhis.govt.nz/moh.nsf/pagesns/32/$File/Hospital_based_Maternity_2005.pdf

PAIN TALKS – *YEAH RIGHT!*

In recent years the anaesthetists have become so concerned about the lack of informed consent surrounding the administration of epidural anaesthesia during labour that they have started giving pain talks to parents-to-be. When the MSCC first started getting feedback about some of what was being said during these sessions, we were so concerned that we organised for someone to attend a session with a pregnant woman and her partner. Suffice it to say, we were not impressed at all with what was reported back to us. The MSCC then contacted National Women's (NW) and protested furiously at the biased and utterly misleading statements that the anaesthetists were making.

As you would expect, the first thing that happened was that no "extras" were allowed to accompany any of the couples coming to classes! Undeterred the MSCC managed to find a clued up set of expectant parents to attend and take notes and we learned that there had been some small improvements made to the epidural promoting pain talks. However, the sessions were still unacceptable in that they did not adequately address other forms of pain relief in a manner that would inspire confidence in those attending the talks. Far more time was spent promoting epidurals and creating unrealistic expectations about what women can expect from having an epidural, especially in terms of their mobility and what happens during the second stage of labour. It is very obvious to us that these talks or clinics as they are sometimes referred to do not meet informed consent requirements and are a thinly disguised attempt by anaesthetists to promote the use of epidurals. Given that there are a number of LMC's actively promoting and encouraging attendance at these talks, you could be forgiven for considering that they too are promoting the use of an epidural in labour!

This year we heard that pregnant women were turning up to these talks in droves because one or two of the anaesthetists were conducting tours of the hospital. As NW had discontinued the tours a couple of years ago and now refer women to the "virtual tours" available on-line, the prospect of getting a real tour of the hospital resulted in an increased demand for the pain talks. While it appears that this practice has stopped, the demand for the talks has continued with more than one talk now been given each month.

The anaesthetists have now produced a promotional leaflet for the pain talks that goes in every information pack that women who book at the hospital get sent to them. When the MSCC queried this we were told that the College of Anaesthetists are so concerned about the need to meet informed consent requirements for women to have an epidural that they are supporting the move for all regions to provide such a service. This raises some very interesting issues.

For example, if the pain talks are regarded by the College and by anaesthetists as being necessary to meet the requirements of the Code of Consumers' Rights for the administration of an epidural will those women who have not attended a pain talk be refused an epidural?

If the answer to that is no, woman will not be refused an epidural, then the MSCC wants to know how the informed consent requirements for those women who have not attended a pain talk will be met.

Another issue is how other methods of pain relief are presented and discussed given that the pain talks are not just about epidurals. The MSCC is keen to know how the College of Anaesthetists will ensure that a balanced and fair representation will be given of all the other forms of pain relief available to women in labour, including the use of water.

The MSCC is also interested in how the College will ensure that those anaesthetists providing information on the various forms of pain relief are giving evidence-based information on all forms of pain relief, including the risks, benefits and side effects of epidural anaesthesia.

So we recently wrote and asked them.

In the letter we referred the College to the UK's National Institute for Health and Clinical Excellence (NICE) guidelines on Intrapartum Care which can be accessed at http://guidance.nice.org.uk/CG55/Guidance/pdf/English.

The evidence statement in the NICE guidelines states: "*Labouring in water reduces pain and the use of regional analgesia. There is evidence of no significant differences regarding adverse outcomes when comparing labours with and without the use of water. There is insufficient evidence on timing of use of water in labour*."

The guidelines also recommend: "***The opportunity to labour in water is recommended for pain relief***." This is not something that is promoted in the pain talks.

That is not all the MSCC has done. We have applied for and got funding to produce another leaflet in "*The Facts*" series – this one will be called "*Epidural Anaesthesia: The Facts.*" We will begin work on the new leaflet in the New Year. So watch this space!

MSCC Meeting Dates for 2010

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 on the 2nd floor, 27 Gillies Avenue, Newmarket. The meeting dates for 2010 are**: 9 February, 9 March, 20 April, 18 May, 15 June, 20 July, 17 August, 21 September, 19 October, 16 November and 14 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.

IN PURSUIT OF SAFE SLEEP FOR BABIES

SUDI is the term now used to describe the sudden unexpected death of a baby in the first year of life. It includes deaths from SIDS (or cot death) as well as deaths from other causes such as suffocation. The umbrella term, SUDI, is used in New Zealand to avoid confusion from different diagnoses of the causes of death and the different interpretations of New Zealand coroners for deaths of babies as they sleep.

Human babies are designed to need protecting, even when they sleep. In New Zealand, about 60 babies per year die sudden unexpected deaths, most of them preventable. Safe Start ™ is our programme of professional and community education to ensure every person in New Zealand knows, accepts and acts of infant safety knowledge.

What is the vision?
As well as broad participation, transformative change requires alignment to a shared vision. The vision of our Safe Start blitz is: **safe sleep for every baby, in every place, at every sleep.**

What about low risk babies?
SUDI is an issue of development. Because it happens during a critical stage through which every baby must pass, there can be no 'low risk' babies. The triple risk[1] understanding of SIDS/SUDI is that a **vulnerable baby** at a **critical stage** of development meets a challenge in the **sleeping environment** that overwhelms them. It is not possible to identify which babies are vulnerable, only which groups of babies are more vulnerable e.g. babies exposed to any smoking, born before 36 weeks gestation, weighing less than 2500 grams at birth, not breastfed or unwell. These markers of increased vulnerability to SUDI are also factors known to suppress a baby's arousal response[2]. A healthy arousal response is an important defense for a baby against life threatening situations that could otherwise result in SUDI.

What is research finding now?
The most recent scientific study of sudden unexpected infant death was published[3] in the British Medical Journal in October, 2009. The study design used two comparison groups, one of randomly chosen families (n=87) and one of high risk families (n=82). Variables were compared amongst the three groups including the group of babies who had died (n=80).

The study confirmed key evidence from other studies (importance of face-up, face clear, smokefree sleep), identified hazards for co-sleeping situations (recent use of alcohol and drugs, co-sleeping on a couch) and added new information about emerging risks (younger age of baby, swaddling, use of pillows).

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[1] Filiano, J.J., and Kinney, H.C. "A Perspective on Neuropathologic Findings in Infants of the Sudden Infant Death Syndrome: The Triple Risk Model." *Biology of the Neonate* 1994; 65(3–4):194–7.

[2] Horne RSC, Safe sleeping promotes protective arousal responses. *Paediatr Child Health* 2006;11(Suppl A):4A-6A

[3] Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EMA, Fleming P. Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England BMJ 2009;339:b3666, doi: 10.1136/bmj.b3666 (Published 13 October 2009)

A strength of this paper was the finding that the two control groups were similar to each other when compared with the babies who died. The authors conclude that the main risk factors are modifiable and **not the direct result of socio-economic deprivation**. This is an encouraging finding for addressing inequalities in infant death rates and brings hope to challenged families.

Also encouraging is the clarification about hazardous 'same surface' co-sleeping. More than half (54%) of the deaths involved co-sleeping compared to just 20% in control groups so there is no doubt that co-sleeping needs to be set up to be safe and not simply assumed to be so. However, much of the co-sleeping excess for babies who died was explained by an interaction between co-sleeping and recent use of alcohol or drugs by parents, or sleeping with a baby on a couch.

As we learn more about hazardous sleeping environments for babies, we also learn more about safety.

Has the safety advice changed?
While the key principles of protection have not changed, how to apply them has been refined. The safety formula promoted in the new Safe Sleep Essentials leaflet is:

safe sleep = face-up + face clear + smokefree.

Since risk factors work together, your education needs to foster awareness of a safe sleeping context of **strong baby** (smokefree from the start), **easy breathing** (face-up for every sleep), **safe environment** (face stays clear). These three principles, when applied together, hold the power to protect most babies from SUDI.

A fourth principle, 'always in a bed designed for babies' is **essential extra protection** for groups of babies known to be more vulnerable, as defined above, or in situations where a parent's ability to respond appropriately to their baby is compromised by, for example, smoking, alcohol, drugs, medications, extreme fatigue.

What about co-sleeping?
Babies need to be close to a parent and safe when they sleep. Both are important. Same-room co-sleeping is protective against SUDI. The evidence from research is that if the parent is asleep, then 'in a room alone' adds risk and 'in a room with a parent' reduces it, for a sleeping baby.

Same-surface co-sleeping is more complex. It is well established that current SUDI rates are lower when babies sleep in beds designed for babies and higher when they sleep in any other place. However, it is hotly debated just what is hazardous: bed sharing per se or how it is practiced. The prevention strategy in New Zealand is for universal promotion of **same-room** co-sleeping, targeted advice on **same-surface** co-sleeping in *conditions well established to be dangerous* and universal promotion of **make it safe**.

What do the principles mean in practice?
The prevention approach described above places the burden of responsibility on parents to apply the safety principles to the specific circumstances of their baby and family. They will be more likely to do that if they understand their baby's vulnerability and you are clear about what is essential. The principles can also support you when parents ask questions. In any situation, if a baby is sleeping face-up, care has been taken to ensure

that the baby's face stays clear throughout the sleep, and the baby is strong (i.e. smokefree, breastfed full term, normal birth weight) then risks have been minimised. The application of the fourth principle 'in own bed' will minimise the extra risk for more vulnerable babies.

- Face-up means *always flat on the back to sleep*, not propped or tipping forward, and never on the side or front. Unsafe positioning, remains a significant factor in SUDI deaths yet we have known 'back is best' for more than twenty-five years.
- Face clear means *a baby's face stays clear throughout their time of sleep*. When babies sleep in places not specifically designed for them there is more opportunity for risk and the 'face clear' principle needs extra consideration. Asphyxia is a significant factor in SUDI deaths. In particular, coroners are seeing unsafe swaddling and use of pillows. Safe swaddling means: wrapped in a light material, firmly but not tight, only if baby is on the back and only in the early weeks, before a baby attempts to turn. Pillows have no place anywhere near a sleeping baby, not as a mattress, or for propping or making barriers to prevent falls. Swaddling and propped on pillows is a potentially dangerous combination for a sleeping baby.
- Smokefree means a baby is *protected from all smoking*, both during pregnancy and after. For parents who smoke, becoming smokefree is essential protection for their baby and there are products and people to help.

How can I update myself?
There are pockets of people whose own knowledge, attitudes and practices relating to SUDI are not current. This is confusing for parents and may undermine the safety of a baby.

To support high levels of alignment to current thinking, we have designed the 'Baby Essentials' programme. You may want to become a Safe Sleep champion and take an education lead in your setting and networks. If so, an orientation hour with us on the phone will prepare you to facilitate education sessions for others. Simply call or email Sharon Bennett (03 3539263 or Sharon@changeforourchildren.co.nz)

You may prefer to update yourself in your own time and we have a certified option 'Baby Essentials Online' if this is the case, which can be found at the following link: http://www.changeforourchildren.co.nz/safe_start_programme/baby_essentials_online.

Summary
Change for our Children is committed to finding local solutions to issues of concern to humanity. The Safe Sleep blitz is an opportunity for us to collectively turn knowledge into action and end for good the preventable deaths of babies as they sleep. Thank you for taking the time to read this article. May it draw you into awareness of the national Safe Sleep blitz and your leadership role within it.

Atawhaitia ahau I roto moemoea
(from my earliest beginnings, pursue protection so that I may dream).

Stephanie Cowan
Change for our Children

3rd REPORT OF THE PERINATAL & MATERNAL MORTALITY REVIEW COMMITTEE (PMMRC)

The PMMRC is responsible for reviewing 'direct' maternal deaths and the deaths of infants born between 20 weeks gestation (or weighing at least 400g if gestation is unknown) and 28 days of age.

This is the third report of the PMMRC and the first full report that is based on 12 months of both perinatal and maternal data – for the year 2007.

Recommendations
The report contains a total of 29 recommendations – 14 are for the Ministry of Health and DHBs, and 11 for clinicians and Lead Maternity Carers (LMC). There are also four recommendations for future PMMRC reporting.

Perinatal mortality
In 2007 perinatal mortality was 9.8 per 1000 births. This rate is comparable to rates in both Australia and the UK although slightly different definitions are used in both those countries.

There was a total of 677 perinatal deaths in 2007 – 144 were terminations of pregnancy (mainly due to congenital abnormality), 366 were stillbirths, and 167 were neonatal deaths.

In New Zealand in 2007, stillbirth was unexplained in 32% of deaths from 24 weeks gestation and 41% of stillbirths at term. Only 31% of the 89 unexplained stillbirth of at least 24 weeks gestation had a post mortem.
In 2007 the report states that there were 10 neonatal deaths of healthy babies recorded that were associated with unsafe sleeping practices, including co-sleeping.

The report also referred to the fact that the perinatal related mortality rate among mothers living in Counties Manukau exceeded the national rate. While this is not a new finding it is one that is of considerable concern.

Maternal mortality
There were 14 maternal deaths in 2006 and 11 maternal deaths in 2007. Maternal related death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."

Direct maternal deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labour or the postpartum period); from interventions, omissions or incorrect treatment; or from a chain of events resulting from the above.

Indirect maternal deaths are those resulting from previous existing disease or disease that developed during pregnancy and was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy.

Coincidental deaths are those from unrelated causes which happen to occur in pregnancy or postpartum.

In 2007 there were 11 maternal deaths – five of these were direct maternal deaths, five were indirect deaths and one death was not able to be classified. Three other deaths were coincidental deaths due to road traffic accidents and malignancy. Neither of the two pregnant women who died as a result of a road accident was wearing a seatbelt.

One of the direct maternal deaths was a result of postpartum haemorrhage, one was a result of a pulmonary embolism, one was the result of peripartum cardiomyopathy, and two were the result of pre-eclampsia.

Eight of the 11 maternal deaths in 2007 were referred to the coroner for further investigation, and all had a post mortem. Five women had a body mass index greater than 30kg per square metre.

In 2006 there were 14 maternal deaths – six of these were direct maternal deaths, seven were indirect deaths, and one was not able to be classified.

Three of the direct maternal deaths were the result of amniotic fluid embolism, one was the result of post-partum haemorrhage, and two were the result of sepsis. Four of the indirect deaths were the result of suicide.

The PMMRC report can be accessed at: http://www.pmmrc.health.govt.nz/

This article first appeared in the Auckland Women's Health Council December 2009 newsletter.

Would you like to receive the quarterly newsletter electronically or by "regular" mail?

Or perhaps you are not on our newsletter mailing list and would like to be!

If you would like to receive an electronic or paper copy then please send an email to Jennie at mscc@maternity.org.nz and she will take you put onto either the electronic or paper newsletter mailing list! Please also note that our newsletters and many of our articles are also available in PDF format on our website: www.maternity.org.nz

Breastfeeding Advocates fight to keep new DVD free

In October the Ministry of Health produced an excellent DVD, *Breastfeeding Naturally*, that it made available free of charge to all pregnant women. Breastfeeding advocates around New Zealand welcomed the DVD and were uniform in their enthusiasm for this wonderful new resource.

Imagine their dismay when on Wednesday 25 November they discovered that a woman in Gisborne was advertising three of these free DVDs on Trademe for $20 each. An email was quickly dispatched to a number of breastfeeding advocates who began bombarding the seller with questions about why she was trying to sell a DVD that the MOH was providing free of charge. We also reported her to Trademe arguing that we felt the sale of these DVDs was unethical, fraudulent and totally inappropriate. The seller did not reply but she immediately dropped the price of the DVDs to $10 each.

The following day several of us received an email from Trademe saying that that we had been reported as trying to interfere with a legitimate sale. In response the following email was sent to Trademe:

"*I have attempted to bring to your attention a sale I believe to be any or all of the following unethical, immoral, fraudulent, and/or illegal. It is certainly inappropriate. And the implications of this sale are enormous and could affect the interests of the 64,000 women who give birth in NZ every year. It about the sale of the new Ministry of Health breastfeeding DVDs. Instead I get an email saying my asking the seller why she is selling free MOH DVDs, and advising her that I have contacted the Ministry of Health is inappropriate. It isn't inappropriate at all.*

If the Ministry of Health stops freely distributing these DVDs to pregnant women because people are trying to sell them then this hugely important initiative to improve the health and future well-being of both mothers and babies is threatened.

I am requesting that you do something about this. Sending me an inappropriate email rather than taking action is unacceptable to me. I have notified the Ministry of Health, and other women who work in this area have also contacted me about the ethics of this sale."

Trademe replied -

"*Thanks for contacting us.*
If we receive advice from the Ministry of Health to remove these DVDs then we will certainly comply with their request. Otherwise, I will pass this message to our site policing team for further review. If you have further questions regarding this issue please reply and we will answer your email as soon as possible."

On Thursday, in response to the emails that had been sent to them, the Ministry of Health phoned to say they were looking into the matter and were getting legal advice.

Meanwhile, the word about the sale of these DVDs was spreading rapidly – via Facebook as well as emails. Others were also contacting Trademe protesting about the sale. The number of people involved was increasing rapidly.

On Friday morning, a number of women received the following email from Trademe -

"*Thanks for reporting the listing for: BREASTFEEDING NATURALLY DVD.*

The Trade Me Customer Support Team have reviewed the listing and has deemed that it is in breach of our terms and conditions. As a result the listing has been removed from the site.

Thank you for bringing this listing to our attention and making Trade Me a better place to buy and sell."

Thanks to the efforts of an unknown number of breastfeeding advocates around the country an important public health measure has been protected from those who would seek to make a profit from a DVD that the Ministry of Health has made freely available to all pregnant women and their families.

BREASTFEEDING NATURALLY DVD

A wonderful new DVD produced by the Ministry of Health which is **freely** available to all pregnant women in New Zealand. Stocks are limited. If you would like to see the DVD, but do not require a hard copy, it can be viewed on www.youtube.com/breastfeedingnz or via the Ministry of Health website www.moh.govt.nz

You can also order a copy directly from:
http://www.healthed.govt.nz/resources/breastfeedingnaturally.aspx

UPCOMING CONFERENCES

Infant, Toddler & Preschooler Mental Health Conference

INTERNATIONAL EXPERTS WILL PRESENT THE LATEST IN RESEARCH AND CLINICAL PRACTICE ON:

Relationship Disorders, Premature Birth, Early Conduct Problems, Autistic Disorder

Date: 18 - 20th February 2010
Venue: University of Auckland, Auckland.

Speakers include:
- Edward Tronick, University of Massachusetts, USA.
- Ruth Feldman, Bar- Ilan University, Israel.
- Louise Newman, Monash University, Australia.
- Denise Guy, Child and Adolescent Psychiatrist, New Zealand

Further information and registration details are available at:
http://www.conferenceonline.co.nz/index.cfm?page=details_conference&pg=1&id=14156