



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

This is the second issue of the MSCC's Newsletter for 2012. Since we sent out the March newsletter we have produced a submission for *Inquiry into preventing child abuse and improving children's health outcomes*, visited the Mangere Refugee Resettlement Centre to discuss maternity care options in New Zealand with refugee community leaders, written to the Minister of Health about the antenatal HIV screening programme, attended the Ministry of Health maternity safety and quality workshops, written lots of grant applications, and mailed out thousands of our pamphlets.

Obtaining funding for our work

Over the past few years the MSCC has struggled to maintain sufficient funding during the months of May and June while waiting for the arrival of the results of our grant application to Lottery Community which arrives towards the end of June. This year has been no different, and despite the arrival of small amounts of funding from a couple of other funding agencies, the MSCC has had to borrow money to survive. Nicola has worked very hard to obtain funding for the organisation over the past five months, and the MSCC usually has four or five grants in the pipeline.

We were therefore extremely delighted to recently receive a wonderful donation from a midwife along with the cheque for \$10 for postage for her order of our pamphlets. It is hard to describe what this donation meant to Nicola and Lynda at that moment.

What's in this issue of the newsletter

The June issue of the newsletter contains a summary of the maternity consumer survey 2011 report, an article on the antenatal HIV screening programme, a report on paid parental leave, and an article on how a WikiLeaks email revealed the lengths the infant formula industry were prepared to go in order to protect the markets for infant formula in the Philippines.

Getting the MSCC Newsletter via email

The MSCC would like to encourage newsletter subscribers to switch to getting the newsletter via email rather than getting a copy in the mail. So please contact us at mscc@maternity.org.nz and we will add you to our email list.

Please note the dates for the MSCC's Steering Group meetings for the rest of the year. The MSCC's AGM will be held at Birthcare at the meeting scheduled for 17 July.

Lynda + Nicola

MATERNITY CONSUMER SURVEY 2011

In March the Ministry of Health released the results of its 2011 maternity consumer survey. The survey is the fourth to be undertaken. Previous surveys were done in 1999, 2002 and 2007. This latest survey used “a more consistent question format that can be used in future surveys and allow surveys to be compared over time.” (1)

However the major section of the report contains none of the comments and descriptions from women that enriched the previous reports eg the *Maternity Services Consumer Satisfaction Survey 2007*. (2) This has effectively silenced the voices of women who wanted to say more about their maternity experience, or did send in their comments. It also allows more control over the reporting of the results and the recommendations on where improvements in maternity services need to be made.

Bereaved women included

For the first time, the 2011 maternity survey also includes a separate survey of bereaved women who have lost a baby between 20 weeks of pregnancy and four weeks of age. It was the feedback from women about the importance of including women who have lost a baby in the survey that resulted in their being able to take part in the latest survey. This section of the report on Maternity Consumer Survey 2011 does include comments from women about their experience and is much richer for it.

The survey was carried out on the 8593 women who gave birth in July or August 2010 and measures the women’s satisfaction with the care they received during their pregnancy, during the birth, in hospital after the birth, and to six weeks after the birth.

A total of 3235 women completed the survey, representing a 41% response rate. The response to each question was divided into five categories – very satisfied, quite satisfied, neither satisfied nor dissatisfied, quite dissatisfied and very dissatisfied. Throughout the report women’s satisfaction or dissatisfaction is referred to, being a combination of “very satisfied” and “quite satisfied,” and very and quite dissatisfied.

Three-quarters of the women who gave birth in July and August 2010 were under the age of 35. Nearly two thirds were European, and two in ten were Maori.

The majority of women involved in this research (86%) gave birth in the maternity unit of a general hospital; 8% gave birth in a small maternity hospital, and 4% gave birth at home.



The most births occurred in the Counties Manukau DHB (13%), followed by Waitemata DHB (11%), Canterbury DHB (10%), and Auckland and Waikato DHBs each with 9%.

The areas of maternity care that were included in the questionnaire were:

- the quality of information readily available,
- the quality of antenatal classes,
- the care received from all health professionals before the birth,
- the way in which they were cared for during the birth,
- the care they received during their hospital stay after the birth,
- the care received at home following the birth,
- the overall care received from the LMC.

Women were also asked to rate their satisfaction with the overall maternity care they received.

LMC care rated highest

The report states that the overall care from lead maternity carers (LMCs) showed the highest level of satisfaction (89% “very satisfied” or “quite satisfied”), with the quality of antenatal classes receiving the lowest rating of satisfaction. Women with disabilities were less satisfied across all areas of care, with the exception of antenatal classes.

The report states that the care received during the hospital stays following birth has been identified as a priority area for improvement. Satisfaction with this area of care was comparatively lower than other aspects of care. Staffing issues, such as getting enough care from hospital ward staff and the availability of expertise, contributed more to the lower levels of satisfaction than the quality of care received.

Care during birth

The care received during the actual birth of the baby had the most impact on women’s satisfaction with the care they received during labour and birth.

Around two-thirds of women were very satisfied with the way in they were cared for during the birth. For women who had a planned home birth, 90% were very satisfied with the care they received during the birth.

Postnatal care

The majority of women surveyed remained in hospital for at least 24 hours after the birth; 52% remained in hospital for more than 48 hours. For first-time mothers, 62% remained in hospital for more than 48 hours.

The majority of women (81%) felt ready to leave hospital when they were discharged. However, around 20% of women left before they felt ready, mostly



those for whom it was their first birth, women with disabilities, and women from Hutt Valley DHB.

Reports from bereaved women

Sands New Zealand, a parent-run group that provides support and information to families who have experienced the death of a baby, was involved in all stages of the development and piloting of this part of the 2011 maternity survey.

A total of 91 women participated in the survey, representing 6% of the 557 women who had experienced a perinatal death and were invited to participate. Two-thirds were satisfied with the overall standard of care they had received during and following the death of their baby; only 42% were “very satisfied.”

However, 14% of mothers were dissatisfied with the overall standard of care they received during and immediately following the death of their baby. Improvements needed include the need to ensure that the birthing location or surroundings are suitable and appropriate for a mother whose baby has died. Women want a clear explanation of why their baby died, and to have a single point of contact to provide practical information and advice. Early involvement of a support person, such as someone from Sands NZ and access to counselling services is also very important.

References

1. www.health.govt.nz/publication/maternity-consumer-survey-2011
2. <http://www.health.govt.nz/publication/maternity-services-consumer-satisfaction-survey-2007>

MSCC Meeting Dates for 2012

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 at 10am on Tuesday mornings – and the days have been fitted around school holidays.

The Steering Group meetings are currently being held at Birthcare in Parnell. The meeting dates for the last six months of 2012 are:

17 July, 14 August, 11 September, 16 October, 13 November, 11 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.



SCREENING FOR HIV DURING PREGNANCY

The Otago University AIDS Epidemiology Group's HIV/AIDS report for 2011 was published on their website earlier this year. (1) Despite the fact that the offer of an HIV test is now part of the routine care provided to women during pregnancy, the report does not include any information on how many women were identified as being HIV+ as a result of the antenatal HIV screening programme.

Official Information Act request

So an Official Information Act request to the AIDS Epidemiology Group was emailed off asking for the numbers and ethnicity of women identified as being HIV+ during pregnancy in 2011. The same request last year and the year before resulted in a reply saying there were three women identified as being HIV+ as a result of being screened during pregnancy.

In 2009 two of the three women diagnosed as a result of antenatal screening were African and one was Maori.

In 2010 one of the three women was European, one was Asian and one was "other" which usually means African. Two of the women lived in the North Island and one in the South Island.

One woman

There was only one woman diagnosed as HIV+ during her pregnancy in 2011. She was identified as "other" and was from the North Island.

The costs of this screening programme

This raises the issue of the cost of a screening programme that is only resulting in the identification of one or two women. To provide further context for this result, it has been estimated that an HIV+ woman has a 25% chance of passing the virus to her baby during pregnancy. So it is quite possible that none of the women identified as being HIV+ over the past 2 – 3 years would have given birth to a baby with HIV.

Aside from the millions being spent on the National Antenatal HIV Screening programme, there are also concerns around the adverse impact on some of the women of being screened for HIV, as well as the lack of informed consent for an HIV test.

Antenatal HIV screening has now become a routine part of the first blood tests that are taken – usually during the first trimester – throughout New Zealand.

Lack of informed consent

Reports from childbirth educators in the Auckland reveal that many pregnant women are unaware that they have been tested for HIV, something women's health groups have been concerned about since the programme was first



proposed. During the roll out of the HIV screening programme there was an emphasis on the need to gain informed consent, not only for an HIV test, but for all the tests included in that first blood test. However, it now appears that the status quo has reasserted itself and in many instances women are sent off for their first blood test not knowing that the HIV test box has been ticked.

The legal requirement to gain informed consent before screening people or 'encouraging' them to take part in other public health initiatives such as vaccination programmes is a vexed issue that still needs to be addressed. To date neither the Ministry of Health nor the office of the Health and Disability Commissioner has been prepared to take any significant action about the practice of ignoring rights 6 and 7 of the Code of Consumers' Rights.

Non-negative results

The other issue of concern is the fact that some women will be screened for HIV and receive what is referred to as a non-negative result. A non-negative result is one in which there was a low level of reactivity to the test which a subsequent blood test will usually provide a negative test result.

Although the percentage of women receiving a non-negative result is much lower than anticipated, the impact of being told that the test for HIV was not negative, and another blood sample is needed in order to do another HIV test is considerable. Women are likely to experience a range of extremely distressing emotions and may not absorb the reassuring information that the second test is highly likely to result in a clear result that shows she does not have HIV.

When screening programmes are introduced the most important maxim is the requirement to first do no harm. Screening programmes are undertaken on well populations and have a significant responsibility to ensure that screening does not do more harm than good. Careful monitoring is therefore needed to ascertain that the benefits of screening far outweigh any possible negative impacts.

When a screening programme only offers a potential benefit to one person it is hard to justify the considerable resources being spent on it, especially when it appears to be doing more harm than good. The MSCC wrote to the Minister of Health, questioning the wisdom of continuing with this particular screening programme, but received an unsatisfactory response that failed to address the issues regarding the harm the programme is doing.

Reference

1. http://dnmeds.otago.ac.nz/departments/psm/research/aids/pdf/69_AIDS-NZ_March_2012.pdf



PAID PARENTAL LEAVE

The issue of the need to increase New Zealand's woefully inadequate provisions for paid parental leave has been thrust back into the spotlight with the drawing from the members' ballot of Labour MP Sue Moroney's bill on extending paid parental leave. The Parental Leave and Employment Protection (Six Months' Paid Leave) Amendment Bill was introduced to Parliament at the beginning of April, but before any discussions could begin Finance Minister Bill English announced that National would veto the bill.

National's position in 2007

In 2007 the Families Commission proposed a three-stage increase from the current 14 week's leave to six months, then nine months and finally a year by 2015. The National Party was occupying the opposition benches then and while it had voted against the introduction of paid parental leave when it was introduced in 2002, National's spokesperson on labour, Kate Wilkinson explained that National had opposed it because it did not include self-employed people and casual workers. As the scheme was extended to include self-employed and casual workers in 2006 (and the National Party did indeed support this move), National was now inclined to support the proposal to increase both the period of leave and the rates of pay, Ms Wilkinson said.

Judith Collins, National's spokes-person on family affairs, said she was also supportive of the need for an increase in paid parental leave and was quoted as saying "As a working woman myself, I could seriously have done with paid parental leave when I had a little child." (1)

Although National's current position was unknown when Sue Moroney's bill was introduced to Parliament, it was expected that it would have the support of other opposition parties, including the Maori Party, the Greens, and United Future leader Peter Dunne.

As New Zealand First leader Winston Peters pointed out, no-one had any accurate analysis of the cost. "The Government keeps crying poor and cutting social services yet it can pour billions into failed finance companies for its mates so perhaps a compromise can be reached," he said.

Bill English is claiming that the current cost of paid parental leave is \$150 million and the proposed extension would cost a further \$150 million a year. However, as the NZ Education Institute has pointed out his estimate does not factor in the resulting reduction in subsidies to early childhood education services. (2)

It also does not take into account the financial, social, physical and emotional benefits that extending paid parental leave would give babies, children, and their families, and the flow-on positive effects to the community.

The benefits of attachment

Parents need time at home to form strong, healthy, loving bonds with their babies, and to adjust to the major changes in their own relationship that occur when a baby arrives. When this does not happen the costs to society are considerable.



Both the World Health Organisation and the Ministry of Health recommend exclusive breastfeeding for the first six months of a baby's life.

Such recommendations are based on research and studies that continue to show that six months of exclusive breastfeeding has proven health benefits, such as increased immunity to infectious diseases, lower rates of asthma, reduced incidence of hospitalisation, higher IQs, decreased risk of obesity, better dental health, etc. In itself this represents a considerable saving to our health system, with the other less tangible but just as important emotional and psychological benefits providing additional arguments for increasing paid parental leave.

Workforce needs

Over the past decades successive New Zealand governments have introduced policies and legislation that have placed the needs of the workforce over and above the needs of families with young children. This despite the increasing body of evidence that shows the first three years of a child's life is crucial in determining their future. The failure to form secure attachments during the first few years of life can have a negative impact on behaviour not only in later childhood but throughout life. The resulting costs to the health, education and justice sectors of children who have not had their needs met are well known and irrefutable.

The cost of the ambulance at the bottom of the cliff to societies that fail to support parents during the vulnerable early years of a child's life is demonstrated very clearly in our health statistics, in the challenges and failures faced by our education system, the rising levels of violence in the young in our society, and is a significant factor behind the production of Paula Bennett's *Green Paper on Vulnerable Children*. Many submissions on *The Green Paper* included the need to significantly increase the amount of paid parental leave as one of a raft of measures that need to be implemented to address the issue of child abuse.

While the costs of dealing with the harm resulting from the current environment are difficult to quantify and put an exact figure on, they would definitely make \$150 million look like a drop in the bucket. Prevention is much cheaper and kinder than our current half hearted and ineffectual attempts at dealing with the results of what government policies are doing to struggling families.

The task now is to somehow convince Bill English and John Key that the cost of not introducing six months of paid parental leave now, and increasing it to 12 months over the next few years, will far exceed the figures that the parties in Parliament are currently plucking out of thin air.

References

1. "Parties agree on parental break for a year." *NZ Herald*. 29 August 2007.
2. "Price tag of extended paid leave in dispute." *NZ Herald*. 13 April 2012.



BREASTFEEDING RATES PLUMMET IN EAST ASIA: WIKILEAKS CABLE REVEALS AGGRESSIVE LOBBYING BY USA ON BEHALF OF INFANT FORMULA INDUSTRY

On 1 May 2012 UNICEF, the United Nations Children's Fund, issued a press release lamenting the major declines in breastfeeding rates across East Asia, and called for greater attention to be paid to the critical importance of breastfeeding for children's survival and cognitive development, as well as economic development in the region.(1)

France Begin, UNICEF nutrition Advisor for East Asia and the Pacific, is quoted as saying "The falling rates of breastfeeding across East Asia are alarming. In Thailand as little as 5% of all mothers breastfeed while the rate is less than 20% in Vietnam. In China, only 28% of babies are breastfed."

UNICEF claims that the low breastfeeding rates are the result of both economic developments enabling more women to enter the workforce, as well as aggressive marketing of infant formula in the region. It is calling on infant formula companies to adhere to the International Code of Marketing of Breastmilk Substitutes, while encouraging the efforts of several countries in East Asia to adopt the Code of Marketing and enforce it through national legislation.

In India where all advertising for formula is prohibited, sales of infant formula remain low and breastfeeding rates are not declining.

In the Philippines breastfeeding rates had declined significantly since 1987 while sales of infant formula have increased dramatically. By 2007 only 16% of babies between 4 – 5 months are exclusively breastfed which is one of the lowest documented rates in the world. As 70% of Filipinos have inadequate access to clean water, the result is a public health disaster. The World Health Organisation estimates that around 16,000 Filipino children die as a result of "inappropriate feeding practices."

At the end of last year the release of more WikiLeaks cables, revealed how in 2005 the US embassy lobbied against a breastfeeding campaign in the Philippines and blocked revisions in the Philippines' Milk Code's implementing Rules and Regulations (IRRs). (2) The Milk Code and its IRRs regulate the advertising of milk formula for infants. They are based on International Labour Organization Maternity Protection Convention 183 and the International Code of Marketing of Breastmilk Substitutes, as well as the UNICEF's Global Strategy on Infant and Young Child Feeding.

WikiLeaks cable 05MANILA5839 referred to a meeting between the US embassy's economic counsellor and the Philippines Department of Health Undersecretary, Alex Padilla on 12 December 2005, held to convince the government to meet with the pharmaceutical companies before signing the revised Implementing Rules and Regulations of the Milk Code into law. At the meeting Padilla provided a copy of the latest draft IRRs, noting that several controversial provisions had already been removed. He pointed out that Philippines has a high mortality rate for children under 5 years of age and that diarrhoea is a significant cause of death for this group. Much to the annoyance of the US embassy staff he singled out infant formula as a major cause of diarrhoea.



Following this meeting, the pharmaceutical industry, through the Pharmaceutical and Healthcare Association of the Philippines (PHAP), continued to lobby the government regarding its objections to the revised IRRs through subsequent talks with Padilla, and sought a Supreme Court order that would restrain the Philippines' Department of Health from introducing the new IRRs.

The chief executive of the US Chamber of Commerce in Washington then wrote a letter to Philippines President Gloria Arroyo, objecting to the new rules which he claimed would have "unintended negative consequences for investors' confidence." The reputation of the Philippines "as a stable and viable destination for investment is at risk." Four days later, the Supreme Court reversed its earlier decision and imposed the restraining order that PHAP had requested.

The Department of Health then asked a senior government lawyer, Nestor Ballocillo, to contest the order. In December 2006 Ballocillo and his son were shot dead while walking from their home. Following the shooting, the Solicitor General said the killing may be linked to Ballocillo's advocacy for breastfeeding, although the murdered lawyer was also involved in other cases that challenged powerful vested interests. (3)

In February 2007 PHAP ran a series of advertisements expressing concern for women unable to breastfeed their children. These ads were described by the UN's special rapporteur, Jean Ziegler, as "misleading, deceptive and malicious in intent" in that they manipulated data with the sole purpose of protecting the interests of the infant formula industry and thus ignored the best interests of Filipino mothers and children. PHAP also filed a suit against the Department of Health secretary and all the undersecretaries and assistant secretaries who had signed the revised IRRs in 2006.

In 2007 the Supreme Court threw out sections 4 & 11 of the Milk Code's IRRs that had banned the advertising, promotion or sponsorship of infant formula, breastmilk substitutes, and other related products. It also declared null and void a section on administrative sanctions. (2) The effect of this ruling meant that the Philippines government was unable to prevent companies from breaking the international Code.

In an email sent out alerting breastfeeding advocates to the UNICEF press release, a breastfeeding advocate commented "*We should all be concerned about these major declines in breastfeeding as New Zealand is playing a big part in the marketing of infant formula in countries such as China and the Philippines mostly through Fonterra/Golden Fern products for example. A globally well respected nutritionist who has worked and lived in China calls the flooding of milk and milk products into China (which had one of the healthiest diets in the world) 'planned nutritional contamination'.*"

References

1. http://www.unicef.org/media/media_62337.html
2. www.abs-cbnnews.com/-depth/09/10/11/wikileaks-cable-us-lobbied-vs-breastfeeding-philippines
3. <http://www.babymilkaction.org/press/press14dec06.html>



CONFERENCES 2012

NZ College of Midwives 2012 National Conference

Conference Theme:

Midwives working with women: integrating community, home and hospital



Venue: The Michael Fowler Centre, Wellington on 24 – 26 August 2012.



PARENTS CENTRE NATIONAL PARENTING FORUM

Parents Centre NZ is holding a National Parenting Forum for Parents Centre members and childbirth educators in Wellington on 15 – 16 September 2012.

Venue: Te Papa, Wellington.

Further information is available at:

www.parentscentre.org.nz/National_Parenting_Forum_Programme.asp

